The mechanisms of social care reform

To realise the values articulated in Chapter 2, in the context of the supply and demand pressures set out in Chapter 3, policy makers in the four nations have instituted a series of reforms. These have focused on questions such as:

- How should care be *funded and allocated* (including more individualised approaches)?
- Who should *access* it and when (including efforts to delay or slow down formal access to care through preventative and asset-based approaches)?
- How should it be *integrated* with health?
- How should people *providing care* (unpaid carers and the paid workforce) be supported?

In this chapter we look at what Pollitt (2002) calls 'decisional convergence' around adult social care in the four nations. In Chapter 2 we looked at discursive convergence on what social care is for, highlighting the goals of wellbeing, fairness, rights and quality as the basis of a sustainable care system. In focusing here on decisional convergence, we look at the following mechanisms that have been used in all four nations across the previous 25 years. These are:

- redistribute the costs of care
- personalise support
- support unpaid carers
- invest in prevention
- integrate with health
- professionalise the workforce.

All of these policies are priorities in the four nations, but the balance between them and the specific policies introduced vary. Chaney (2022), in his analysis of 20 years of manifesto commitments on social care in the four nations, finds that the manifestoes of English parties focus on funding solutions, whereas in Wales the foremost issue is integration with health. Addressing care worker pay and conditions is the lead social care issue in party manifestoes in Scotland and Northern Ireland. We discuss these issues and the balance between them in the sections that follow.

Redistribute the costs of care

The question of who should pay for social care has been one of the big unresolved public policy issues of recent decades. Whereas health is provided free at the point of use by the NHS, social care has to be purchased privately by individuals who have assets above the means test threshold. In all four jurisdictions, it is recognised that the funding system requires reform, as set out in Chapter 2. The lack of risk pooling for social care along the lines of health means that people potentially face very high care costs that undermine fairness, wellbeing and sustainability. The Labour-appointed Sutherland Commission in 1999 recommended a tax-funded system, ruling out private forms of risk pooling: 'Private insurance will not deliver what is required at an acceptable cost, nor does the industry want to provide that degree of coverage' (Sutherland, 1999). In 2011, the Dilnot Commission, appointed by David Cameron's Conservative–Liberal Democrat coalition government to look at care funding, again concluded that a private insurance model was not appropriate for social care (Dilnot, 2011).

With private insurance off the table, two main options for redistributing the costs of care have been considered. The first, which gained the highest level of support in New Labour's 2009 public consultation on social care, was what they called the 'comprehensive offer'. This was defined as: 'people get their care free when they need it in return for a compulsory contribution' (DH, 2009: 12). Such an approach would bring social care funding into closer alignment with the way that the NHS is funded and was in line with the recommendation of the 1999 Sutherland Report. The second option was a cap on private care costs, which was recommended by the 2011 Dilnot Report and was passed into law in the Care Act 2014 (although not implemented). These approaches are looked at in turn.

Free personal care

The majority report from the Sutherland Commission (1999) recommended 'free personal care', with the state paying the costs of activities such as personal washing, dressing, eating and drinking for anyone who met a needs threshold. Even in this 'comprehensive offer', accommodation costs in residential care were to be paid for privately, subject to a means test. Nonetheless, this proposal was rejected for England and Wales, with the Westminster government agreeing with the minority report from the Sutherland Commission, which said it was unaffordable (Brindle, 2009). It was also noted that ending private payment for social care would mainly benefit the better-off. Bosanquet and Haldenby put it this way in a letter to *The Guardian* in 2021 when options for funding care in England were again being considered: '[Free care] would be a massive subsidy to the longer

lived, mainly the more affluent in the south–east – ie an end to levelling up before it had started' (Bosanquet and Haldenby, 2020).

In Scotland, in the first major policy divergence from England and Wales after devolution, the Sutherland proposals were accepted (Hassan and Shaw, 2020). Free personal care was introduced initially for people over 65 (in 2002) and later (2019) for disabled people of working age. People in Scotland who meet needs assessment criteria are entitled to 'free personal care' (including support with washing, dressing and eating). Local authorities are still able to charge people for other types of care (including meals on wheels, transport, day services, laundry, alarms and aids and adaptations). A fixed rate was established for personal care and nursing costs in residential care homes in Scotland (£212.85 and £95.80 respectively per week in 2022), with accommodation and food costs for people in residential care chargeable for people with assets above the means test threshold (£28,750 in 2022). It is estimated that free personal care meets about 25 per cent of the total weekly cost of a residential care home place (Bell, 2018). Withdrawal of Attendance Allowance for Scottish care home residents following the introduction of free personal care meant they lost up to £86 per week in social security benefits.

