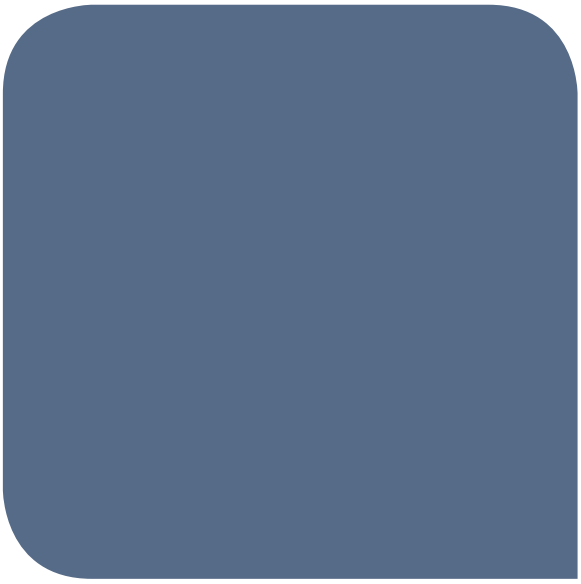
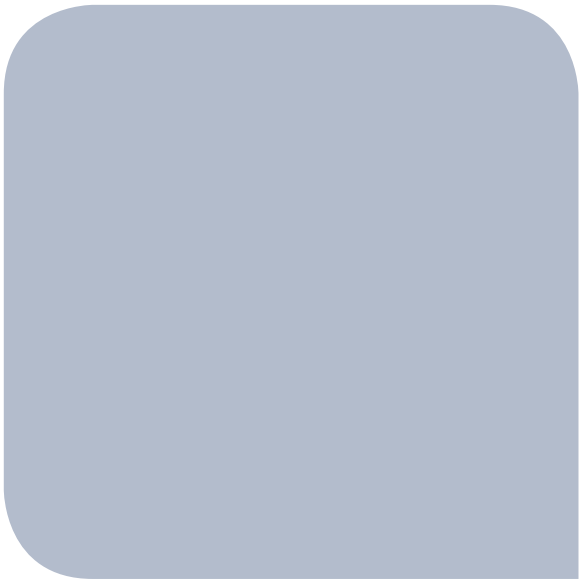
Developing social care: the past, the present and the future





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Developing social care: the past, the present and the future

Gerald Wistow

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	Summary of key points	**iv**
	Introduction: aims and background	**vi**
	The policy context	vi
	An overview of the project	vii
	The purpose and structure of the report	viii
1	**Consulting with stakeholders**	**1**
	Consulting with service users	1
	Consultations with focus groups	3
	Responses to the Minister's thinking	5
2	**Literature review: the current position of social care**	7
	From institutional to community care	7
	Supporting independence and promoting choice	8
	Diversity of provision	8
	Matching needs and priorities to services	8
	Inter-agency working	9
	Management	9
	Human resources	9
	Developments in funding and expenditure flows	9
3	**Literature review: values and principles of social care**	10
	The debate about children and families	10
	The debate about adults	11
	The 'social model', human rights and inclusion	11
4	**The social care vision and its context**	**13**
	Principles of public sector reform	13
	Local government reform and sustainable communities	14
	Adult social care and the reform framework	15
	Social care and the NHS	16
	Adult social care and the vision for disabled people	17
	The vision for mental health	17
	The vision for people with learning disabilities	18
	Inclusion, independence and older people	19
	The vision for children and young people	20
	Towards a vision for adults	20
5	**Strategy and delivery**	**22**
	Service development strategies	22
	Supporting strategies	26
	Delivering the vision	29
	Conclusion	**31**
	References	**32**

Summary of key points

This report brings together key themes and findings from the first stage of SCIE's *Looking to the future* project on developing social care for adults, children and families. It concentrates especially on the emerging vision for adult social care. It will contribute to the consultation on the Green Paper, *Independence, well-being and choice: our vision for the future of social care for adults in England*, and to changes to service focus and delivery that may arise from the Green Paper.[1]

Developing social care: The past, the present and the future draws on a wide range of evidence from literature reviews, surveys and focus groups. It reflects perspectives on current and future challenges at all levels in personal social services.

Much has been achieved since the last major legislative changes in adult social care following the NHS and Community Care Act 1990. Real shifts have taken place in the balance between home, residential and hospital care. With those shifts have come more choices and opportunities for more independent lifestyles.

Although our sources of evidence all emphasise that shortcomings remain – especially in terms of personalised care, social inclusion, early intervention and user control – the prospects for the next stage of change seem promising. There appears to be a broadly based consensus about what people want from adult social care. Moreover, the values and principles underlying that vision are consistent with the wider government strategy for public service reform and the vision outlined in the Green Paper on adult social care. Now the vision has to be put into practice.

This paper aims to contribute to that vision and highlight some of the implications of delivering the vision. The key themes and findings are summarised below.

Putting people at the centre of social care

- Adult social care services should be designed to improve outcomes for everyone who uses them, prioritising service users' views about quality of life.
- Significant shifts of power and influence to service users, to their carers and to community interests will need to take place, with active support from local infrastructures for capacity building.
- The new vision implies a shift in emphasis from 'choice and independence' for some service users and carers towards 'control and interdependence' as an expression of what most citizens expect in everyday living. In practice, therefore, the vision is shifting from values that are essentially individualistic and consumer-based to values that are founded more in collectivism and citizenship.
- A focus on inclusion and well-being will offer and engender greater control over opportunities for independent living.

Achieving a better balance

- Adult social care has become increasingly focused on social services for people with high-intensity needs, at the expense of preventing exclusion and promoting well-

being. Explicit choices now need to be made about the best balance between these two approaches. Re-balancing the system will require good financial management.

- Individual and community capacity will be strengthened through combining:
  - > personal care for individuals with support for them to live full lives in sustainable communities
  - > preventative work with remedial work.
- A strategy for promoting the well-being of the many as well as the few would have the following components:
  - > a focus on community and citizens, based on empowerment, engagement, social inclusion and safe environments
  - > low-level support, reducing the need for specialist services, maintaining independence, minimising the impact of mental or physical disability
  - > strategies for active rehabilitation and/or intensive support in locations of choice.
- Stronger communities are both the source and outcome of improvements in well-being based on more opportunities for independent living.

Connecting services and integrating local governance

- The integration of outcomes-driven service commissioning at strategic level should be matched by connected service delivery and unified budgets at neighbourhood level.
- Strong seams need to be constructed between services, so that service users and carers experience services as being joined up by the right people at the right place and right time.
- Realising the new vision for adult social care – no less than for children and families – is central to local authorities' community leadership role in terms of promoting citizenship, integrating mainstream commissioning and demonstrating shared accountabilities.

Making it happen and making it stick

- Developing the new vision is only the first step. The forthcoming White Paper will need to contain a full range of strategies for putting it into practice.
- Converting the vision into lasting reality requires a dual approach which can be summarised as 'making it happen and making it stick' – using change-management programmes to support the transition to new ways of working and then embedding these new approaches in the social care system's culture and practice.

The next stage of this project will contribute to that process by clarifying how effective change can best be supported and how current gaps in the new framework can be filled.

Introduction: aims and background

The Social Care Institute for Excellence (SCIE) established its *Looking to the future* project in January 2004 to examine the present and future role of social care in England, Wales and Northern Ireland. For the project, the term 'social care' was defined as encompassing:

- social work and care management
- all the responsibilities of local social services authorities for commissioning services, service provision and direct payments in relation to children, adults, families and other carers
- the management roles underpinning those responsibilities
- service provision in the private and voluntary sectors.

Unlike some public services, social care is characterised both by an extensive range of charges and number of self-payers. Some 30 per cent of those using social care services meet the costs of their own care. In what follows, it is assumed that the underlying values and principles of social care would apply to all those purchasing and providing elements of adult social care which are regulated by the state.

The project was led by SCIE in partnership with stakeholders in England, Wales and Northern Ireland. Despite some significant differences, all three administrations wanted similar outcomes. Key issues included:

- the departure, in England, from unified social services departments and the fear that organisational changes might dilute the contribution of social care to the well-being of individuals and the wider community
- the more explicit policy definition of outcomes for children and families than for adult groups and the need for the values and principles of social care as a whole to be better defined and understood
- the emergence in adult social care of greater emphases on interdependence, control, rights and stronger communities
- the need to locate social care within the wider context of public health and well-being, neighbourhood renewal and the creation of social capital
- the importance of increasing public confidence in social care and the quality of its workforce.

The policy context

In autumn 2003, the Green Paper *Every child matters* (Department for Education and Skills, 2003) set out a vision and direction for children's services.[2] The Community Minister, Dr Stephen Ladyman, planned to release a parallel Green Paper about adults in summer 2004.

The Minister's initial thinking was based on the government's wider principles for public service reform. He proposed that adult social care should be:

- person-centred – tailored to individuals' circumstances and enabling them to fulfil their potential
- proactive – intervening in time to prevent problems and help maintain independence
- seamless – working with partners to eliminate gaps and improve access.

While SCIE's *Looking to the future* initiative pre-dated the Department of Health's announcements about establishing a new vision for adult social care, it became clear that there were advantages in aligning some aspects of the exercises. As a result, less attention has been given to services for children and families and to the positions in Northern Ireland and Wales. But it seemed preferable to influence government thinking as the Department of Health initiative unfolded rather than after the event.

