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The origins and development of social care

SUMMARY

Current debates about the provision and funding of social care must be viewed against the policy shifts of the past five decades. This chapter sets out the key landmarks in the focus and role of social care services since the 1980s and provides a picture of the current system. It includes the following important themes.

- The fragmentation at both local and central government levels in the responsibility for social care, as outlined in the influential 1988 Griffiths review. The review also highlighted the ‘perverse’ financial incentives that were encouraging local authorities to place older people unnecessarily in residential care.
- The revolution in service provision as a result of the 1989 White Paper, *Caring for People*, (enacted in the 1990 Community Care Act) which declared that local authorities should be the brokers and care managers of social care, but not necessarily the direct providers. This led to a huge growth in the independent sector, which now provides the majority of state-funded residential care and 69 per cent of adult domiciliary care contact hours, compared with just 2 per cent in 1992.
- A new emphasis on prevention and rehabilitation, as outlined in the 1998 White Paper *Modernising Social Services*, amid the realisation that existing policies had removed support from those receiving ‘lower levels’ of help. Achieving timely hospital discharges by older patients became a key goal.
- A review of how to fund long-term care for the elderly through a Royal Commission report in 1999. This recommended that personal care should be free, a proposal that was rejected by the government.

Today, some 1.2 million people aged 65 and over use publicly funded social care services and a further substantial number are reliant on privately funded residential and domiciliary care. Choice, independence and prevention are the government’s avowed underlying values for the system. But a breakdown of total local authority expenditure shows almost 60 per cent is still committed to residential placements, with another 20 per cent for home care services.

In a significant development, the 2006 White Paper, *Our Health, Our Care, Our Say*, seeks greater integration of health and social care, and to manage performance against shared outcome targets. The challenge for government is whether continued incremental adjustments will be enough to achieve this subtle shift from partnership towards integration.

1 Introduction

It is impossible to understand fully debates about the future of social care without having some awareness of the history of welfare and the key policy developments that have shaped policy and practice in 2006. The purpose of this chapter is to provide some background and context to illuminate some of the current and emerging debates both about the funding of social care for older people and about its relationship with other public services, most notably the NHS. A summary of the origins of social care from 1948 is given in the box below.

The present phase of social care development dates from major debate and subsequent reforms which emerged in the late 1980s. In December 1986 Sir Roy Griffiths was commissioned by the Secretary of State to undertake an overview of community care policy. This marked the beginning of a period of significant reform that underpins social care of the present day. Specifically, the terms of reference required a review of ‘the way in which public funds are used to support community care policy’ and to make recommendations on how such resources might be used more effectively. The report of the Griffiths review in 1988 accepted that the work of the Audit Commission and of the House of Commons Select Committee inquiry into community care contained ‘the essential facts’ on which to base the analysis (House of Commons 1985).

The Griffiths report acknowledged the many submissions received addressing inadequacies of funding. This was outside the remit of the review, and the major focus was on achieving the more efficient use of resources, while it was accepted as self-evident that resources should be consistent with agreed responsibilities and objectives. Alongside questions of funding, the other major difficulties appeared to lie in divided responsibilities and fragmented services: ‘the complex network of relationships and responsibilities at the local level between the various authorities, voluntary groups etc’. The problems of fragmentation did not end at local level and were also evident in the split responsibilities between central government departments. The consequences for policy and practice were famously summed up by the report in the observation that ‘community care is a poor relation; everybody’s distant relative but nobody’s baby’ (Griffiths 1988). In response, the Griffiths report set out proposals to achieve clearer lines of responsibility and accountability from the level of the Minister to those delivering services to individuals.

A key component of the Griffiths recommendations concerned the use of social security resources within funding for social care. The ‘perverse incentives’ identified by the Audit Commission were concerned with the use of Supplementary Benefit payments (the equivalent to Income Support in current terms) to pay for residential care. A person who qualified for Supplementary Benefit and who wished to enter a private or voluntary sector residential care home could do so with their care fees being paid through the social security system. For local authorities trying to protect limited budgets this allowed a useful mechanism for diverting demand to another source of funding. However, the rapid growth in the numbers of people being supported through public funds, and the clear conflict which this introduced with an apparent objective to achieve community care, were the major factors driving the need for reform. The situation was summed up succinctly by Sir Roy Griffiths: ‘This particular benefit is at the interface between the social security open-ended financial commitment based on entitlement and a budgeted provision against priority of need, which is the social services approach. Prima facie the two approaches are diametrically opposed (Griffiths 1988, para 15).

ORIGINS FROM 1948

The origins of social care can be traced to the 1948 National Assistance Act and the birth of the ‘Welfare State’ (see Table 1, pp 27–29, for a time line of critical policy events). However, the origins of welfare support lie much further back in time, particularly in the mutual and friendly societies of the 19th century, and prior to that in the Elizabethan Poor Law and the workhouse. Insurance-based coverage for some health services and unemployment support was established by the Liberal government that came to power in 1906 (following the model established in Germany by Chancellor Bismarck). However, the need to establish a more coherent basis for welfare underpinned the establishment of the Beveridge inquiry in 1941 and the report of the following year (Beveridge 1942) laid out plans for vanquishing the ‘Five Giants’: want; disease; squalor; ignorance and idleness. The incoming Labour government of 1945 embarked on a series of reforms which laid the foundations for the welfare state, the key features of which remain to this day.

The 1948 National Assistance Act set out in broad terms the responsibilities of local authorities. These were few and largely concerned with residential provision. Thus Section 21 of the Act stated the duty of every local authority: ‘... to provide residential accommodation for persons who by reason of age, infirmity or any other circumstances are in need of care and attention which is not otherwise available to them’.

Beyond this the responsibilities of the local authority were narrowly conceived and had nothing to say about any remit for promoting the well-being of the community (as has characterised more recent developments). The most significant point about the origins of the welfare state is that while health care provision under the newly established National Health Service (NHS) was free at the point of use, social care services provided by the local authority could carry charges and would be subject to means-testing of the recipient. Moreover, while the NHS was regarded as a service for all citizens, the services of the local authority were viewed as a more residual provision (Means 1986).