The Health Foundation (Bell, 2018) has warned against seeing free personal care as central to Scotland's care system, noting that it only constitutes 20 per cent of total public expenditure on care homes (the remainder is spent on people whose income and assets are below the means test threshold). The Feeley Review (2021) noted that the amount paid for personal care and nursing care for self-funders had fallen behind what was paid for state-funded residents, recommending that these should be brought into line.

A funding cap

A second option for funding care, recommended by the Dilnot Commission (2011) and passed into law in England's Care Act 2014, was to 'cap' lifetime payments for care to a fixed maximum amount. The Dilnot Commission proposed both a lifetime limit on care contributions of £35,000 and raising the means test threshold for individuals to £100,000 (based on income and assets). Drafting of the Care Act 2014 took inspiration from its report but did not take all its calculations on board. It legislated for a lifetime cap of £72,000 and left the means test threshold unchanged. This was a big step forward in terms of limiting the liabilities faced by private individuals. In practice, however, this cap was never implemented. Following a warning from English local authorities that they could not administer the cap amid other financial pressures facing them, this part of the Care Act was postponed and eventually abandoned (Foster, 2021).

There have been various efforts since to revive or reinvent the Dilnot Commission's cap on care costs for individuals. The Conservative Party's incoherent and unpopular reforms proposed in the 2017 General Election (a 'floor' on spending enabling people to keep £100,000 of assets and incorporating the value of their housing assets into the means test for home care) are one such example. These were quickly dubbed a 'dementia tax' by opposition parties and the tabloid press, and effectively abandoned after several days of negative coverage (BBC News, 2017). The perceived damage done to the Tories' poll rating during the rest of that election campaign was a reminder of how politically toxic care funding reform can be. It draws attention to new winners and losers, often failing to remind people how many people are already losers in relation to care expenditure.

Boris Johnson became Prime Minister in 2019 and promised that he had a social care plan ready that would fix social care 'once and for all' (Campbell, 2019). However, it was another two years before the plan emerged (with some of this delay being due to the COVID-19 pandemic). In relation to paying for care, the key element turned out to be a revival of Part 18(3) of the Care Act 2014, which had legislated to introduce the cap. The new proposals put the maximum care contribution at £86,000 for care expenditure incurred after October 2023, with plans to make the means test more generous so fewer people would be required to fully self-fund their care. New 'fair costs of care' proposals were set out by the Department of Health and Social Care (HM Government, 2021). These would require local authorities to work with providers to set realistic fee levels and ensure self-funders could have their care purchased for them by their local authority, ending the self-funder subsidy (HM Government, 2021). As the detailed proposals emerged in autumn 2021, however, it transpired that they were less generous than those in the Care Act, and likely to hit people with assets close to the £86,000 threshold harder than the more affluent (Tallack and Sturrock, 2022). During preparations for these reforms ahead of implementation in 2023, major concerns emerged from local authorities and care providers about the investment required and rapid implementation timetable (CCN, 2022). In autumn 2022, the Chancellor announced that implementation of the cap would yet again be postponed, at least until 2025 (HM Treasury, 2022).

Incremental change

Wales has made some progress on reforming care funding, although developments fall well short of Scotland's commitment to free personal care. The Welsh Government had planned to follow England's intended 'care cap' route, but plans were put on hold after England failed to implement the cap (Boyce, 2017). An interviewee from local government indicated that the

lack of progress on reform in England continued to influence discussions in Wales: "The conversation keeps coming back to: well, shall we see what England's doing? And until we resolve that bit of it, I think that's the big stumbling block."