The Department of Health asked SCIE to administer, analyse and report on a survey of responses to the Minister's speeches. The survey was jointly designed by departmental officials and SCIE. In addition, SCIE organised a programme of focus groups to secure views on the Minister's initial thinking on the development of adult social care. (See Chapter 1.)

The Minister decided not to issue a further statement in summer 2004. Instead, he published SCIE's initial survey report and asked SCIE to continue the consultation on its website. He wanted to "maximise the contribution that older and disabled people can make to the next vital stage" of policy and asked SCIE to organise a series of consultations with service users.

Dr Ladyman praised respondents who had put social care 'in a wider context' by highlighting the need for social care to be connected to mainstream services like housing, education, leisure, employment and public health, as well as community resources. He also stressed the links between his vision and Deputy Prime Minister John Prescott's wider vision for local governance: "adult social care has to move on and be a significant mover and shaker in building sustainable, caring and healthy communities ... although I am calling my vision 'a vision for social care', I actually want it to be rooted in a much wider context".

An overview of the project

In addition to the survey of responses to speeches and the focus groups, SCIE's *Looking to the future* project included two literature surveys. One, *Developing social care: The current position*,[5] was carried out by the Personal Social Services Research Unit (PSSRU) at the London School of Economics and Political Science and focused on trends in service development (see Chapter 2). The other, *Developing social care: Values and principles*,[9] covered the values, principles and models of social care and was produced by Synergy Research and Consulting (see Chapter 3). The completed documents were shared with the Department of Health and corresponding organisations in the rest of the United Kingdom.

Many individuals have contributed to this project. The research teams and focus group facilitators, identified above, all worked to tight deadlines. We are grateful for their thoroughness and commitment. Sara Lewis and Catherine Leonard supplied much needed project management skills and ensured that the focus group work was well structured and effectively implemented. Jane Simmons and Richard Wistow provided invaluable assistance in the preparation and analysis of the questionnaire data. Our reference group helped provide the initial focus for the work and made very helpful suggestions about an earlier draft of the report. Amanda Edwards also made many useful comments its various drafts. Finally, Don Brand was a much valued source of support and encouragement to the author throughout the project.

The purpose and structure of the report

This report focuses on adult social care in England against the background of the Minister's proposals for the development of adult social care, which have been published in a Green Paper called *Independence, well-being and choice: our vision for the future of social care for adults in England*.[1] Subsequent SCIE reports will focus on social care in Wales and Northern Ireland, together with opportunities for learning across the United Kingdom.

However, this report does not entirely neglect services for children and families, arguing that the five outcomes in *Every child matters* are relevant to adult social care. In addition, transitions from children's to adults' services are common, and families may be users of both services.

Moreover, all service users have a shared interest in developing healthy and sustainable communities which promote and protect the well-being of local residents. All these interdependencies demand that adults' and children's services be managed within a common framework of integrated local governance.

This report also aims to contribute to the debate about the Green Paper *Independence, well-being and choice* within the context of the wider agenda for public service reform and community governance. Its starting point is the perspective of service users, their carers and other supporters, which lies at the heart of all SCIE's work and is also central to the principles of public service reform.

The report describes the findings of the consultations and the two literature reviews, goes on to look at the wider background of public service reform and, finally, discusses both the vision for adult social care and specific strategies for service development and delivery.

1 Consulting with stakeholders

Following the announcement of the Department of Health's intention to publish a vision for adult social care, consultations for this project focused on responding to the initial thinking of the Community Minister, Stephen Ladyman (see the Introduction for more about the policy background). SCIE also agreed to conduct and publish an analysis of responses to a brief postal/e-mail survey of views about the Minister's speeches on the subject. The results of these consultations are summarised below. Each was conducted and analysed for SCIE, independently of the Department of Health.

Consulting with service users

Shaping Our Lives, an independent user-controlled organisation, consulted service users through 13 discussion groups across England on behalf of SCIE. The meetings were largely organised by independent user-controlled organisations and were mostly facilitated by social care service users. In total, 112 service users took part.

Shaping our Lives published the consultations in a report called *Developing social care: Service users vision for adult support*.[3] As the report points out service user organisations have been working for at least a quarter of a century on developing a new vision for social care based on direct experience and personal knowledge. Consequently, the report emphasises, of the key new directions that social care has taken in recent years, "almost all, if not all", seem to have originated with service users.

Building user involvement

User involvement still faces many problems, the report argues, including tokenism and a focus on passive feedback rather than continuing dialogue.

Two key routes to more effective user involvement were identified:

- adequate funding and support of local user-controlled organisations
- opportunities for involvement to extend beyond existing social care practice and provision through a "participatory process of social care development".

Social care today

Service users generally highlighted more problems than positive features in current services. Some groups strongly felt that provision had deteriorated. There was also much comment about the variability of services between councils.

More specific problems raised included:

- the struggle to secure support
- inadequate levels of support
- excessive levels of paperwork and bureaucracy
- the unreliability and inflexibility of services and care workers

- poor-quality staff
- departmentalism
- lack of continuity in care
- the "demeaning and disempowering" ways in which participants are sometimes treated.

While identifying aspects of good practice in existing services, participants suggested that too many demands are placed on care workers. Workers become overburdened, stressed and liable to burnout, all of which affect the quality and continuity of care. A significant number of participants felt that staffing problems would remain as long as workers had low pay and low status. Any real change would need to be properly resourced.

Re-valuing social care

Many of the concerns of the people consulted suggested that social care and its employees, as well as service users, need to be re-valued. Participants felt that social care is still the "poor relation to the NHS". It has disproportionately fewer resources, lower status, poorer employment conditions and lower priority. It was also felt that the design of services and the practice of care workers should focus on improving the self-image of service users.

Social care as well as personal care

A distinction between 'personal' care and 'social' care underpinned many responses. The former was characterised as basic support; the latter as enabling people to play a full part in society. One service user defined social care as being about "providing a level playing field with those around you, to give you opportunities for interaction".

A more integrated approach should encompass education, housing, training, leisure and transport. Better access to such 'mainstream' services was seen as important in its own right, as a means of helping people to live fuller lives in local communities.

Views about health services were more ambivalent. On the one hand, community services were identified as supports for independent living. On the other hand, health workers were felt to have less understanding than social workers of service users' needs and user involvement. Health and social care integration was resulting in a return to a medical model at the expense of the social model of disability.

Independent living and rights

Independent living was identified as the essence of the social model and defined in terms of "ensuring the support needed to make it possible for people to live their lives to the full alongside others". The independent living movement was developed by disabled people, but other groups of service users spoke in similar terms.

Service users talked much less about 'needs' than about 'rights'. They said that they should be treated not only as individuals but as individuals with rights and entitlements. But they reported that, in practice, they lacked self-confidence and felt

guilty about asking for services. As one person said, "A culture of dependency and gratitude is everywhere".

Direct payments

Service users "were almost invariably positive" in their comments about direct payments – if they had been able to access them. One person commented, "It has given me my life back". Others said it had boosted their self-esteem, ended their feelings of isolation and secured a better standard of care.

Other participants, however, reported continuing difficulties in accessing direct payments and in finding sufficiently well-trained staff.

Listening to service users

The report concludes that "if one word sums up what service users want from social care, it is listening". Almost all the groups highlighted this issue and several identified it as making a difference between positive and negative experiences of social care. They felt that what they termed 'active listening' or 'listening and understanding' was lacking at all levels, from local frontline staff to national politicians.

Service users' vision for social care

In *Developing social care: Service users' vision for adult support*, Shaping Our Lives reports that service users have "strong, well thought-out ideas" about the future of social care, which should:

- involve greater support from wider society rather than over-reliance on families and friends
- transcend disability and include education, training and support: "[people's] aspirations are greater than services"
- provide help in an understanding manner
- enable people to lead more fulfilling lives and to be independent
- give people choice and control, helping them to lead their lives in the way that they choose.

Consultations with focus groups

The Kings' Fund was commissioned to facilitate a series of focus groups with a broad geographical and organisational spread. There were 365 participants in all.

The facilitators identified a number of key themes.

The role of social care

A central concern of the focus groups was to increase focus on prevention and social well-being in general, rather than crisis intervention and remedial work with individuals who meet formal eligibility criteria. Parallels were drawn with the increased emphasis on public health in the NHS.

The role of community

It was emphasised that individuals see themselves as belonging to different kinds of community, defined by geography, employment, interest, belief, ethnicity and kinship, for example. Focus group participants said that community capacity building improved social well-being by increasing opportunities for giving and receiving in each type of community.

They also argued that a community approach promotes social well-being by focusing on generic risk factors such as those associated with safety, transport, employment, education, leisure and isolation. Participation in such everyday activities strengthened citizenship and delayed or removed the need for individually targeted services.

The role of informal care

People enter the formal care system when informal care fails, but a tendency was identified for formal care to substitute for informal care and for insufficient attention to be directed at preventing breakdowns in informal care. Community capacity building must therefore, participants argued, embrace the recognition, protection, development and support of families and other sources of informal care, including volunteering.

Participants raised concerns about the need to improve employment rights, pensions and other benefits, leave entitlements, training and other support for informal carers.

Choice and the management of risk

Participants argued that society has increasingly expected risk to be taken and managed by professionals. However, the extension of choice and person-centred care was seen as implying some transfer of risk to individuals and their carers.