From the late 1940s onwards the idea of ‘community care’ began to develop as a concept. Initially the merits of developing care outside of residential settings emerged in the child care field. The poor physical, emotional and cultural facilities in much institutional care highlighted by the report of the Curtis Committee (Care of Children Committee 1946) led to the development of fostering as the preference in providing for looked-after children. It was another decade before similar transitions began to develop in other areas of care and a shift was envisaged from long-stay hospital care to community-based alternatives. During the 1950s a consensus began to emerge about the preference of supporting older people to remain in their own homes as long as possible. This was driven in part by concerns to reduce financial pressures on state provision, but also by more humanitarian issues, particularly by the growing evidence from academic and other sources about the continuing poor quality of life offered in many residential homes (Townsend 1964). Into this new environment The Hospital Plan of 1962 similarly envisaged a major programme of institutional closure with a halving of numbers of psychiatric beds by 1975 and the development of facilities within general hospitals rather than in specialised institutions.

By the mid-1970s the need to expand services for the ‘priority groups’ in health and social care was an indication of how little development of community-based services had been achieved. A consultative document issued in 1976 set out objectives for achieving a re-distribution of resources away from the acute hospital sector and into community services for older people; those with physical disabilities; people with a mental illness and those with learning disabilities (Department of Health and Social Security 1976). Over the next few years a series of policy documents set out the various objectives for these different client groups, all of which shared the emphasis on redirecting development towards the community and away from residential and institutional facilities.

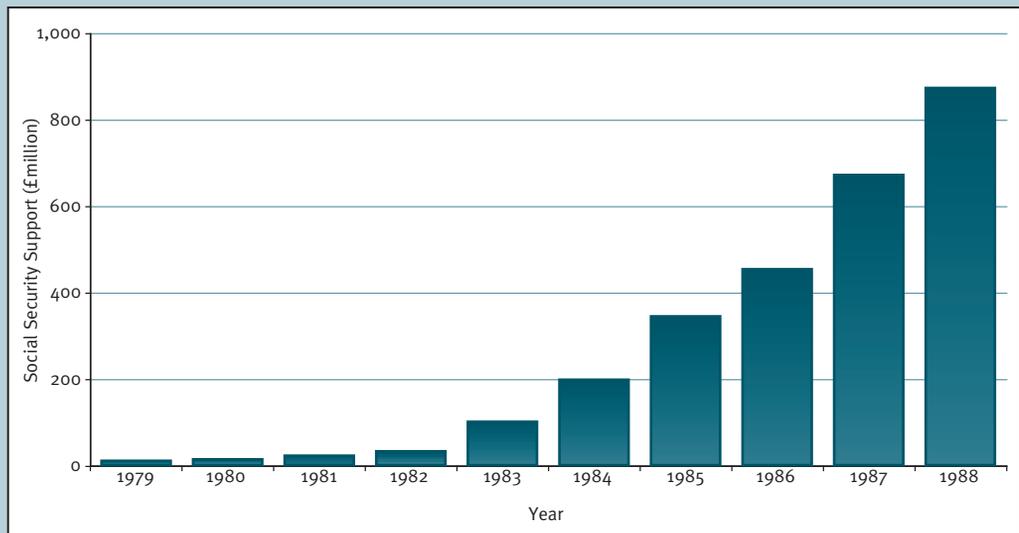
From the 1960s onwards attempts to co-ordinate health and social care also became evident. In the early days 10-year plans were developed for hospital and community care services, but were short-lived. By the 1970s it was becoming increasingly evident that the separation of health and social care was problematic. The creation of integrated social services departments in 1971 was shortly followed by the reorganisation of the health service in 1974 which served to move many services out of local government control and into the NHS. Attempts to improve the coherence of health services were arguably at the price of creating further barriers, gaps and overlaps with local authority social services (Hudson and Henwood, 2002).

It was accepted that the use of social security funding for residential care was ‘not wholly bad’. Many people who would have needed such care had been enabled to have it, but the availability of the budget took no account of whether it was the best option for the individual concerned, nor made it possible to explore alternative arrangements. As Griffiths concluded, with limited resources available there was a risk that this route into residential care would absorb funding that might otherwise be directed towards other means of supporting people in their own homes, and: ‘To use an increasingly expensive social security provision as a safety valve to keep the lid on the pot of community provision would be inconsistent with governmental and managerial responsibility.’ (Griffiths 1988, para 16)

It was the fact that this ‘safety valve’ relieved direct pressure on local authority social services budgets, while diverting it to a less conspicuous pot of money that allowed the situation to develop unchecked for as long as it had. Local authorities had every incentive, as the Audit Commission had pointed out, to develop services that were ‘social security efficient’ and shunted the costs of care elsewhere. Figure 1 below demonstrates the exponential growth rate in social security expenditure that occurred in less than a decade (from £10 million to almost £900 million). It was increasingly evident that the social security budget could not be allowed to continue to rise unchecked.

It was not only social services authorities that were making creative use of the availability of social security funds in this way. Health authorities too were maximising the opportunities to close long-stay hospitals (particularly for people with learning disabilities) by transferring patients to private and voluntary care homes where their fees would be paid through the social security system (Glennerster and Korman 1989; Henwood *et al* 1991). For both health and local authorities the availability of this funding might also be

1 SOCIAL SECURITY SUPPORT TO PEOPLE IN INDEPENDENT CARE HOMES, 1979 TO 1988



Source: House of Commons Social Services Committee 1990

seen to provide an alternative strategy to investing in often tortuous partnership working; such arrangements could simply be by-passed (Hudson and Henwood 2002).

2 The 1990s community care reforms

The Griffiths proposals recommended that local authorities would be responsible for assessing local community care needs, and setting priorities and objectives. At the individual level they would also be responsible for assessing needs and arranging packages of care. The idea of the local authority as broker and care manager, but not necessarily as direct provider was revolutionary at the time. The view that 'the role of the public sector is essentially to ensure that care is provided', but that *how* it was provided was a secondary consideration required a new way of working and a completely new role for the local authority social services department.

The Griffiths report provided the foundation for the community care reforms subsequently set out in the 1989 White Paper, *Caring for People*. Local authorities were assigned the lead role in planning community care (but would need to do so in co-operation with health service partners). The 'key components' of community care were identified as:

- services that respond flexibly and sensitively to the needs of individuals and their carers
- services that allow a range of options
- services that intervene no more than necessary to foster independence, and
- services that concentrate on those with greatest needs (Department of Health 1989).

The central objectives for service delivery which flowed from these aspirations are summarised below.