In place of wider-ranging reform, the Social Services and Well-being (Wales) Act 2014 introduced a cap on the maximum weekly charge for home care (£100 in 2022) and raised the means test threshold for free care in residential settings (set at £50,000 in 2022). These changes were designed to be short-term fixes ahead of a longer term settlement. An interministerial group on paying for care was established in 2018, and the Welsh Government has commissioned a number of reports on options for reforming the funding of social care (Holthman, 2018; LE Wales, 2020). The new Welsh income tax powers that came in 2019 create a context in which the Welsh Government can consider raising additional funding for social care (LE Wales, 2020). Following the Scottish route is one of the options being considered: "We're certainly looking at free personal care, we're looking at workforce options, we're looking at some of those cliff-edge costs and how they can be possibly smoothed a little, or the kind of things that have been on the table like Dilnot" (Wales, civil servant).

Following the 2021 elections the governing Labour Party signed an agreement to work with Plaid Cymru on a number of agreed items (Welsh Government, 2021a). This included setting up an expert group to create 'a National Care Service, free at the point of need, continuing as a public service', with an implementation plan to be in place by the end of 2023 (Welsh Government, 2021a: 3).

Ending risk-pooling

Northern Ireland is in a different position to the three other nations in relation to care funding reform. Progress on this, as on other issues, has been hampered by the broader lack of legislative activity on social care. The long-standing integration of health and social care means that funding arrangements differ from elsewhere in the UK. Care is arranged through Health and Social Care Trusts (HSCTs), with no charges made to individuals for personal care at home. As a result of this and Northern Ireland's socioeconomic profile, there are very few self-funders (as discussed in Chapter 3).

Our exploration of convergence and divergence indicates that in England, Scotland and Wales the focus has been on limiting individual liability for care costs through a cap or by risk-pooling. As discussed in Chapter 2, in relation to fairness, the policy debate in Northern Ireland has been focused on reform in *the opposite direction*, with proposals to introduce private payment for home care (Kelly and Kennedy, 2017: 65). However, the difficulties of

policy-making in the region have contributed to policy inaction on this issue, as on others. As one interviewee put it:

> 'Now, politically, within Northern Ireland, there are two things that our politicians know probably need to happen. And because of the way Northern Ireland is, whether any politician will ever put this on the table to do it, I don't know. One is charging for domiciliary care and two is introducing water rates. And they have been kicked around for so long and I don't know if they can ever do it.' (Northern Ireland, care commissioner)

One interviewee suggested that, as in Wales, a lack of progress in England had contributed to this stasis: "We do this thing here in Northern Ireland – and we don't just do it on care, we do it with a lot of things – wait and see what happens over there" (Northern Ireland, regulatory/oversight body).

We have focused in this section on who pays for care at the point of use, rather than how funds are brought into the system, a related, but separate, issue. Given the extent to which austerity has intensified the care crisis in parts of the UK, clearly more investment is needed. In England alone, the Health Foundation has estimated that an extra £1.9 billion is needed by 2023–24 to meet demand, without addressing quality or unmet need (The Health Foundation, 2021). Government funding for care (in the form of a block grant to local authorities) has reduced in England and Wales, although it has increased in Scotland and Northern Ireland, as previously discussed. The devolved nations have some capacity to raise funds through taxation and to decide how much to allocate to social care within their block funding. In December 2021 the Scottish Government's budget included a substantial increase in spending on social care, from less than £400 million to more than £1.1 billion, making it the policy domain with the biggest increase. Some of this money will go to local authorities to improve the pay of care workers and some to fund the creation of Scotland's planned National Care Service (Scottish Government, 2021). The UK Government's planned health and social care 'levy' (from October 2023) would have introduced a hypothecated tax, designed to increase care funding across the UK (DHSC, 2021b). However, the levy plan was abandoned in 2022, with the government reverting to short-term influxes of cash (HM Treasury, 2022). Critics have highlighted the missed opportunity to put social care on a sustainable, long-term, financial footing (Laing Buisson, 2022b).