Participants questioned whether service users currently possess enough information to make informed decisions about the level of risk they face and are prepared to assume.

Integration and seamless services

The concept of a 'seamless service', as proposed by the Minister, was felt to be unhelpful and distinctions were drawn between the requirements for:

- users and carers to experience services as though they were seamless
- service commissioners and providers to integrate what would otherwise be separate services.

Among the barriers identified to improved joint working, the most substantial was the fundamental difference between universal and means-tested services. In addition, the health sector was considered insufficiently interested in social care because performance measures are not aligned.

Participants said that social care was nervous of repeating the experience of mental health services, in which integration was perceived as a take-over by the NHS, leading to the dominance of the medical model.

A further difficulty was the fear that pooled budgets would lead to a loss of financial control. Finally, it was felt that integration should be modelled by central government, especially to bring social inclusion and regeneration into the social care context.

Delivering service improvement

Participants had little enthusiasm for structural change, which was felt to be a distraction from service improvement and undermined by 'change fatigue'. Participants generally thought that better outcomes could be delivered within the current structure if systems and processes were improved, for example by streamlining the assessment process. In fact, there was considerable interest in extending the role of self-assessment, and participants thought that a case-management model like that being developed for long-term illnesses in the NHS might have some merit. However, they said it should be built on a social model rather than a medical model (the recovery model in mental health was offered as a prototype). They also said that too many people were being pushed into domiciliary care, without sufficient attention being given to their emotional and psychological needs for companionship, friendship and intimacy.

The voluntary and private sectors

Participants said that short-term funding was damaging to partnership working because it promoted short-term thinking rather than long-term relationships. People also felt that local authorities did not consult sufficiently with providers and that their commissioning capabilities were poor.

Inequalities of terms and conditions within and across sectors were a source of frustration, especially as barriers to staff recruitment and retention.

Responses to the Minister's thinking

As mentioned previously, SCIE assisted the Department of Health in obtaining responses to the Minister's vision for adult social care, by administering a brief questionnaire. In August 2004, SCIE produced a report, with a covering statement by the Minister, on the first set of responses.[4]

The survey covered seven main issues: three focused on overall direction and four dealt mainly with the conditions and support necessary for service delivery.

In total, 452 questionnaires were received. Over half (55 per cent) of those supplying information about their organisational role were frontline managers or operational staff (33 per cent and 22 per cent respectively). This was a very encouraging response from this section of the workforce. In comparison, only a fifth (21 per cent) reported that they were in senior management positions. In addition, a further 10 per cent were classified as service users and four per cent as informal carers.

The number of responses for users and carers was relatively small and almost all were received in the second round, after the Minister had asked SCIE to collect more opinions by re-opening the consultation on its website. Users' and carers' responses represented more than a fifth (23 per cent) of the second round of consultation. Further responses from user interests were from the voluntary sector, which also increased substantially in the second round (from 18 to 34 per cent).

Respondents to the consultation overwhelmingly agreed that change was needed and should be broadly along the lines suggested by the Minister:

- Eighty-two per cent agreed that some models of care can lead to increased dependency.
- Ninety-five per cent agreed that services should in future be person-centred, proactive and seamless.
- Fifty-three per cent agreed that adult social care had not got the balance right between 'positive intervention' and 'unnecessary interference' in people's lives.

Respondents also had a realistic appreciation of what was needed to implement the new vision:

- adequate and flexibly deployed resources
- cultural change
- learning and training to support early intervention and low-level support for person-centred care.

Overall, the survey results suggested that the Minister's objectives may be within reach. However, the question of resources was the supplementary point most frequently raised, so it seems that there are doubts about whether resources will match policy ambitions.

In addition, capacity and confidence building were seen as no less important for the workforce than for service users. Respondents stressed that education and training would be required to deliver the relevant skills and competencies in social care and mainstream services – the debate should focus as much on the tools for the job as on the grand design.

2 Literature review: the current position of social care

SCIE commissioned a literature review to draw together what was known about trends in, and relationships between, resources, needs and outcomes since the late 1980s. SCIE appointed the PSSRU of the London School of Economics and Political Science to conduct the study.

The findings of the report, *Developing social care: The current position*,[5] were summarised against the conclusions from the final overview report of the Joint Reviews Team (Social Services Inspectorate and Audit Commission, 2004).[6] The Joint Reviews Team had concluded that services had changed in five principal ways since the mid-1990s. Services had moved:

- from institutional forms of care to a wider range of community-based provision
- from administering care to supporting independence
- towards a greater diversity of service providers
- towards a more organised approach to matching needs and priorities to services
- towards better coordination across health, education and housing.

The report broadly confirms that the changes highlighted by the Joint Reviews Team have indeed taken place.

From institutional to community care

The report confirms that the balance of care has shifted significantly towards community-based systems for each of the five main groups of service users: children and families, older people, people with learning difficulties, people with physical disabilities and people with mental health problems. In the case of older people, for example, it argues that:

> Despite an ageing population, the number of older people accommodated in long-stay hospital settings is smaller today than it was in 1990 and recent years have seen a noticeable shift away from residential and nursing homes in favour of home care provision.[7]

They also cite Sheldon and Macdonald[8] to make the point that the social services community has not always recognised the scale of its achievements.

> The social care field is almost wilfully bad at celebrating its achievements. The policy of care in the community, a project on the stocks for thirty-odd years, was put in place – admittedly not without pain both to service users, carers and to staff, but nevertheless implemented in three to four years – is an amazing achievement.

The achievement is all the more striking, given the pessimism about whether local authorities successfully manage the transition from demand-led social security funding to their own capped budgets. But the price of success may have been too high in terms of the mismatch between professional values and social care markets.

There have, indeed, been many challenges associated with this shift in the balance of care, the report points out. These include:

- the need to overcome perverse financial incentives
- political commitment to higher costs in the short run
- developing more local models of care for people with high support needs
- minimising the risks of adverse events, while maximising opportunities for independence
- training the workforce to support people in more independent settings
- offering flexibility in community services to widen the choices open to individuals who need support.

Supporting independence and promoting choice

The promotion of choice is identified as a central plank of much current public policy. 'Choice' in this context includes user participation, independence and empowerment. But lack of service diversity (and sometimes a basic lack of services) can limit the choices available, the report says, and it remains unclear whether choice leads to improvements in service quality or to improvements in user outcomes. Attention to the use of direct payments may provide useful insights here.

Diversity of provision

There has been a growing diversity in services, the authors observe, along with an increased diversity of providers and a changing balance in provision between sectors, with many common trends across service areas.

Developments include intermediate care, supported employment schemes, person-centred planning, intensive care management, crisis teams, early intervention services, new forms of day activity settings, and housing with care.

Considerable attention is now being given to the financial fragility of many small providers, evidenced, for instance, by closures (and changes of ownership) of care homes for older people, with growing awareness of the vulnerability of social care markets to external forces.

Matching needs and priorities to services

Services appear to be becoming more responsive to individual needs, the report suggests, but progress has been slower in practice than in policy.

The explicit targeting of services on those with greatest need has been successful in the case of older people, but less widely achieved for other groups. And the impact of such targeting on people who cease to qualify for state-funded services is unclear and may undermine preventive activity (although there is growing attention to the need for preventive services).

Across service user groups, people from black and minority ethnic communities are reported to be less well served than people from the white majority.

A feature of policy discussion has been some rethinking of the concept of 'need', with more emphasis on the positives (promoting independence, choice and control) and less on the negatives (overcoming 'problems', compensating for deficits, reducing 'shortfalls').

Inter-agency working

Important new alliances have been created across agencies. Professional and organisational cultural barriers are still found to be widespread, however, and the new powers of budget flexibility are still rarely used. There are particular problems at points of transition or at times of crisis.

Management

The report comments favourably on improvements to management capacity and capability which have become evident since the 1990s. It particularly stresses improvements in financial management.

Similarly, its overall assessment of market management and commissioning is that improvements have been made, although real shortcomings remain. Social services' experience of working in 'external' markets is considerably greater than any of the other 'human services', including the NHS (as the stakeholder consultations also recognised).

Human resources

The recruitment and retention of social care staff have long been challenges, but the report identifies increasing attention to such issues in local authorities. However, the level of pay relative to responsibility – for instance for home care workers – is a persistent problem, and a number of unmet training needs remain.

Developments in funding and expenditure flows

Expenditure on social care has grown in real terms over the period of this review. However, the report notes that some of the growth is the result of the redirection of money, which previously reached services through social security channels, and some substitution for health service expenditure. It is difficult to know the overall scale of the funding change, because statistics are inadequate in the increasingly complicated mixed economy of social care.

Whether apparent recent rates of growth will be maintained is debateable. In the July 2004 spending review, it was announced that social services expenditure would be expected to rise by less than three per cent each year over three years, with most of the growth to be in 2005/06 and little in the subsequent two years. Local government efficiency savings of 2.5 per cent per year could mean almost no real increase in social care spending.

In conclusion, the PSSRU report presents a pattern of real improvements accompanied by continuing major gaps in services. Few users are able to manage their own care, and opportunities for independent living or rehabilitation vary across the country. As the authors note, there is no room for complacency. Equally, there is less cause for self-criticism than is sometimes evident.