The 1989 White Paper was intended to provide the framework for social care for the 1990s and beyond. While many of the developments were highly controversial at the time, in

SIX KEY OBJECTIVES OF CARING FOR PEOPLE

- To promote the development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible.
- To ensure that service providers make practical support for carers a high priority.
- To make proper assessment of need and good case management the cornerstone of high quality care.
- To promote the development of a flourishing independent sector alongside good quality public services.
- To clarify the responsibilities of agencies and so make it easier to hold them to account for their performance.
- To secure better value for taxpayers' money by introducing a new funding structure for social care.

Source: Department of Health (1989), *Caring for People*, Cm 849, London: HMSO, para 1.11

retrospect it is striking to realise how similar this agenda is to the one confronting policy-makers in the early part of the 21st century. What this also begins to indicate is how challenging this agenda has proved to be and the relative failure of services to achieve the vision set out over the past 20 years. But it is also evident that many of the difficulties which confront adult social care today are in large part the consequences (often unanticipated) of the reforms of the 1990s. A particular example is the effect of concentrating resources on people in greatest need. The targeting of services in this way inevitably led to a withdrawal of support at lower levels of need and raised the threshold for access to help and support. More recently the consequences of this for reducing the role that services might play in preventing needs increasing have been the focus of growing concern.

The 1989 White Paper was enacted in the NHS and Community Care Act of 1990. Initially implementation was planned for April 1991, but a major delay was announced which led to phased implementation with most of the changes not taking effect until April 1993. Considerable debate over the reasons for (and consequences of) this delay ensued at the time. The official justification concerned the lack of readiness of local authorities to assume their new responsibilities. Other likely factors included political unease over the financial implications of transferring these responsibilities to local government at the very time that alarm over local council spending and the impact on the poll tax was at its height (Hudson 1994).

The rationalisation of financial and managerial responsibilities for social care was reflected in the creation of new funding streams for local authorities (particularly the Special Transitional Grant (STG) for community care). This increased the transparency of funding for social care which also fuelled the debate about the apparent under-funding of this area.

A further strand of the *Caring for People* reforms worthy of exploration is the relationship between health and social care. In assigning the lead responsibility for community care to local authorities it was nonetheless recognised that there was an important interface with other key services, particularly those of the NHS. The White Paper stated that: 'Community

care is about the health as well as the social needs of the population (...). In some individual cases, it may well be difficult to draw a clear distinction between the needs of an individual for health and social care. In such cases, it will be critically important for the responsible authorities to work together.’ (Department of Health 1989, para 4.1–4.2).

The need for authorities to ‘work together’ had been a recurrent theme of policy probably since the 1948 Act. *Caring for People* acknowledged that joint planning achievements had been ‘mixed’, and generally fell short of the aspirations of the 1970s. In clarifying responsibilities the White Paper claimed to offer a fresh approach to collaboration, but stated a familiar message that ‘further efforts are needed to improve coordination between health and social services’.

The other main element of the 1990 Act, which saw the development of a market in social care, needs also to be seen as part of a wider movement in which Thatcherite policies were seeking reform of public sector bureaucracy and the introduction of the discipline and rigour of the market place. As other commentators have remarked, this brought some challenges to joint working and collaboration which had relied on co-operation between partners. In the new climate, competition became a more significant driver and the management of inter-organisational networks became considerably more complex and demanding (Hudson and Henwood 2002).

In the wake of the 1990 Act there were therefore significant challenges for social care. Some of these difficulties owed as much to what was *not* in the Act as to what was. In retrospect the failure of the Act to address health and social care issues in the round is striking. The 1989 White Paper observed (notoriously) that ‘the key functions and responsibilities of the health service as a whole remain essentially unaltered by the proposals’ (Department of Health 1989, para 4.2). Indeed, a separate document (*Working for Patients*) addressed reforms for the NHS. The failure to address these as an integrated agenda ensured that loose ends dangling from both would eventually unravel and require more fundamental attention.

3 Continuity and change: developments since the mid-1990s

The landslide victory of a Labour government in 1997 did not mark an immediate or substantial change of direction in social care. However, the new government did set up a Royal Commission on the funding of long-term care in December 1997 to explore ‘a way to fund long term care which is fair and affordable for the individual and the taxpayer’ (Royal Commission 1999). The Royal Commission looked at the system of funding arrangements at the time – which mostly prevail to this day – and highlighted a series of problems. The Commission was critical about the unfairness of the system, particularly its penalising of those with savings or homeowners. The system was also criticised as offering limited choice, being inconsistent, and having in-built incentives for care home use. Furthermore, the system was complex and provided no sense of security to people. The Royal Commission looked at private sector funding options but concluded that private insurance was unlikely to become a major part of the funding map.

The main recommendations were to provide personal care free of charge on the basis of need only, funded from general taxation and to establish a National Commission to

monitor progress, assess standards and develop social care. The Royal Commission members were, however, divided over the recommendations; a minority of the commissioners rejected the idea of free personal care, instead suggesting a more generous means-test. The government decided against the free personal care recommendation, but the other recommendations were largely accepted. A number of the specific options for funding were adopted by government, such as a three-month disregard for means-testing and making nursing care free. A number of options were also presented for alleviating the means-test, such as increasing the upper asset threshold to £60,000 (at 1995 prices), and limiting liability on service users by providing care used for four years or more free of charge.

In 1998 a White Paper was published which re-affirmed the broad commitment to promoting community-based care and promoting people's independence (Department of Health 1998). However, the document did open with a significant statement that indicated a change in the positioning of social care. In place of the residual model that characterised much of the history of welfare, it stated: 'Social Services are for all of us. At any one time up to one and a half million people in England rely on their help. And all of us are likely at some point in our lives to need to turn to social services for support, whether on our own behalf or for a family member.' (Department of Health 1998, para 1.1)

In re-affirming the importance of social care the incoming Labour government did not promote a highly ideological position about a return to public sector services. Rather it took the early opportunity to set out 'the third way for social care', which rejected both 'the last government's devotion to privatisation' and the 'one size fits all' approach' that had too often characterised old style local authority provision: 'Our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families.' (Department of Health 1998, para 1.7)

Prevention and low level support

While marking considerable continuity with earlier policy objectives, the 1998 White Paper also signalled an important shift in emphasis. The idea of targeting support on greatest need which had run through policy since the 1950s and which had been a central tenet of the *Caring for People* reforms, was recognised as problematic. It was acknowledged that the policy had led, for example, to an increase in the intensity of home care services, but also a reduction in coverage. A more intensive service was being provided but to a smaller group of people, and those most likely to lose support were those receiving 'lower levels' of help. The short-termism of this strategy was acknowledged in the admission that: 'This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised. That is good neither for the individual nor, ultimately, for the social services, the NHS and the taxpayer.' (Department of Health 1998, para 2.6)

A central concern of the White Paper was therefore to engineer a new emphasis on 'helping people achieve and maintain independence wherever possible' through the twin tracks of prevention and rehabilitation strategies. Specific grants were subsequently introduced to facilitate such developments.