Personalise support

Making social care more person-centred has been a key reform principle in all four parts of the UK, albeit with some differences of emphasis. The

'personalisation agenda', as it is sometimes called, has been a feature of decades of campaigning by disability rights organisations for choice and control over how people are supported. Since the 1980s, the human rights-oriented message demanding greater recognition of personhood (linked to the UN Convention on the Rights of Disabled Persons) has chimed with the increased 'individualisation' of a more consumerist welfare agenda (Needham, 2007). The Independent Living Fund, introduced in 1988, provided disabled people with cash allocations enabling them to pay for personal assistance (Glasby and Littlechild, 2016). Some local authorities were very receptive to experimenting with new, more individualised, ways of providing support, such as 'direct payments' (Glasby and Littlechild, 2016). Sustained campaigning by disabled people, and the framing of individualised funding as a way to minimise state spending, led to direct payment legislation being introduced by John Major's Conservative government (Zarb and Nadash, 1994; Pearson et al, 2020). The Community Care (Direct Payments) Act 1996 gave local authorities the power to allocate funds directly to older people (and from 2000, to disabled people). This became a duty for local authorities in England and Wales in 2001, in Northern Ireland in 2002 and in Scotland in 2003 (Glasby and Littlechild, 2016).

Take-up was low and geographically patchy, however, leading to initiatives to broaden the reach of the policy (Pearson, 2000). In England, the *Putting people first* concordat was signed in 2007 by central government, local government and the social care sector, giving new momentum to this agenda. The concordat widened the focus beyond individualised funding (HM Government, 2007) to include early intervention, prevention, social capital and improved access to universal services. However, it was personal budgets – which expanded direct payments to include new forms of individualised funding that could be managed by a local authority or third party – that drew most attention and follow-up.

The Care Act 2014 reaffirmed the government's commitment to personalisation in England. Expectations were set out in statutory guidance accompanying the Act:

> Local authorities should facilitate the personalisation of care and support services, encouraging services (including small, local, specialised and personal assistant services that are highly tailored), to enable people to make meaningful choices and to take control of their support arrangements, regardless of service setting or how their personal budget is managed. (DHSC, 2022: Section 4.46)

The person-centred approach was further endorsed in the 2021 *People at the heart of care* White Paper: 'Person-centred care is a key theme running through this [10 year] vision. Genuine choice and control about personalised

care and support can enhance quality of life and promote independence in a way that matters to individuals' (DHSC, 2021b).

The Social Care (Self-Directed Support) (Scotland) Act 2013 similarly emphasised principles of choice and control through individualised funding. Pearson (2004) notes that in Scotland the original direct payment legislation of the mid-1990s was viewed with some suspicion, as a form of 'backdoor privatisation'. The 2013 Act was broader than this, offering a range of ways in which people with an assessed care need could direct their care (Pearson et al, 2018). The Act states that all councils must offer self-directed support, through a direct payment, a managed budget, a third party or a mix of these options. As with personalisation arrangements in England, the legislation weaves together responses to disability rights campaigns for independent living and co-production with concerns for cost-efficiency and effectiveness (Pearson and Ridley, 2017).

In Wales, the 2006 *Beyond boundaries* review of local service delivery called for more personalised services, and for 'citizens (to) receive high quality, personalised, joined-up services, planned across organisational boundaries'. Nonetheless, it warned against 'relying on a simplistic version of choice between service providers, whereas what citizens may value most is different forms of choice, personalisation and the opportunity to express preferences and influence provision' (Beecham, 2006: 5). As in Scotland, the language of personalisation was later dropped. The *From vision to action* report used the language of 'citizen directed support' (Independent Commission on Social Services in Wales, 2010: 54), while other documents focused on 'voice and control', in contrast to the 'choice and control' approach favoured in England. The Welsh Government's White Paper *Sustainable social services* explained the choice of vocabulary: 'We believe that the label "personalisation" has become too closely associated with a market-led model of consumer choice' (Welsh Assembly Government, 2011: 15). The Social Services and Well-being (Wales) Act 2014, implemented from 2016, made a clear commitment to voice and control through 'citizen centred support', although Llewellyn et al (2020) note that what is meant by 'voice and control' isn't clearly defined in the Act.