3 Literature review: values and principles of social care

One of the starting points for the *Looking to the future* project was the perception that the move away from unified social services departments might dilute their influence within larger organisations dominated by the values of education or, potentially, medicine and nursing. As a result, there was concern that the unique contribution of social care might be lost.

A literature overview was therefore commissioned to clarify:

- the underlying values and principles of social care and how they relate to the developing agendas in local governance for community leadership, healthy communities, sustainability and social inclusion
- the essential characteristics of social models of care and support, together with the significance of the human rights framework for such models
- the characteristics and contributions of social care that should be retained within any new organisational arrangements.

SCIE commissioned Synergy Research Consultancy to carry out the review.

The debate about children and families

The Synergy report *Developing social care: Values and principles* suggests that, compared with debates about other client groups, debates about children and families have been characterised by more explicit discussions about values and ideology.[9] It was thought this might be because politicians had had to engage simultaneously with three agendas: the child/family/state relationship; the need for children to be protected (prompted by repeated 'scandals'); and concerns about the rights of children.

Until the Children Act 2004, the most recent primary legislation was the Children Act 1989, which enshrined a clear set of values including:

- the paramount nature of the interests of the child, particularly in court decisions
- the notion that the primary responsibility for the upbringing of children rests with parents
- the requirement that the state work in partnership with parents.

The Green Paper *Every child matters* laid out a new hierarchy of values within the government's overall framework for reducing social exclusion. The Synergy report argues that the public focus on the child protection agenda has tended to obscure the fact that the government has developed an explicit set of desirable outcomes for *all* children.

The Children Act 2004 gives agencies a duty to improve the well-being of children under five broad outcome categories. In addition, it emphasises early (voluntary) rather than later (compulsory) interventions to support families. Synergy notes some close parallels between this framework and ministerial thinking about the vision for adult social care.

The debate about adults

The White Paper *Caring for people* highlighted choice and independence as the key values underlying adult social care.[10] However, in reality, these values were secondary to those of expenditure control and cost-effectiveness.

The Synergy report identifies the key values regularly cited in stakeholder publications as independence, citizenship, empowerment, social inclusion and respect for diversity, together with care and protection for vulnerable adults, children, young people and the community.

Some aspects of key values have been prioritised to the exclusion of others, the Synergy report suggests. In the 1980s and 1990s, for example, citizenship came to be identified with the concept of the 'active citizen', with its emphasis on the social obligations of citizens rather than their rights. Similarly, social exclusion has become associated with the primacy of paid work, although a broader interpretation would link it to citizenship and human rights. Tensions between values are also identified, the most fundamental being those between 'caring' and 'control'.

The report suggests that key values in adult social care have originated in 'bottom-up' influences, citing, for example, the 'ordinary living' philosophy, the disability movement and carers' interests. But it concludes that, despite the fact that values tend to be seen as straightforward and their meaning taken for granted, there is considerable ambiguity both about their underlying definitions and about the extent to which they describe current practice or represent aspirations for the future.

The 'social model', human rights and inclusion

The Synergy report identifies the social model of disability as representing one of the key shifts in values. The social model argues that disadvantage comes not from any incapacity but from social processes that exclude people from the mainstream.

The report suggests that the social model, although originating in the disability movement, is relevant to all groups. Moreover, it questions whether changing working practices in social care would, in itself, be enough to bring about the desired outcomes, since the social model requires change in the way society as a whole is organised. Human rights, social inclusion and community capacity building are therefore identified as central elements in the future of social care.

The authors make the point that, in practice, the operation of the social model must be determined by the user. However, they also point out that user-controlled services need to be reconciled with resource control and, by implication, accountability.

The report argues that the UN Convention on the Rights of the Child 1989 and the Human Rights Act 1998 have had a greater influence on modern children's legislation and practice than on developments for adult groups. However, the human rights framework is fundamental to the social model of disability and underpins its relevance to all users of adult social care, with its focus on discrimination and denial of access.

The essence of the model, the report suggests, is to treat service users in the same way as other members of society. Disability, old age and mental illness are conditions likely to face most of us at some point. So academic and policy approaches that segregate adult service users from the rest of the population should be challenged.

Social inclusion and community capacity building are seen as further necessary elements of the social model. The report cites Demos as providing a valuable overview, identifying the key dimensions of inclusion as access to social goods, empowerment, and institutional trust.[11] These can best be achieved by developing the capacities of marginalised people.

This approach has been enshrined in the Local Government Act 2000, with its provisions for a power of well-being[12], which encompasses social, econmomic and environmental quality of life, and a community leadership role, which includes the preparation of comprehensive community plans through local strategic partnerships. But the Synergy report suggests that thinking about the role of social care in such arrangements is still at an early stage.

Finally, the authors note two common threads in the development of social care for adults and children:

- the idea that services should be configured around the needs of individuals within their own circumstances and environments
- the recognition that collaboration between voluntary and statutory sectors is necessary to ensure the seamless delivery of care when individuals have needs in addition to those met by social services.

4 The social care vision and its context

As the Synergy report makes clear, the debate about the future of adult social care is not taking place in isolation. It is a consequence of the separate policy decisions affecting children and families which have required a re-assessment of the 1968 Seebohm framework, which created unified social services departments as we know them today. Other local services, including housing, education, social security, criminal justice and the NHS, are also engaged in modernisation.

The new NHS commitments[13,14] to public health, primary care, the management of long-term conditions and the reduction of emergency admissions provide opportunities for new roles by social care and the wider local authority (see 'Social care and the NHS', page 16). Indeed, the community leadership role of the latter potentially brings all local services within a common strategic framework based on more equal local partnerships.

Two further elements of this macro policy framework are relevant here: the wider approach to public sector reform, and the more specific proposals for reforming local government.

Principles of public sector reform

The Prime Minister, Tony Blair, set out four principles of public service reform to underpin what he described as a long-term programme of modernisation designed to bring "opportunity and security for everyone".[15] These principles comprise:

- national standards for the things that matter most to people, to ensure that citizens have the right to high-quality services wherever they live
- devolution and delegation to the front line, giving local leaders responsibility and accountability and the opportunity to design services around the needs of local people
- flexibility for public organisations and staff to meet the aspirations of users
- more choice for service users.

The overall aim of this approach is frequently expressed as 'putting people at the centre of public services'.

The idea that public services should be 'personalised' is, as Leadbetter argues, a potentially powerful idea which could "reorganise the way we create public goods and deliver public services".[16] He characterises personalisation in the following terms: "by putting users at the heart of public services, enabling them to become participants in the design and delivery, services will become more effective by mobilising millions of people as co-producers of the public goods they value".

Personalisation is supported by the concept of 'public value', which argues that the key things citizens value fall into three categories: outcomes, services and trust.[17] This concept contrasts with previous approaches to public management, which tended to use a more limited range of performance measures primarily focusing on inputs and outputs.

From the public value perspective, therefore, Kelly and Muers suggest people will be more likely to support government interventions that:

- are focused on outcomes rather than activity levels
- provide fair access to, and choice of, services they value
- are delivered by staff and systems in which they have trust and confidence.

Local government reform and sustainable communities

The recent document *The future of local government*[18] emphasises that local government has a key role in one of the government's central priorities: the creation of 'sustainable communities' (see below). In addition, the document emphasises local government's unique ability to provide democratically accountable leadership. Local people can be involved in tailoring national services to local needs and priorities, finding innovative, joined-up solutions to local problems and coordinating the delivery of other locally provided services.

It also recognises that 'the empowerment of users to challenge performance is a potentially powerful driver for improvements in services.... This might include the right to demand an alternative model of provision when a service is not meeting expectations'.

In 2005, the Office of the Deputy Prime Minister published a five-year plan for sustainable communities based on 'people, places and prosperity'. It defines such communities as:

> places that offer people:
>
> - a decent home that they can afford
> - a community in which they want to live and work
> - the chance to develop their skills and interests
> - access to jobs and excellent services
> - the chance to get engaged in their community and to make a difference.[19]

The resonance between these objectives and the feedback from the SCIE consultations is immediate and powerful. So too are the ways in which the voices of SCIE respondents and the findings of the Social Exclusion Unit (SEU) reinforce each other.

The SEU has produced a number of literature reviews on the impact of government policy on different population groups. In addition, it has conducted studies of social exclusion in relation to mental health and ageing. For example, Phillipson and Scharf's literature review concludes the following about older people and community care:

- There has been much innovation since 1993, enabling more older people to express their views and remain in their own homes.
- However, this work should now be broadened, since it has focused on 'survival' needs rather than low-level support and bringing older people into mainstream life and activities.
- This broader approach required links with area-based initiatives for prevention (such as Health Action Zones), urban and rural regeneration, social participation

and empowerment at community and neighbourhood levels.
- Community care should be re-focused on social inclusion, including the capacity of communities to support and sustain independent/interdependent living.[20]

The report on social exclusion and mental health covers similar territory in terms of, for example:

- people receiving help before they reach crisis point
- people having genuine choice and a real say about what they do and the support they need to fulfil their potential
- health and social care working with employment and community services
- recognition of the fundamental importance of people's relationships, family and caring responsibilities, a decent home and participation in social and leisure activities.[21]

The SEU's work is significant for the current SCIE project precisely because it focuses on the excluded status of many who use adult social care and who experience prejudice and discrimination. Moreover, the promotion of social inclusion is seen as a form of low-level intervention in its own right. It helps enhance participation, extend choices about lifestyles and build the richer relationships necessary for better health and well-being (see, for example, Wilkinson on low social status and weak social networks as two of the three most important risk factors for health and well-being[22]).