The importance of these agendas for the smooth operation of the NHS was clearly an important consideration in trying to bring about such a shift. In particular, the interface between health and social care services was sharply focused around the difficulties of achieving timely discharge from hospital, especially of older and frail patients. The development of models of ‘intermediate care’ that might avoid hospital admissions being required, or provide short term and focused support in the period following discharge from hospital, has been a key element of this strategy.

Partnership working

A further aspect of policy continuity was evident in the emphasis on the need to improve partnership working. Indeed, it would be more accurate to see the emphasis on partnership under New Labour as a rebirth for a concept which had gone somewhat stale over the preceding decade. *Modernising Social Services* underlined the importance of social services working with a number of statutory and non-statutory agencies. The desire to remove the ‘Berlin Wall’ that too often separates health and social care was stated alongside the objective of establishing ‘integrated care that puts users at the centre of services provision’. However, this did not signal a major structural reorganisation that would have rebuilt the architecture of the two services and removed the boundary which has often proved problematic. This radical solution was rejected over concerns that it would merely generate new service boundaries, divert management attention and cause destabilisation. Rather there was to be ‘a new spirit of flexible partnership working’.

Arrangements to remove some of the legal obstacles to joint working were announced and new partnership ‘flexibilities’ made possible (building on the model that had been outlined in the consultation document *Partnership in Action*). These were subsequently enacted in the Health Act 1999. The box below summarises the provisions created. It is important to note that these introduced permissive powers rather than duties; that is, authorities who wished to avail themselves of these new ways of working could do so. A short-lived attempt to make such arrangements compulsory was laid out in *The NHS Plan* of 2000, but was later diluted.

THE SECTION 31 HEALTH ACT FLEXIBILITIES

Section 31 of the Health Act 1999 removed legal obstacles to joint working by introducing a series of flexibilities allowing the development of:

- **pooled budgets** – where health and social services authorities put resources into a single budget to fund care services
- **lead commissioning** – where either the local authority or health authority/primary care group takes the lead in commissioning services on behalf of both
- **integrated provision** – where local authorities and health authorities can merge their services to provide a ‘one-stop’ package.

The development of the new flexibilities immediately raised fundamental issues about the different basis of health and social care services. When services are developed through pooled resources, or when integrated services are developed across health and care, it becomes increasingly artificial to maintain a distinction over what parts of the service are ‘free’ at the point of use, and which should carry charges as social care services. Concerns

over the unfairness of charging for social care had been a recurrent issue. The 1998 White Paper acknowledged the need for ‘greater transparency and fairness in the contribution that people are asked to make towards their social care’ (Department of Health 1998, para 2.37).

However, it was also noted that there were considerable inconsistencies in the charging regimes for non-residential care operated by local authorities. These were discretionary systems which meant that unlike residential care where there are national rules concerning how income and assets are taken into account and charges calculated, each authority could decide on its own approach to charging. An attempt to provide a more systematic approach was subsequently set out in guidance (Department of Health 2001c).

The NHS Plan reiterated many of the key messages around partnership working and developing models of intermediate care as a bridge between hospital and home. As with earlier emphasis on such developments it was apparent that the impetus for this policy owed much to the combination of a number of factors including:

- NHS waiting list pressures and targets and the consequent need to maximise throughput of patients
- renewed concerns over levels of delayed discharges
- reduced capacity in the care homes market reducing the options available to service commissioners trying to develop appropriate care packages.

The strategy set out in *The NHS Plan* (Department of Health 2000b) had three inter-related strands incorporating an emphasis on ‘whole systems working’ across health and social care economies; the development of intermediate care (as a means of improving health and social care integration while also improving outcomes for individuals), and building capacity for care through a ‘Cash for Change’ grant to develop capacity across the health and social care systems primarily to reduce hospital delays.

It is striking that the objectives of promoting independence, developing intermediate care, and improving partnership working, were recurrent across a number of health and social care policy documents from the mid-1990s onwards. These remain the key objectives of current policy (as will be outlined below). Their enduring presence in policy documents is testimony to the difficulties in achieving the significant changes required to deliver the objectives. It also points to the fact that increasingly the difficulties of managing two parallel but separate systems of health and care are being managed by strategies that attempt to integrate their respective agendas as far as possible.

Despite the continuities of policy since 1997, the other major theme is that of change. This has been a period of considerable change across health and social care, reflected in a series of Green and White Papers, plans, strategies and National Service Frameworks. One enduring difficulty has been the extent to which such developments have continued to take place in narrowly defined terms which take insufficient account of their impact on other service areas.

A further development in social care that should be noted is the extent to which other partners have become involved, both at local and national levels. The wider role of local government, beyond conventional social care responsibilities, is of particular importance. *The NHS Plan* recognised the need for the NHS and local government to engage more

comprehensively via neighbourhood renewal strategies and the development of Local Strategic Partnerships. This wider conceptualisation of partnership is also consistent with the objectives of social care around prevention and promoting independence. In addition to the conventional health and social care services, such strategies have implications for other dimensions including housing, education, leisure, transport, the built environment and income support. This wider conceptualisation of partnership and service development, and the attempt to establish a 'joined-up approach' was a defining feature of the initiative Better Government for Older People programme (BGOP) established in 1998.

The complexity of partnerships, and the potential fragmentation of policy, is clear in the fact that in addition to the responsibilities of the Department of Health a number of other government departments are involved. The Secretary of State for Work and Pensions is the Government Champion for Older People; and the Department for Work and Pensions (DWP) is the lead department on older people. While responsibilities for communities reside within the Office of the Deputy Prime Minister (ODPM), responsibility for social care lies within the Department of Health. The relationship between key policy initiatives across these departments is often far from clear (ADSS 2005).

A new vision for social care?