Northern Ireland has had the same direct payments legislation as the rest of the UK since 1996, although it lacks the more recent legislative endorsement of self-directed support and personalisation seen in the other three nations. Northern Irish policy documents confirm the importance of this agenda. The *Transforming your care* review states the first key principle of social care reform as being, 'Placing the individual at the centre of any model by promoting a better outcome for the service user, carer and their family' (Health and Social Care Northern Ireland, 2011). However, in 2015, a detailed analysis of home care (*A managed change*) noted: 'relatively modest progress when compared to other areas of the UK. In recent years the rate

of uptake has reached a plateau and there have been small reductions in some Trusts/programmes of care' (Health and Social Care Board, 2015: 31). The document then went on to reaffirm the commitment to self-directed support: 'Self-directed support is regarded as one of the HSCB's [Health and Social Care Board] major reform projects in the delivery of community based care and support for older people and those with disabilities' (Health and Social Care Board, 2015: 31). In using the language of self-directed support, Northern Ireland has drawn on the Scottish model (Pearson et al, 2018). As in Wales and Scotland, some avoid the language of personalisation. As one interviewee put it: "Personalisation is not a word that I come across too often here. To me, it is a very English word" (Northern Ireland, carers' organisation).

Conversely, Northern Ireland's *Power to people* report (one of whose authors, Des Kelly, has worked in England for many years) used the term 'personalisation' liberally, alongside self-directed support, talking also of the importance of 'consumer sovereignty' in social care – a concept that contrasts with the perspective adopted in Scottish and Welsh documents (Kelly and Kennedy, 2017). Just as the care funding debate evokes contested accounts of fairness, we can see in debates about person–centred care the underpinning tensions around rights and markets. These play out differently in the four jurisdictions. We can also see some reluctance in the devolved nations to use language too closely associated with England, a point of divergence we return to in later chapters.

Support for unpaid carers

In all parts of the UK, there has been increased formal recognition of the role played by unpaid carers. Their contribution is crucial to a sustainable care system, and they are increasingly recognised as needing, and being entitled to, support themselves (Yeandle et al, 2012). COVID-19 in particular was seen to magnify the strains on carers across all four nations. The UK nations, with the exception of Northern Ireland, legislated to improve the support provided to carers in the 2010s. In England, the Care Act 2014 gave carers the right to support following an assessment. A Carers Action Plan to support implementation followed (DHSC, 2018). The 2014 Act also aimed to make support for carers more consistent across local authorities (Marczak et al, 2022). Improved support for carers was a key element of the Social Services and Well-being (Wales) Act 2014. As in England, it gave carers the right to support following an assessment, and established in law that they had the same rights as those they care for. The Carers (Scotland) Act 2016 gave all carers in Scotland the right to a support plan and to having their eligible needs met, as identified in their plan. The Feeley Report noted that relatively few unpaid carers receive statutory respite support and recommended a

'right to respite' (Feeley, 2021), which the Scottish Government (2021) was considering as part of its National Care Service consultation.

Northern Ireland has not enacted specific legislation on carers since the Carers and Direct Payments (Northern Ireland) Act 2002. The 2017 *Power to people* report proposed bringing Northern Ireland's rights for carers into line with those for England in the Care Act 2014, but this has not yet happened. HSCTs in Northern Ireland have a duty to inform carers of their right to an assessment, but (unlike other parts of the UK) no duty to meet needs identified by that assessment. Northern Ireland also lacks a legal definition of a carer (which other UK nations have). The definition in the Care Act 2014, for England, is 'An adult who provides or intends to provide care for another adult'; the Welsh definition is similar; and the Scottish definition includes care for disabled children as well as adults. Wales and England have national eligibility criteria for carers' support, whereas in Scotland this is decided by local authorities, and in Northern Ireland, it is at the discretion of HSCTs. Carers who meet the eligibility criteria for Carer's Allowance, a welfare benefit first established in 1976 (when it was entitled 'Invalid Care Allowance'), can receive this weekly amount in England, Wales and Northern Ireland, provided they are not receiving other 'overlapping' payments from the state (such as State Retirement Pension). In Scotland, since 2019 (following devolution of social security arrangements to Scotland) this benefit has been increased, with a Carer's Allowance Supplement designed to align its value with the unemployment benefit 'Jobseeker's Allowance'.

As we have shown, there is clear divergence in legal and financial entitlements for carers. The Scottish approach is the most generous financially. Northern Ireland lags behind on carer legislation. Implementation of legislation intended to support carers has been patchy and problematic in England, Scotland and Wales, as we discuss in the next chapter, but the existence of a formal definition and of specific rights in law is nonetheless recognised as an important achievement in these three nations in the last decade.