Adult social care and the reform framework

Any new vision for adult social care must be compatible with wider reform. Just as the new vision for local government explicitly fits within that provided by the Prime Minister's four principles of public sector reform, so the vision for social care should fit within the wider local government framework.

There are no major theoretical obstacles to achieving this. The similarity between the principles of reform based on 'personalisation' (see 'Principles of public service reform' page 13) and the vision advanced by service users in the SCIE consultations is striking. Thus service users' vision for adult social care focused on:

- greater equity, responsiveness and flexibility in service delivery
- reducing discrimination and increasing social inclusion
- achieving outcomes defined by users
- securing relationships with care workers and services based on confidence and trust.

Moreover, as already highlighted, the advocacy of independent living by service users in the SCIE consultations had much in common with the concept of 'sustainable communities' in the documents from the Office of the Deputy Prime Minister. Both seek opportunities for all to live in communities that are worth living in; where individuals, and especially those in vulnerable and marginalised groups, are empowered to shape local services; and where social inclusion is promoted and communities enabled to lead themselves.

The views expressed in the other stakeholder consultations commissioned by SCIE harmonise both with those of service users and with the principles of public service reform. Participants endorsed community living and community capacity building together with self-management, better integration across services and sectors, performance measurement focused on outcomes and the promotion of social models. Like the service users, they were worried that the integration of health and social care might lead to the primacy of the medical model.

These findings suggest a broad-based consensus on the necessary direction of change. However, agreement at the level of well-meaning principle may not survive when it comes to devising practical programmes for change and still less their implementation, as stakeholder interests become increasingly threatened by the reality of service re-design. Moreover, the availability of appropriate skills and funding streams has yet to be addressed (an issue strongly highlighted by respondents to the SCIE survey).

Social care and the NHS

The emerging vision of social care demands increased choice and control for users of health services, as well as early interventions, low-level support and the promotion of well-being. Reducing discrimination is also a major issue from the social care perspective. There is evidence that adults and children with physical disabilities, mental health problems or learning disabilities all experience inequalities in the NHS, as do older people.

Fortunately, there are a number of positive NHS policy developments in this respect. Shifting the balance to public health and primary care is designed to promote health and well-being, prioritise early interventions and reduce health inequalities. The new targets to reduce emergency hospital admissions and to manage long-term conditions more effectively in the community potentially also fit well with the vision.

Moreover, the choice initiative places the individual more at the centre of health services, and the extension of local authority scrutiny arrangements to the NHS, together with rights for patients and the public to be involved in decision making, all potentially increase opportunities for citizen engagement.

Complementary policy objectives reflect greater coherence in central government's vision for local services, based on the four principles for public sector reform. This coherence can be overstated, however, as can its practical implications. Coherent objectives do not guarantee integrated delivery or integrated outcomes. Nonetheless, the potential for alliances is clear.

Adult social care and the vision for disabled people

The Prime Minister's Strategy Unit report on improving opportunities for disabled people says that "by 2025, disabled people in Britain should have full opportunities and choices to improve their quality of life and will be respected and included as equal members of society".[23]

The report contains both a strategy for realising that vision and a comprehensive package of measures for securing it. The centrepiece, it asserts, 'must be the promotion of independent living', defined as being about 'choice, empowerment and freedom' cutting 'across a number of different policy areas – social care, health care, housing, transport, education and beyond'.[24] Finally, it identifies a series of measures as the first steps to be taken to achieve its vision.

This report provides, therefore, a model for the vision of social care, as well as its strategy and implementation. However, the social care vision needs to cost its implementation more fully and give greater attention to the knowledge and skills development programmes required to put it into practice. Both of these issues were emphasised in the SCIE consultations, especially by respondents to the questionnaire.

The vision for mental health

There is no lack of information about what service users want in the field of mental health. Robbins' overview from inspections, *Treated as people*, makes the important point that "what service users want is not to be 'service users' at all. What *people* want is good mental health and effective support and treatment if and when they need it."[25] If they do need help, the report says, they want it to be immediate, appropriate and well coordinated, and they want choice between different kinds of treatment.

Similarly, Robbins suggests that people want to be "seen as whole people within families and communities, with plans and futures.... Non-stigmatising practical help, which supports people in getting their own lives back on the rails, was repeatedly mentioned in the responses to our questionnaires".[26]

The work of the SEU[27] in relation to mental health is referred to elsewhere (see 'Local government reform and sustainable communities', page 14). The SEU's building blocks for breaking the cycle of social exclusion are of major significance in delivering a more socially oriented model:

- inclusive communities
- early intervention
- empowerment and the right to individual choice
- a focus on employment
- promoting broader social participation
- securing entitlements
- acknowledging social networks and family relationships
- building confidence and trust.[28]

The SEU's emphasis on promoting independent living within non-stigmatised settings and relationships is given added significance by the recent publication of the five-year review of the National Service Framework (NSF) for mental health.[29] The NSF set out a 10-year programme of modernisation and investment for mental health services which included giving priority to tackling stigma and promoting social inclusion.

The five-year review by the mental health 'Tsar', Louis Appelby, suggests that services are becoming more responsive to the people who use them. He points out that modern

treatments are in widespread use and most service users report positive experiences of mental health care.

He also recommends that services should be aligned with the new direction for the NHS as a whole – towards patient choice and the care of long-term conditions. Moreover, the focus should be broadened out from specialist mental health services to the mental health of the community as a whole. Tackling social exclusion and inequalities of care are among the specific priority areas he identifies.

This broader approach is also important in the context of giving greater prominence to the social model of care, bearing in mind that a number of contributors to the SCIE consultations suggested that more integrated working was leading to more emphasis on the medical model.

The vision for people with learning disabilities

A modern vision for people with learning disabilities was set out in the 2001 White Paper, *Valuing people*[30]. It was based on four principles: civil rights, independence, choice and inclusion. It adopted a lifelong approach, beginning with integrated services for disabled children and their families and then providing new opportunities for a full adult life.

A recent Department of Health report on progress suggests that the strategy has, in many respects, been a success. Significantly, the Minister's foreword argues that the strategy had been "ground breaking in its insistence on putting people with learning disabilities and their families at the centre of the picture".[31] This policy can undoubtedly be seen as a 'pathfinder' for social care more widely.

The report identifies five areas in which progress has been made:

- listening to what people want
- person-centred planning
- more people living independently
- more people receiving direct payments
- better local cooperation.[32]

At the same time, however, the report recognises that more needs to be done. For instance, as Mencap has emphasised, people using learning disability services continue to have worse general health than the rest of the community.[33]

In addition, the Department of Health report warns of a wider problem in implementation. Although the White Paper was generally welcomed when it was published, "too many people in public services see 'Valuing people' as being 'optional' – something they can get away with not doing".[34] This suggests that, if similar principles are to be successfully applied across adult social care, attention needs to be given to incentives and accountability.

Inclusion, independence and older people

There is much evidence from older people about what independent living means for them. In contrast, perhaps, with some aspects of thinking within the disability movement, older people have seen independence as being "less about doing things for oneself and more about choice and control".[35] The same source also emphasises that older people point to "the reality of interdependence with others that characterises their lives and helps them to maintain their morale and self-esteem".[36]

This point is reinforced by a 2004 Women's Royal Voluntary Service press release about isolation among older people.[37] A National Opinion Poll survey for the WRVS found that 72 per cent of older people saw a maximum of two people per day compared with 20 per cent for most of their younger counterparts. Some saw no one for days or weeks. Twelve thousand older people were found to have died alone undiscovered each year, and 20 per cent of all suicides involved pensioners. The report concluded that older people were being robbed of their will to live by a lack of personal contact with friends and visitors.

A Demos publication further highlighted increased social isolation among older people.[38] The authors estimated that, with current trends, the number living in isolation would grow by a third to 2.2 million in 2021. They argued that social policy should help people to develop 'resilience' to the risks of loneliness through the encouragement of volunteering, membership of clubs and groups, and acquisition of new skills.

The work of the SEU, as already noted, similarly focuses on the importance of inclusion, emphasising the extent of isolation among older people and those with mental health problems.

These reports highlight the limitations of independence as a goal of policy. The concept of social inclusion, by definition, recognises that full and fulfilling lives are rooted in *interdependent* relationships. Although many older people may wish to remain in their own homes for as long as possible and to live alone rather than with others, almost none would choose to live in isolation. A lack of social contact and personal relationships can lead to a loss of confidence, the onset of depression and a downward spiral in morale and motivation.

Interdependent relationships, however, based on 'reciprocity rather than dependence', enable people to give as well as receive.[39] They counteract images of older people as frail and passive recipients of care and show that they can help improve their own well-being and that of others.

Interdependence is, however, only one of the factors older people have identified as making the difference between dependence and independence. The Audit Commission's 2004 review also includes good-quality housing, safe neighbourhoods and getting out and about, as well as having useful, enjoyable ways of contributing to neighbourhoods.[40] Adequate income and access to good information are prerequisites.