A Green Paper on adult social care issued in March 2005 set out a new 'vision for the future'. The approach outlined in that document is part of a wider reform of public services in the 21st century, and the introduction of 'an entirely different dynamic' characterised by more personalised services offering 'true choice, excellence and quality'. While the focus of social care remains sharply on promoting independence, the latest policy developments are more concerned with the nature of service support, and with the ways in which it is provided. In short, the Green Paper stated that 'it is not acceptable to continue to deliver social care in the way we do today' (Department of Health 2005f). The aspirations of a modern social care system are clearly a long way from the original (and minimal) intent of the 1948 Act. In place of basic services for a small minority of the population, there is a shift in emphasis, which promotes the concepts of citizenship and choice. The Foreword to the Green Paper underlined the importance of social care 'to us all'. The Secretary of State observed that: 'Social services and social care for adults touch all our lives at some point or another and, because of that, they are not about "other" people. They are about families and friends, neighbours and communities, in the towns and in the countryside in every corner of England.' (Department of Health 2005f, p 5).

The need for reform of social care was set in the context of rising demand (particularly associated with population ageing and wider demographic trends), alongside rising public expectations. The Green Paper introduced a focus on key outcomes for social care which should be applicable to all adults – whether or not they use social care services (see box below). The underlying values on which services should be built were restated as independence, empowerment and choice.

The emphases of the Green paper on choice, independence and prevention, and on seamless approaches to care, were familiar themes from previous policy documents. Criticisms of the paper raised questions about the coherence of the agenda with other important developments in public policy, particularly those in ageing, disability, long-term

WELL-BEING OUTCOMES OF SOCIAL CARE FOR ADULTS

Social care for adults can provide the following outcomes in terms of well-being:

- improved health
- improved quality of life
- making a positive contribution
- exercise of choice and control
- freedom from discrimination or harassment
- economic well-being
- personal dignity.

Source: Department of Health (2005f), *Independence, Well-being and Choice*, p 26.

conditions, the role of communities, and the interface with housing, children and families, and with the NHS (ADSS 2005).

From partnership to integration?

The Department of Health announced that it would take forward the Green Paper by developing an integrated White Paper across health and social care. That document was published at the end of January 2006 (Department of Health 2006). The central tenet of the policy is summed up in the objective to ‘move towards fitting services round people not people round services’. Four main goals were set out for health and social care services, namely:

- better prevention services with earlier intervention
- more choice and a louder voice for patients and service users
- tackle inequalities and improve access to community services
- more support for people with long-term needs.

There is no argument with the key objectives identified for social care in the 21st century. However, there remain questions about whether the White Paper offers the way forward. Many of the challenges confronting health and social care are long-standing. Indeed, particular difficulties at the boundary between the two services are the result of the historical legacy of the 1948 Act which established a separate constitution for health and social care. The White Paper re-emphasised this separation, making it clear that ‘social care is not a universal service’ (para 4.5), and highlighting the ‘major difference between the NHS and social care services’ whereby (with the exception of certain charges) ‘NHS care is free at the point of use’, while social care ‘is something that we generally provide for ourselves and each other’, and where needs are greater than friends and family can cope with ‘public resources get to those who need the most help and who cannot afford to pay for that extra support themselves’ (Department of Health 2006, para 4.4).

As has been outlined above, the solution to-date has focused primarily on improving partnership working. The White Paper continued this emphasis, but with some shift in the mechanisms through which to achieve it and a move towards increasing integration. In place of more exhortation there is a clearer attempt to establish some levers that might engineer the strategic shift required. An important aspect of this will be the development

of outcome measures to apply to both health and social care, reinforced through consistent performance assessment and inspection processes.

This more integrated approach across health and social care is to be further strengthened through aligning the budgetary and planning cycles of the NHS and local authorities. Tackling practical barriers of this nature is consistent with the approach that underpinned the introduction of the S31 flexibilities. Local area agreements (LAAs) and local strategic partnerships (LSPs) are seen as important (albeit relatively untested) tools in developing partnership. The other mechanism for improving coherence across health and social care is to be through stronger local commissioning between local authorities and primary care trusts (PCTs).

The quest for improved integration is further addressed in a number of ways in the White Paper. Improved co-terminosity of local authority and PCT boundaries would, it is believed, 'make it easier to achieve better integration of health and social care'. Decisions on PCT configuration were still a matter of consultation when the White Paper was issued. Others (notably the Health Select Committee) have observed that realigning PCT boundaries may remove some organisational boundaries, but is likely to create others: 'Links forged with providers of services at a district council level, such as housing, may founder if there is a return to larger, county-based structures, and several unitary councils (...) have argued that moving back to large, county-based structures would be a retrograde step, undoing much good work that has been done locally to address health inequalities.' (House of Commons Health Committee 2006)

Better integration of assessment across the NHS and social care information systems is seen as a further mechanism for facilitating shared care plans 'as part of an integrated health and social care record'. Integrated care for people with complex long-term needs is recognised as a particular challenge. This is to be met by encouraging the creation of multi-disciplinary networks and teams between PCTs and local authorities. More broadly, further integration is to be sought through the development of more co-location of key services within the context of joint commissioning frameworks. The expansion of practice-based commissioning (PBC) is seen as a further development that will lead to 'more responsive and innovative models of joined-up support', and increased use of the Health Act flexibilities. PBC is presented as the 'health equivalent of individual budgets in social care'; this might be debated, but certainly both measures are concerned with devolving purchasing power and bringing about more responsive and local services.

The aspirations of the White Paper will command widespread support. The government presents the plan as the first attempt ever 'to lay out both a comprehensive and compelling vision of preventative and empowering health and social care services and an effective programme for making this vision a reality'. Whether it succeeds in doing so remains to be seen. However, some important questions need to be asked about the solutions that are proposed.

4 A snapshot of the current social care system for older people

This chapter has set out a brief synopsis of how and why the present social care system for older people has evolved. So what does the current system look like? Local authority social

care spending has risen significantly in real terms and has more than doubled in the past decade. Total gross expenditure on adults and older people has risen from £6.55 billion in 1993/4 to £12.84 billion in 2003/4 (in 2003/4 prices) (*Public Expenditure Questionnaire 2005*) – see Chapter 6 for further details.

Approximately 1.2 million older people in England use social care services organised by their local council (Commission for Social Care Inspection 2005b). Typically an older person enters the social care process because of a short-term crisis (such as following a fall or a stroke), or increasing frailty and disability whereby they can no longer manage to live independently without some additional support. The 150 local councils in England have responsibilities for social services, and receive funding from a combination of central resources allocated through the Revenue Support Grant and an additional element from local council tax. Access to social care is managed through a process of assessment (and councils have a statutory duty to assess the needs and circumstances of anyone seeking help). A social worker or care manager will assess the needs of the person (and of any carers or other family members) and develop a care plan to meet those needs. Councils with social services responsibilities are the main commissioners of social care services. Commissioning services involves assessment and care planning alongside the procurement of services. The process of care planning will take account of the resources available to the local authority and will also assess the financial means of the service user to determine what, if any, contribution they will be required to make to the costs of their care.

The services arranged through local authorities are broadly classified in terms of residential/nursing care; domiciliary care (that is, support to people in their own homes), and day care (services and activities which are available to support people in other settings).

Regulation of care services

The Care Standards Act of 2000 established a framework for the regulation both of care services and of social care workers. The components of the regulatory framework are summarised in the box below.

The pattern of service provision

On 31 March 2005 there were just over 19,000 residential care homes for adults registered in England, providing 441,000 places (Commission for Social Care Inspection 2005b). It is believed that the total number of residential places is declining, and has fallen by around 5 per cent (20,000 places) in the past two years (Commission for Social Care Inspection 2005b). Homes providing care for older people are becoming larger (providing for more residents), while those providing for younger adults are getting smaller. Most providers are not large corporate bodies with multiple businesses. Annual analysis of market trends by Laing & Buisson indicates that only a third of residential care providers in the private and voluntary sectors have three or more care homes. However, the market is changing and the residential care market overall is becoming more concentrated with fewer, larger homes. On 31 March 2005 there were over 4,000 domiciliary care agencies and 900 nursing agencies registered with the CSCI (Commission for Social Care Inspection 2005b). The requirement to register was introduced in 2003 so trend data is not available. However, other research into the

THE REGULATION OF SOCIAL CARE

The Care Standards Act 2000 led to the establishment of the **Commission for Social Care Inspection (CSCI)** in April 2004 as the single, independent inspectorate for all social care services in England. CSCI brought together responsibilities that had formerly been split between the Social Services Inspectorate (SSI), the SSI and Audit Commission Joint Reviews Team, and the National Care Standards Commission.

The CSCI is responsible for registering local care services that are required to meet national standards. Further changes will see the merger in 2008 of the CSCI with the Health Care Commission to create a single new inspectorate across health and social care.

The **General Social Care Council (GSCC)** was established in October 2001, also under the Care Standards Act 2000. The GSCC is the social care workforce regulator for England (equivalent bodies exist in Scotland, Wales and Northern Ireland). The development of a Social Care Register for those working in social care began with social workers. Protection of title means that since 1 April 2005, anyone calling themselves a 'Social Worker' must be registered as such with the GSCC. Registrants must have completed appropriate training, abide by the GSCC Code of Practice, and be physically and mentally fit to do their jobs. The register will be opened to other groups of social care workers in the future. The next groups to be registered will be domiciliary and residential care workers (in both adult and children's services). It is believed that this will amount to more than 750,000 workers.

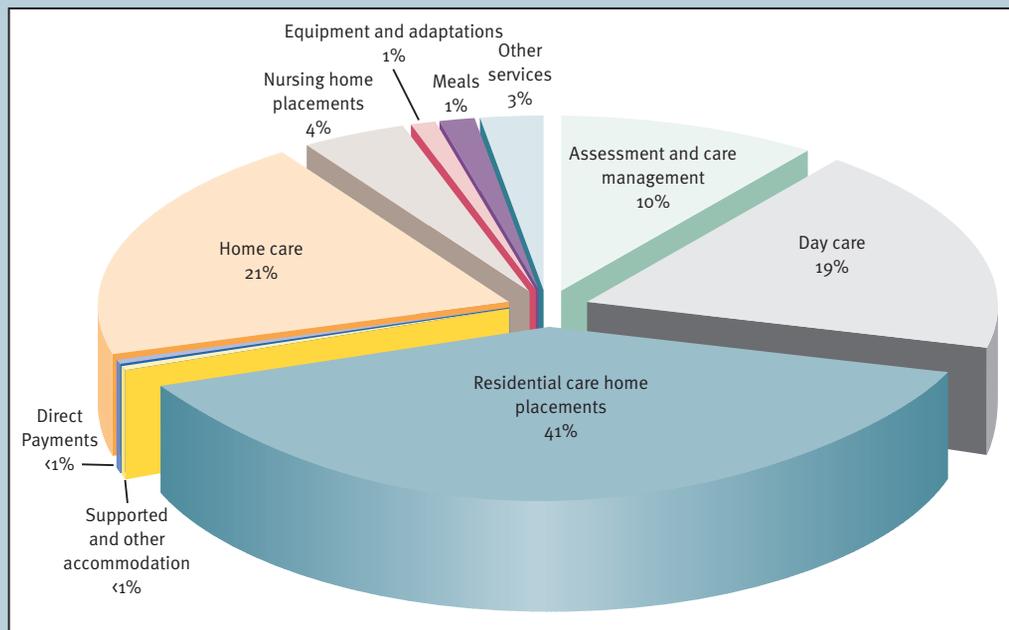
domiciliary care market (notably by Laing and Buisson) indicates that the market is characterised by multiple small providers.

Figure 2 overleaf demonstrates the percentage of council expenditure committed to different components of services for older people. Clearly the largest proportion of expenditure (almost 60 per cent) is committed to residential placements, with another fifth being committed to home care services. The share of personal social services (PSS) resources committed to residential care has remained largely constant in recent years.

The role of the local authority has shifted dramatically since the *Caring for People* reforms of the 1990s, and increasingly it is responsible for commissioning and procuring services, but much less so for direct provision. The majority of residential care is provided in the independent sector. In March 2004 there were 277,000 council-supported adult residents, accounting for 70 per cent of occupied residential places. People funding their own care accounted for 115,000 further places. However, it is likely that the level of self-funding is actually higher than this; CSCI points out that approximately 10,000 people who are fully self-funding but have their care managed by the local authority appear in the statistics as council-supported residents when in fact they are not. The key conclusion is that at least 30 per cent of places in care homes are occupied by people paying for their own care (Commission for Social Care Inspection 2005b).