In addition, the Association of Directors of Social Services (ADSS)/Local Government Association (LGA) report *All our tomorrows*, recommends a shift towards a focus on

well-being and embracing the many as well as the few.[41] This approach depends crucially on an extension of universal services. Although the model was developed in the context of older people's services, it is of wider applicability, as a 2004 ADSS/LGA/NHS Confederation report points out.[42] It provides a basis for a comprehensive preventive strategy based on approaches which not only anticipate and delay costly, intensive interventions but also promote quality of life and community engagement.[43]

Thus, the promotion of healthy ageing and mental well-being, with a greater focus on low-level interventions, are at the heart of a re-balanced approach to social care.

The vision for children and young people

As suggested in the previous chapter, one of the starting points of the Department of Health, work on a vision for adult social care was the need to carry out a parallel exercise to that conducted through the Green Paper *Every child matters*.

Every child matters set out five desired outcomes for children and young people:

- Be healthy – children should enjoy good physical and mental health and live a healthy lifestyle.
- Stay safe – they should be protected from harm and neglect and grow up able to look after themselves.
- Enjoy and achieve – they should be getting the most out of life and developing skills for adulthood.
- Make a positive contribution – to the community and to society, without engaging in anti-social or offending behaviour.
- Achieve economic well-being.

These outcomes are significant, first in being the product of consultations with children and young people, and second in being advanced by government as outcomes for *all* children, not just those in need of care and protection. The universal nature of policy for children and young people is explicit in the new legislation and expressed through the integration of 'care and protection' with education services.

Towards a vision for adults

So could the universal approach be applied to adults? And could the overarching outcomes for children provide a similar framework for adult social care? In principle, the answer to both questions is yes, especially if supported by a statement of universal rights and responsibilities on the one hand, and a unifying philosophy on the other. Arguably, the 1998 Human Rights Act constitutes the starting point for the former, while the concepts of independent living, control and interdependence provide the framework for the latter.

In summary, therefore, this analysis of SCIE consultations and other data suggests that:

- The vision for adult social care should be shaped by principles relating to process as well as content.

- The process should:
  > start from and be rooted in outcomes for all those who directly use services
  > give priority to users' views about a good quality of life, and the extent to which they are being realised.
- The content should be:
  > founded on a statement of individual and collective rights and responsibilities based on citizenship, inclusion and non-discrimination
  > universal in coverage, while recognising individual differences through appropriate support and assistance
  > expressed through a unifying statement of values and principles which maximise opportunities for independent living through control and interdependence
  > holistic in terms of social, physical and emotional outcomes
  > reviewed and assessed through the five outcome domains identified for children, modified as appropriate.
- Finally, the vision should be expressed in terms consistent with the principles of public service reform, not least in order to secure political ownership and implementation support.

5 Strategy and delivery

While experience inevitably varies across the country, the evidence from this project suggests that adult social care has achieved much since the 1990s, both in the development of a new vision and in its implementation. The major service development trends have been usefully summarised in the PSSRU report *Developing social care: The current position* (see Chapter 2); the reversal of the seemingly inexorable growth of residential and nursing care is especially notable. Moreover, this success has been secured in the face not just of demographic pressures but also of substantial increases in hospital activity and reductions in delayed discharges.

Much remains to be achieved, however, as all the sources confirmed. There was a broad consensus that the reality of social care today too often fails to match the reasonable expectations of service users and their supporters. Social care can be disempowering as well as empowering. It does not always maximise opportunities for user involvement, and still less for control.

Clearly, a new vision for adult social care needs to be supported by an effective strategy, which must identify what has to change or be changed. The Community Minister's initial thinking emphasised a strategy based on services which were person-centred, proactive and seamless, and so committed to promoting well-being while reducing dependency.

The SCIE consultations broadly supported such an approach and generated a number of further ideas about its development and implementation. Some of these approaches could be described as 'service' development strategies and others as strategies which support their delivery. The first category includes: promoting well-being; strengthening communities; the contribution of personal social services; and reinforcing choice and control. The second incorporates: effective partnerships; connected care; supporting the workforce; and managing the money. This second set of strategies may be seen as the means to enable services to deliver the required outcomes.

The strategies outlined below are designed to help ensure that the vision becomes a lasting reality.

Service development strategies

Promoting well-being

Dr Stephen Ladyman called for services to be proactive in promoting independence rather than reinforcing dependency. The whole thrust of thinking described in this report strongly supports such an approach. However, the bulk of resources are currently focused on a small minority of the population. For example, some 90 per cent of expenditure on mental health is spent on some 10 per cent of the population. In the case of older people, the proportions are 85:15 per cent.[44] A similar pattern is also true of the amounts invested in 'direct' service users compared with informal carers.

To a large extent, resources are concentrated on specialist services targeted on those with the most severe needs. As a result, relatively few resources are invested in the great majority of people with lower-level needs, including support to participate fully in local communities.

Re-balancing the system will involve complex and demanding challenges in terms of synchronising the direction and timing of financial flows as well as maintaining high-intensity services for those with high-intensity needs.

Nor is the latter objective merely a transitional concern. Prevention is only better than cure when it works. Some level of crisis response will continue to be required, as will high-intensity care.

A strategy for promoting well-being by focusing on the many as well as the few would have the following components:

- a community and citizen focus to promote well-being, based on empowerment, engagement, social inclusion and safe environments
- low-level support to prevent and delay access to more specialist services, maintain independence, minimise the impact of mental or physical disability, support informal networks
- diversion from more to less restrictive environments based on active rehabilitation and/or intensive support in locations of choice.

This strategy complements the higher priority in the NHS for promoting physical and mental health in line with the Wanless report.[45] It supports the promotion of health for an ageing population by maintaining health and reducing dependency at all stages in the life cycle[46] and also depends upon reducing health inequalities.

Finally, the promotion of well-being in the context of social care can be seen as an expression of the more general power to promote social, economic and environmental well-being under the Local Government Act 2000. This legislation also gave councils the duty to prepare plans to promote or improve well-being in their local areas through their own service provision and partnerships in the public, private and voluntary sectors. The intention is to enable localities to address crosscutting: an issue which fragmented local governance structures are poorly designed to address.[47]

Strengthening communities

Healthy communities promote and sustain well-being. Dependence decreases and personal fulfilment increases through social contacts and involvement in local communities. Social exclusion and discrimination are also greatly reduced in healthy communities.

People need both to be supported and to feel supported in their communities of choice. This is important not only for service users but for their families and neighbours. Similarly, communities need to feel safe and be safe, requirements which involve strategies to promote safety just as much as strategies for managing risk.

This is a two-way process. Communities are strengthened by the richness of local networks and the extent of community engagement. Relationships based on giving and receiving benefit both individuals and the communities in which they live. Modern social care must, therefore, build and reinforce the interdependence of individual and community well-being. User-controlled organisations and other parts of the local voluntary and community sectors have a critical role to play in this.

Community capacity building, as part of the new vision for adult social care, offers the possibility, therefore, of creating a virtuous circle in which multiple objectives can be met simultaneously by strengthening collective networks and using them to meet individual needs. The task of building and strengthening communities rests particularly with Local Strategic Partnerships (LSPs) and local authorities in their community leadership role. Councils and LSPs would therefore have a central role in implementing the new vision. As will already have become evident, other components of the strategy for realising that vision will make similar demands on the same mechanisms.

Personal social services

The SCIE consultations with service users revealed a strong feeling that major changes were required in the ways that the personal social services worked. In part, these views related to the belief that there should be greater choice and control for service users (see below).

In addition, service users felt that too much emphasis was placed on the 'personal' and too little on the 'social' aspects of their role. By making this distinction, they were contrasting an approach focused on the individual in isolation and one focused on the whole person in their wider social context. The latter approach would necessarily embrace the full range of interventions affecting people's ability to live full lives in communities that care.

The personal social services are, therefore, only one of potentially many players with a role in delivering a new vision for adult social care which focuses on independent living, engagement and social inclusion. The same is true of strategies for shifting the balance between dependence and well-being.

Such developments pose questions about the future of the personal social services which are, in some respects, even more fundamental than the division between children's and adult services. They have always had to manage tensions between their reactive and anticipatory roles, their individualistic and community dimensions, and their specialist and universal ambitions.

Each of these tensions was present in the Seebohm Report, which led to the creation of unified social services departments in 1971.[48] And in each, the former of the roles – the reactive, individualistic and specialist – seem to have gained the upper hand. For the most part, this outcome has been understood, if only imperfectly, as the product of mismatches between demand and resources, together with national policies which prioritised increased activity in acute hospitals or substituting community for hospital provision in the long-stay sector.

These long-term trends were reinforced by the community care changes after 1993, which led to an increased focus on services targeted at people with the highest level of immediate needs and funded by cash-limited budgets (see Chapter 2).

Those who manage, deliver and regulate the personal social services face some hard choices in relation to delivering a new vision. They have, in effect, and not necessarily by choice, become the acute sector of the adult social care system. Planned and preventive work tends to be squeezed out by the concentration of resources on emergencies and crisis response.[49]

Future choices include:

- Is this acute service role to remain so dominant?
- Do the services accept a specialist role which largely concentrates on those with the most intense needs?
- Can they combine that role with a more preventive one, possibly extending into community development and supporting social networks?
- Should they both be responsible for specialist services while also providing the gateway into more generalist, universal services?
- Should their principal functions be more closely focused on the areas of assessment, care packaging, advocacy and brokerage?

Choice and control

Strategies for enhancing control and making choice a reality include giving users and carers more influence over service design and priority setting, especially in respect of collective decision making. At the individual level, direct payments and other forms of personalised budgets are the critical instruments.