The transformation of domiciliary care is evident in the fact that for England as a whole in 2004 the independent sector was responsible for 69 per cent of total contact hours of

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Source: Based on data from the Commission for Social Care Inspection (2005b)

Note: Due to rounding, percentages do not add up to 100 per cent.

home care/home help. This compares with 66 per cent in 2003, but dramatically contrasts with *just 2 per cent* of such hours provided in 1992 prior to the introduction of the community care reforms (*Public Expenditure Questionnaire 2005*). With a diminishing role as a direct provider, councils increasingly have a vital role in commissioning and securing the delivery of services in their area. Strategic commissioning requires councils to ensure there are sufficient services (both in volume and type) to meet the needs of the community. In planning on the basis of population needs assessment, councils also have critical roles in actively developing and managing local care markets.

The council is also responsible for assessing the needs of individuals and for developing appropriate plans to meet those needs. In the case of services for older people this should be facilitated through the operation of the Single Assessment Process (which was integral to the National Service Framework for Older People). In practice, implementation of these arrangements has been slow and patchy (see Chapter 4).

The CSCI highlights the wide variation which exists between councils in the availability of different types of service. There appears to be some amount of substitutability in services with fewer residential care places being associated with more use of intensive home care and more people being supported at home (the opposite is also true, and for every 10 additional residential places per 1,000 older people there is a decrease of 2 percentage points in the amount of intensive domiciliary care used, and 3 fewer older people per 1,000 are supported at home) (Commission for Social Care Inspection 2005b) .

The overview of services provided by CSCI, and from other sources such as the Department of Health, paints a broad picture. It is not possible from this to describe the nature of the

services provided in much detail. In particular, the data does not reveal anything about innovative service developments (such as those under the banner of Partnerships for Older People where prevention and well-being pilots are bringing together health, social care, housing, social security, and other local services). 'Home care', for example could be providing routine support with personal care needs, or it could be part of an intensive package of support associated with intermediate care. The CSCI notes that in many councils the profile of services still tends to be more traditional, with insufficient attention to promoting choice, control, flexibility and independence.

It is not only the pattern of service provision that is important, but also the quality of those services. Standards of care were laid down in the 1984 Residential Care Act, and subsequently developed in the Care Standards Act of 2000. Recent evidence on service quality comes from the CSCI's inspection against National Minimum Standards which address key domains of: choice; health and care; daily life; complaints & protection; environment; staffing, and management & administration. While the majority of services meet these standards, 20 per cent of residential providers and 30 per cent of domiciliary care agencies do not. The CSCI argues that there is evidence of service improvement since inspections against national standards began in 2002/3, however, 'some of the areas where there is little improvement are those that people using services tell us they value the most.' (Commission for Social Care Inspection 2005b, para 8.24). This includes factors which have a profound impact on quality of life, especially around issues of choice and independence.

Inspection of domiciliary care agencies against national standards began in April 2004 and not all services have been inspected at this stage. The standards least likely to be met in domiciliary care are also those which are of greatest concern to people using the services. These are issues of privacy and dignity, and being able to get the right kind of help. Problems with poor continuity of service, and of frequent changes of care worker, have been highlighted over several years and continue to be the most common reason for failing to meet standards on privacy and dignity.

Variation is also evident in the quality of services provided. This is true geographically, but there is also significant variation between providers in the private, voluntary and council-run sectors. In overall terms CSCI inspections indicate that both residential and domiciliary care provided by voluntary sector bodies significantly out-perform similar services in the private sector, and council-run services 'perform the poorest overall' (Commission for Social Care Inspection 2005b, para 8.105).

As Figure 2 opposite demonstrates, a small proportion of expenditure (0.3 per cent) on older people's services is committed to Direct Payments. The Community Care (Direct Payments) Act of 1996 introduced powers whereby certain categories of people eligible for social care services could receive a cash payment in lieu of services. Initially this did not include older people, but the scope of the arrangements was expanded in 2003, and the power to provide them was changed to a duty to offer direct payments to people able to make use of them. The take-up of Direct Payments is increasing, but from a very low base. Between 2001/2 and 2003/4 the numbers of adults receiving direct payments increased from 5,468 to 13,796 (Commission for Social Care Inspection 2005b, para 5.27). Most of those using Direct Payments are people with physical and sensory disabilities.

5 Conclusions

This brief overview of the development of social care has highlighted some important themes. First, has been the shift in the focus of the role and purpose of social care services, and in the models of care required to deliver this. Thus, from the 1950s onwards social care became increasingly concerned with trying to support people ‘in the community’ rather than favouring institutional care. Over time there has also been a shift from a highly marginal service likely to be required by a small segment of the population, to something far more mainstream and likely to be of relevance to everyone at some time in their lives. This has been accompanied by an emphasis on making care more responsive to individual needs and recognising the vital role of services in contributing to citizens’ quality of life.

The snapshot of services outlined above indicates the current shape of social care for older people and the extent to which the aspirations of policy are being translated into practice. It is evident that further progress is needed, and that the quality of services often falls short of standards.

Second, there has been a recognition – through the establishment of the 1998 Royal Commission – of deficiencies in the way social care was funded at the time. The main recommendation to provide free personal care was rejected; the government’s argued concerns were that the extra resources required would not necessarily improve services and would not help the least well off (Department of Health 2000c). These issues are tackled in Part 3 of this Review.

The third strand of policy development has been how best to manage the interface between social care and other key services, particularly the NHS. The birth of the Welfare State in 1948 not only established two parallel services with different constitutions, different funding mechanisms and a separate basis of eligibility, but ensured that the two policy streams would evolve in ways that were at times poorly related and even contradictory. Since the 1970s, attempts to rationalise services and improve the coherence between health and care have largely been directed towards incremental adjustments that have tried to establish a mechanism to mitigate the worst effects of organisational fragmentation. This has been reflected at different times in policy initiatives to encourage, cajole or require different degrees of collaboration and partnership working.

The most recent stage of this evolution has seen a subtle shift from partnership towards the language of ‘integration’. The manifesto for this particular redirection of health and social care is the 2006 White Paper: *Our Health, Our Care, Our Say*. In seeking greater integration of health and social care (and indeed of other local authority services) the White Paper has signalled the intention to replace exhortation with requirements, and to manage performance against shared outcome targets. This could be a highly significant development. All the experience of partnership working to-date has demonstrated that so long as collaboration remains an optional activity, it will remain marginal and merely the territory of ‘good practice’.

TABLE 1: POLICY TIMELINE: CRITICAL DEVELOPMENTS IN ADULT SOCIAL CARE, 1948 TO 2006

1948	National Assistance Act (based largely on a report by Sir William Beveridge, <i>Social Insurance and Allied Services</i> (1942)) set out the basis for an insurance-based system for health services and unemployment support. The Act established the framework for the establishment of the welfare state, which separated local responsibilities for welfare from national responsibility for social security. This created the National Health Service (NHS) as a universal service free at the point of need, alongside selective social services provision organised through local authorities and subject to means-testing and charging both for residential and non-residential services.
1957	Publication of a report entitled <i>Royal Commission on the Law Relating to Mental Illness and Mental Deficiency</i> .
1959	Mental Health Act aimed to establish community-based services for people with mental health needs and to close down long-stay hospital provision.
1968	Publication of Seebohm report, <i>Local Authority and Allied Personal Social Services</i> , which recommended the establishment of a family service and ‘one door to knock upon’.
1970	Local Authority and Social Services Act addressed the establishment of integrated local authority personal social services departments in England.
1973	NHS Reorganisation Act established unified health authorities responsible for services previously divided between hospital boards, management committees, executive councils, and local authorities. The Act coincided with reorganisation of local government, and an attempt was made to align the boundaries of area health authorities and local authorities.
1974	Joint planning arrangements were established in the form of Joint Consultative Committees.
1975	White Paper, <i>Better Services for the Mentally Ill</i> , sought the expansion of local authority social services, with specialist mental health services provided through local general hospitals.
1977	Joint Finance introduced alongside Joint Care Planning Teams. Joint Finance was earmarked health service money intended for spending on joint projects with the local authority where it was believed this would ‘make a better contribution in terms of total care than would deployment of equivalent resources directly on health services.’
1978	Consultative document, <i>A Happier Old Age</i> , published with the intention of setting the agenda for a wide-ranging debate ‘to develop a long-term strategy to ensure the well-being and dignity of all elderly people.’
1980	Health Services Act brought further reorganisation, removing area health authorities and establishing district health authorities from April 1982. Previous co-terminosity between health and local authorities was lost in many localities.
1981	White Paper, <i>Growing Older</i> , emphasised that, in future, ‘care in the community must increasingly mean care by the community’ and the role of public services should be ‘helping people to care for themselves and their families.’
1983	Establishment of Care in the Community initiative to support the resettlement of people from long-stay hospitals.

continued overleaf

TABLE 1 *continued*

1986	Appointment of Sir Roy Griffiths to undertake a review of community care policy. His report <i>Community Care: Agenda for action</i> was published in 1988.
1988	Publication of <i>Residential Care: A positive choice</i> , a report of the independent review of residential care chaired by Gillian Wagner. The review had been commissioned in 1985 and set out to promote a change in the perception of residential care and its place within ‘the spectrum of social care.’
1989	Publication of the White Paper <i>Caring for People: Community care in the next decade and beyond</i> .
1990	NHS and Community Care Act made local authorities responsible for organising community care, emphasising support for people in their own homes where possible. Introduced the requirement for local authorities to promote the independent sector. The implementation of the Act was phased over three years with the main changes introduced on 1 April 1993.
1995	The Carers (Recognition and Services) Act introduced the right for carers providing regular and substantial amounts of care to request an assessment of their needs when the person they are caring for is being assessed for community care services.
1996	The Community Care (Direct Payments) Act introduced powers for certain categories of people to be able to receive a cash payment in lieu of services that they could use to arrange their own support.
1997	Establishment of the Royal Commission on Long Term Care for the Elderly to explore options for funding long-term care that are fair and affordable for the individual and the taxpayer.
1998	Establishment of Better Government for Older People initiative to support pilot partnerships to develop local strategies for an ageing population.
1998	Publication of White Paper, <i>Modernising Social Services: Promoting independence, improving protection, raising standards</i> .
1999	Passing of The Health Act, which was particularly noted for Section 31, which introduced new ‘flexibilities’ facilitating joint working between the NHS and local authorities through use of pooled budgets, lead commissioning arrangements and integrated provision.
1999	Publication of <i>With Respect to Old Age: Long term care – rights and responsibilities. Report of the Royal Commission on Long Term Care</i> . The key recommendation (although not supported unanimously) was to remove personal care from means-testing altogether, although a co-payment should be made to cover living and housing costs.
2000	Launch of <i>The NHS Plan</i> , which rejected the central recommendation of the Royal Commission concerning personal care. The Plan emphasised the development of intermediate care as a bridge between hospital and home.
2000	The Care Standards Act established a National Care Standards Commission responsible for the registration and regulation of care services, and a General Social Care Council to make provision for the registration, regulation and training of social care workers.
2000	The Carers and Disabled Children Act extended carers’ rights to an assessment and introduced powers for services to be provided to carers in their own right including direct payments.

continued overleaf

TABLE 1 *continued*

2001	<i>The National Service Framework for Older People</i> set out standards to improve the quality of support in health and social care. Four themes informed the NSF: respecting the individual; developing intermediate care; providing evidence-based specialist care, and promoting healthy, active lives.
2003	<i>Direct Payments Guidance: Community care, services for carers and children's services (direct payments)</i> extended the scope of direct payments, making it a duty (and not merely a power) for direct payments to be offered to eligible people.
2003	The Community Care (Delayed Discharges etc) Act introduced new duties for councils with social services responsibilities and the NHS to communicate about the discharge of patients from hospitals. The Act also established a system of reimbursement for delayed hospital discharges where the council would be held responsible for the delay because it had failed to put in place the services required.
2004	The Carers (Equal Opportunities) Act meant that carers' assessments had to take account of carers' lives in terms of employment, life-long learning and leisure activities. Carers had to be informed of their rights and local authorities could enlist the support of other agencies in supporting carers.
2005	<i>The National Service Framework for Long Term Conditions</i> set out quality requirements and evidence-based markers of good practice in health and social care services for people with long-term neurological conditions and their carers.
2005	Publication of <i>Opportunity Age: Meeting the challenges of ageing in the 21st century</i> , a strategy document from the Department for Work and Pensions in partnership with other government departments.
2005	Publication of a Green Paper, <i>Independence, Well-being and Choice: Our vision for the future of social care for adults in England</i> , focusing on 'choice, excellence and quality' within the context of promoting independence.
2006	Publication of a White Paper, <i>Our Health, Our Care, Our Say: A new direction for community services</i> , presenting key policy reforms for health and social care focused on better prevention; more choice; tackling inequalities, and support for people with long-term needs.