As the service user consultations highlighted, direct payments have greatly increased the control which some service users experience over their lives. Not all service users may wish to take up direct payments and plan and manage the delivery of their own care and support. However, the numbers who do are probably greater than the current total, which is modest both in absolute numbers and as a proportion of all those with community care assessments.

Control over care processes and outcomes is inseparable from control over the resources needed to fund them. It depends on resources being placed in the hands of users and carers or those who will use the budget in partnership with them.

The initial aim of care management was to take funds out of services and put them into people. Unfortunately that role never properly emerged. It is now time to develop direct payments more fully and to develop a wider repertoire of mechanisms for personalising budgets so choice and control can be reinforced and extended.

Supporting strategies

Making connections

Dr Stephen Ladyman advocated that services be 'seamless'. Participants in the stakeholder consultations argued that this was best interpreted in terms of service users' and carers' *experience* of service delivery rather than as a characteristic of service design and delivery itself.

In fact, commissioning and service delivery systems need have robust 'joins' at appropriate points. To extend the metaphor, it is not helpful to conceive of social care as a 'seamless' garment. It is the seams that make clothes fit properly. The same applies to connections between services.

This way of thinking makes the task more manageable, focusing attention on the points in the system that need to be joined. It also highlights the need for different kinds of joins and, therefore, of relationships and behaviours at different points and levels in the system. In particular, it helps distinguish the mechanisms and relationships needed for commissioning from those needed to support service delivery and co-production.

Effective commissioning partnerships

The new vision for adult social care will demand more effective partnerships operating across a broader range of activities. Progress in this area has been uneven and traditionally most measures of progress have been process- rather than outcome-based.[50] Much of the evidence about effectiveness concerns the functioning of inter-agency relationships rather than outcomes for service users.

The Joint Reviews Team concluded that between 1996 and 2003 there had been a marked shift from 'good relationships to strategic partnerships'.[51] It suggested that these were more likely to be successful when seen as a means to an end rather than an end in themselves, and especially if:

- there is clarity of shared purpose in user outcome terms
- there is clarity of governance and decision making
- there are wins for each partner
- there are efforts to establish a common culture.

Situations in which partnerships were less likely to be successful included those that were driven by national directives and mainly by questions of resources, and where there were major differences in culture and governance.

However, the PSSRU report commissioned by SCIE (see Chapter 2) argues that the Joint Reviews Team was unduly optimistic "even in its own terms and on its own evidence".[52] For example, they suggest that by concentrating on the relationship of social care with the NHS, the Joint Reviews Team neglected "deeply problematic" relationships with other public services.

In addition, the PSSRU report stresses the impact of a turbulent policy environment and fear of other reforms: "short-term and sometimes unpredictable pressures generated by the wider policy environment and political backdrop have tended to undermine the stability that [is needed] for the system to function effectively".[53]

While the jury may still be out on the ultimate impact of partnerships between health and social care, not least because of the lack of long-term systematic evaluation of partnership outcomes rather than processess, the PSSRU report concludes that it is "difficult to avoid an essentially negative assessment".[54]

The emergence of a common framework for local partnership working LSPs has promise but is still becoming established. The extension of Local Area Agreements (LAAs) should help by bringing together what would otherwise be separate programmes, targets and budgets within a single, public statement and a common framework of performance management.

Strategic commissioning for social care needs to be addressed within the context of LSPs and LAAs partly because of the breadth of the new vision and partly to locate it within wider governance systems, including those for committing resources, managing performance and securing accountability across partner organisations. Thus commissioning and governance arrangements have to match the scope of a new vision based on well-being and independence. It follows, therefore, that such arrangements must be capable of encompassing a wide range of commissioning partners and performing convincingly in the eyes of potential providers in all sectors.

Connected care

Partnership working is equally necessary in service delivery relationships between providers and also between providers, service users and their carers. For many years, multidisciplinary teamwork has been the preferred delivery vehicle. This is increasingly structured through pathways of integrated care.

The concept of connected care has been developed by the Institute of Public Policy Research and Turning Point to describe a model of care for deprived neighbourhoods.[55] It has been particularly associated with connected care centres, although it is perhaps better understood as a structured set of processes and ways of working rather than as a building. It has a number of parallels with the Sure Start initiative for children and families.

Connected care is, therefore, a mechanism for meeting the needs of those with complex needs (whether complex in depth or breadth). It is envisaged as a tool for closing the gap between health, social care and social exclusion strategies. Staff will be committed to assertive outreach working and other principles of good practice, including: co-location of NHS, local authority and voluntary sector staff; common assessment procedures; information-sharing procedures; shared training; single point of entry; round-the-clock support; managed transitions; and continuing support.[56] In effect, these principles represent the connections necessary for care to be experienced as seamless.

It is envisaged that local models should be based on social needs identified by the local community in partnership with commissioners to ensure that they are defined by the needs and aspirations of local residents rather than by existing supply. A further feature is the role of 'service navigators' to help provide case management, advocacy and support. The approach also lends itself to supporting devolved and unified budgets, whether to neighbourhood level, as encouraged by the Office of the Deputy Prime Minister,[57] or to individuals through direct payments or the introduction of personalised budgets.

The purpose of this discussion is not to advocate a chain of connected care centres. However, it is potentially valuable in identifying some of the key issues that will need to be addressed locally to deliver an holistic vision based on needs defined by local service users and residents. Allied to devolved funding, personalised budgets and direct payments, this is an approach which potentially provides opportunities for exercising choice and control in a wider context of community capacity building and social inclusion.

Developing the workforce

Many respondents to the SCIE consultations raised issues about the workforce. Service users identified concerns about the quality and continuity of staffing arrangements. They were critical of the status of social care staff, their employment conditions and the limited time sometimes allowed to meet users' needs. Staff were also conscious of these factors. In addition, they were acutely concerned about the need for workforce training and development focused on the new vision and its implications for ways of working.

Empowering relationships between staff, service users and their carers are among the most essential vehicles for delivering support which is person-centred, proactive and seamless. An appropriate workforce development strategy is not some 'add on' to the new vision but an integral element in its realisation. The vision will fail unless the workforce understands, owns and is properly equipped to deliver it.

Winning hearts and minds also involves adequate support and resources (see 'Managing the money', page 29). In addition, the Joint Reviews Team highlighted five issues consistently identified as most important to staff:

- feeling they are making a positive difference to service users' lives
- being clear about what is expected of them and being given constructive feedback
- having attention paid to their personal development
- having a voice in the organisation
- having fair workloads and terms and conditions.[58]

SCIE will soon publish 'People management' (www.sciepeoplemanagement.org.uk), a web-based self-audit tool designed to assist social providers to review their strategies and skills for managing people.

Managing the money

Responses to the SCIE consultations suggest that the new vision will lack credibility with the workforce and the public unless it is convincingly costed and adequately funded over defined timescales. The absence of costings or funding commitments was an immediate criticism of the Prime Minister's Strategy Unit's 2004 paper on people with disabilities.

The Wanless review has provided the basis for substantial funding increases in the NHS.[59] In 2002, Wanless also recommended that a further review be carried out after five years to cover health and social care. He further concluded that "there is an important role for social care in minimising the demand for health care".[60]

More recently, the independent King's Fund has commissioned Wanless to review the future demand, supply and funding requirements of social care for older people. Hopefully, the intention to extend this work to other groups can be fulfilled quickly.

Adequate levels of funding are not the only prerequisite of a financial strategy capable of supporting the new vision. Other issues include ensuring the compatibility of funding flows for different services and functions. The ability to pool budgets locally is essential to align patterns of investment and disinvestment with local needs and development strategies.

LSPs and LAAs offer a framework for such pooling as long as all major local services, especially the NHS, are included within them. They should also become the focus for integrating all local planning and resource allocation decisions rather than just earmarked grants. A closely related issue is the need, in some circumstances, for prior investment in new services to free them from historic patterns of service provision.

Delivering the vision

As SCIE's consultations made clear, there is considerable dissatisfaction with social care today and especially its perceived failure to deliver the outcomes and choices defined by service users. Vision and strategies therefore need to be supported by a well-developed delivery programme. The latter has two functions: to make change happen, and to make it stick.

This package requires a tailored knowledge management programme. Its first role would be to ensure that the vision and strategies are founded on the best available information about what works. Its second would be to ensure that the change management process was itself appropriately designed and implemented. Finally, it would need to manage the preparation of implementation support tools and other materials, together with the collection, synthesis and dissemination of good practice as it emerges.

Other components would include development programmes and the mapping of critical paths through the implementation process. The vision may tend to lose its power as it is implemented through pre-existing structures and systems. It may, therefore, be desirable to establish stakeholder panels at national and local levels to

act as 'product champions' and help guard against dilution of the vision and strategies by defenders of the status quo.

Such panels' influence would be greatest if they contained significant numbers of well-supported service users. Such delivery programmes would have to operate over two timescales: a relatively immediate one, for the initial programme of change; and a longer period to ensure that change was embedded and not diverted or diluted.

The community care implementation support programme of the early 1990s was exceptionally successful in managing the introduction of new arrangements but was limited to merely ensuring that all localities reached the starting post. The new vision will require more sustained support if it is to achieve lasting change. SCIE's existing strengths in knowledge management and user engagement enable it to contribute such support.

Conclusion

The *Looking to the future* project identified a striking degree of consensus about the future of adult social care. Its findings confirm that thinking has moved on from the objectives of the 1989 White Paper *Caring for people* – from "choice and independence" to "control and *inter*dependence".[61] What is more, this new consensus places adult social care at the heart of thinking about the modernisation of all public services.

Summarising the project's findings makes this clear (see 'Summary of key points', page iv). No single statement can possibly distil the full range of evidence, but the overarching objectives and outcomes might be described as:

> The personalisation of individual support to enable the fullest possible participation and inclusion in the mainstream of community living, as part of wider strategies to promote independence, control and wellbeing for all citizens.

This approach represents a recognition that both the aims and the outcomes of social care need to be broadened, so that independent living in caring communities becomes the norm. But the personalisation of services also embraces an emphasis on properly meeting individual needs, whether low level or intensive. The degree of participation and inclusion may vary with those needs, but the existence of need can no longer be used to justify exclusion or the denial of citizenship rights.

Looking to the future: the next stage

The second stage of this project is taking place while, in England, work continues to implement initiatives in relation to *Every child matters*, and at the same time to analyse responses to the Green Paper on adult social care, to prepare and publish a White Paper, and to develop a draft bill on changes requiring legislation. Wales and Northern Ireland are taking forward broadly similar policies, although the emphasis, priorities and timescales may differ significantly.

Clearly, although apparent agreement on aims and outcomes is a good start, it is only a start. The new vision must be made to happen and made to stick. Continuing gaps between professional visions and the experience of service users demand it.

This project will therefore now focus on making its contribution to a working framework which successfully promotes independent living in sustainable communities and gives people greater control over their own lives. Part of this task involves understanding and embedding appropriate strategies for change management. SCIE has already conducted literature reviews on change management and commissioned work on management development, practice change and the workforce. In addition, SCIE proposes a series of case studies to consolidate knowledge about what works, and how it works.

References

1 Department of Health (2005) *Independence, well-being and choice*, London: The Stationery Office.

2 Department for Education and Skills (2003) *Every child matters*, London: The Stationery Office.

3 Beresford, P., Shamash, M., Forrest, V., Turner, M. and Branfield, F. (2004) *Developing social care: Service users' vision for adult support*, London: Shaping Our Lives.

4 Wistow, G. (2004) *The new vision for social care: A report on the results of a survey undertaken by SCIE between 18th April and 30th June*, London: Department of Health and Social Care Institute for Excellence.

5 Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science.

6 Social Services Inspectorate and Audit Commission (2004) *Old virtues, new virtues*, London: Audit Commission.

7 Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science.

8 Sheldon B. and Macdonald, G. (1999) *Research and practice in social care: Mind the gap*, Exeter: Centre for Evidence-based Social Services, University of Exeter.

9 Waine, B., Tunstill, J., Meadows, B. with Peel, M. (2004) *Developing social care: Values and principles*, London: Synergy Research and Consulting Ltd.

10 Department of Health (1989) *Caring for people*, London: The Stationery Office (formerly HMSO).

11 Demos (2003) *Inside out: Rethinking inclusive communities*, London: Demos.

12 See, for example, Stewart, J.D. (2003) *Modernising British local government*, Basingstoke: Palgrave.

13 Department of Health (2004) *The NHS improvement plan*, London: The Stationery Office.

14 Department of Health (2005) *Creating a patient-centred NHS: Delivering the NHS improvement plan*, London: Department of Health.

15 Office of Public Services Reform (2002) *Reforming our public services*, London: Office of Public Services Reform, p 3.

16 Leadbetter, C. (2004) *Personalisation through participation*, London: Demos, p 19.

17 Kelly, G. and Muers, S. (2002) *Creating public value: An analytical framework for public service reform*, London: Cabinet Office.

18 Office of the Deputy Prime Minister (2004) *The future of local government*, London: Office of the Deputy Prime Minister.

19 Office of the Deputy Prime Minister (2005) *Sustainable communities: People, places and prosperity*, London: The Stationery Office, para 1.2.

20 Phillipson, C. and Scharf, T. (2005) *The impact of government policy on social exclusion among older people*, London: Office of the Deputy Prime Minister, pp 53-65.

21 Social Exclusion Unit (2004) *Mental health and social exclusion*, London: Office of the Deputy Prime Minister.

22 Wilkinson, R. (2004) 'Status and shame: the impact of social structure on health', *Human Givens Journal*, vol 11, no 1, pp 30-34.

23 Prime Minister's Strategy Unit (2004) *Improving the life chances of disabled people*, London: Cabinet Office, p 4.

24 Prime Minister's Strategy Unit (2004) *Improving the life chances of disabled people*, London: Cabinet Office, p 8.

25 Robbins, D. (2004) *Treated as People*, London: Department of Health, para 1.5.

26 Robbins, D. (2004) *Treated as People*, London: Department of Health, para 2.3.

27 Social Exclusion (2004) *Mental Health and social exclusion*, London: Office of the Deputy Prime Minister.

28 Social Exclusion (2004) *Mental Health and social exclusion*, London: Office of the Deputy Prime Minister, pp 22–23.

29 Appelby, L. (2005) *The national service framework for mental health: Five years on*, London: Department of Health.

30 Department of Health (2001) *Valuing people: a new strategy for learning disability for the 21st century*, London: The Stationery Office.

31 Valuing People Support Team (2005) *The story so far*, London: Department of Health, Ministerial foreword, p 3.

[32] Valuing People Support Team (2005) *The story so far*, London: Department of Health, Ministerial foreword, p 5.

[33] Mencap (2004) *Treat me right*, London: Mencap.

[34] Valuing People Support Team (2005) *The story so far*, London: Department of Health, Ministerial foreword, p 6.

[35] Audit Commission (2004) *Older people: A changing approach*, London: The Stationery Office, para 15.

[36] Audit Commission (2004) *Older people: A changing approach*, London: The Stationery Office, para 28.

[37] Women's Royal Volunteer Service (2004) 'Society must challenge loneliness and save lives', Press release, 8 March.

[38] McCarthy, H. and Thomas, G. (2004) *Home alone*, London: Demos.

[39] Singleton, N. and Painter, A. (2003) *All our tomorrows: Inverting the triangle of care*, London: Association of Directors of Social Services and Local Government Association, p 9.

[40] Audit Commission (2004) *Older people: A changing approach*, London: The Stationery Office.

[41] Singleton and Painter (2003) *All our tomorrows: Inverting the triangle of care*, London: Association of Directors of Social Services and Local Government Association.

[42] ADSS, LGA and NHS Confederation (2004) *Our future in our hands: Putting people at the centre of social care*, London: Local Government Association.

[43] Wistow, G., Godfrey, M. and Waddington E. (2004) 'Living well in later life: from prevention to promotion', in K. Skinner (ed) *Community leadership and public health: the role of local authorities*, London: The Smith Institute.

[44] Singleton and Painter (2003) *All our tomorrows: Inverting the triangle of care*, London: Association of Directors of Social Services and Local Government Association.

[45] Wanless, D. (2004) *Securing good health for the whole population*, London: HM Treasury.

[46] Wistow Wistow, G., Godfrey, M. and Waddington E. (2004) 'Living well in later life: from prevention to promotion', in K. Skinner (ed) *Community leadership and public health: the role of local authorities*, London: The Smith Institute.

[47] Stewart (2003) *Modernising British local government*, Basingstoke: Palgrave.

[48] Seebohm, F. (1968) *Report of the committee on local authority and allied social services*, London: HMSO.

[49] Wistow, G. (1995) 'Aspirations and realities: community care at the crossroads', *Health and Social Care in the Community*, vol 3, no 4, pp 227-40.

[50] Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science, p 21.

[51] Social Services Inspectorate and Audit Commission (2004) *Old virtues, new virtues*, London: Audit Commission, para 4.4.

[52] Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science, p 30.

[53] Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science.

[54] Knapp, M., Fernandez, J., Kendall, J., Beecham, J., Northey, S. and Richardson, A. (2004) *Developing social care: The current position*, London: PSSRU, London School of Economics and Political Science, p 31.

[55] Rankin, J. and Regan, S. (2004) *Meeting complex needs: The future of social care*, London: Institute of Public Policy Research.

[56] Rankin, J. and Regan, S. (2004) *Meeting complex needs: The future of social care*, London: Institute of Public Policy Research, pp 66-67.

[57] Office of the Deputy Prime Minister (2005) *Sustainable communities: People, places and prosperity*, London: The Stationery Office.

[58] Social Services Inspectorate and Audit Commission (2004) *Sustainable communities: People, places and prosperity*, London: The Stationery Office, para 4.7.

[59] Wanless (2004) *Securing good health for the whole population*, London: HM Treasury.

[60] Wanless (2004) *Securing good health for the whole population*, London: HM Treasury, p 10.

[61] Wistow, G. (2003) 'The future aims and objectives of social care', in I. Kendall and L. Harker (eds) *From welfare to wellbeing*, London: Institute of Public Policy Research.

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Developing social care: the past, the present and the future

This position paper discusses the past, the present and the future of social care. It is designed to contribute to the green paper consultation on the future of adult social care and outlines some of the implications of delivering the vision. The position paper pulls together the results of SCIE's web consultations from 2004 as well as information from stakeholder focus groups, service user focus groups and two commissioned literature reviews.

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