Invest in prevention

Supporting people *before* they need statutory social care services has also been a central part of social care policy in all four nations. As Miller et al note:

> [T]here is growing recognition that the system has too often concentrated only on those with the greatest and most complex needs, leaving fewer and fewer resources, financial and otherwise, to meet lower-level needs. Early intervention and prevention are seen as an essential component of achieving a more personalised social care

system through ensuring that service users are supported to retain independence for as long as possible. (Miller et al, 2013: 120)

However, whereas the areas of reform already outlined have clear mechanisms for change (for example, a funding cap, a direct payment, a carer's assessment), prevention remains ill defined. It aims to stop something happening, and less progress has been made in specifying what that means and how it could be achieved.

In England, Tew et al (2019: 10) highlight the importance of the Care Act 2014 in increasing the ambition of preventative approaches. Whereas prevention activity was underway before the Act, this focused on a relatively narrow set of interventions such as reablement, falls prevention and signposting. In contrast:

> 'Second wave' approaches to prevention and capacity building ... have become more prominent since the implementation of the Care Act 2014. ... This has involved more fundamental revisioning of the role of local services and the relationships between services, citizens and communities – and a more positive and holistic focus on enhancing wellbeing, opportunity and social connectivity, as opposed to a more defensive focus on mitigating risk and providing services in response to identified needs. (Tew et al, 2019: 10)

With this 'second wave' has come an interest in asset-based and strengths-based approaches that focus on people's skills, capabilities and networks rather than their needs and deficits (Milne et al, 2021). Models include 'Local Area Coordination', the 'Three Conversations' approach and 'Asset-based Community Development'. A scoping review by Milne et al (2021) found that strengths-based approaches are increasingly mainstream within local authorities. Definitions remain fluid, however, and it is unclear how their effectiveness and feasibility should be evaluated.

Cairney et al (2016) highlight prevention as a key pillar of the 'Scottish approach'. The Christie Report of the Commission on the Future Delivery of Public Services (Christie, 2011) formed the basis for Scotland's public services strategy, and placed a strong emphasis on prevention. In its response to Christie, the Scottish Government talked of developing a 'decisive shift towards prevention' (Christie, 2011: 1). The subsequent National Care Service consultation reaffirmed this focus:

> Done well, a focus on early intervention and prevention avoids the need for more costly action at a later stage. For example, supporting unpaid carers so that they can continue their caring relationship, supporting families to prevent family breakdown, or ensuring appropriate care to

prevent deterioration or falls resulting in a need for hospital treatment, all result in benefits for individuals and families, and for our health and care services. (Scottish Government, 2021: 6)

Similarly in Wales, the 2003 report into the health and social care system placed a strong emphasis on prevention: 'There should be a strategic adjustment of services to focus them on prevention and early intervention. Potentially this offers significant long-term cost and quality of life gains' (Welsh Assembly Government, 2003: 2). The Well-being of Future Generations (Wales) Act 2015 gives a particular focus to its ambitions around prevention, requiring public bodies to take account of prevention as one of the 'ways of working' required by the Act. Guidance to accompany the Act indicates:

> Understanding the underlying causes of the problems people and communities face can help us find different solutions, intervene early and prevent problems from getting worse or arising in the future. But this is not just about addressing problems – it is about finding enabling solutions and early interventions at the right time to make progress in achieving the well-being goals. (Welsh Government, 2015a: 23)

In Northern Ireland, investing in prevention is identified as a key principle in *Transforming your care* (Health and Social Care Northern Ireland, 2011), and has been restated subsequently. The Bengoa Report in 2016 described a prevention focus across the heath and care system as vital to avoid system collapse (Bengoa, 2016). However, the 2017 *Power to people* report highlighted the lack of a prevention focus to date:

> [O]ur system is currently focused almost entirely on 'Failure Demand' defined as demand caused by a failure to do something or do something right for the customer. ... We have to work out how to make a fundamental shift away from a crisis dominated system into a long-term solution focusing on prevention and early intervention in which care and support is based initially around people and their communities. (Kelly and Kennedy, 2017: 45–6)

Technology is seen as playing a key role in relation to prevention and early intervention, particularly to enable people to live at home for as long as possible (Wright, 2020). All four nations have a digital strategy that incorporates social care. The Scottish Government's *Health and social care delivery plan* notes that, 'Digital technology is key to transforming health and social care services so that care can become more person-centred' (Scottish Government, 2016: 23). England's 2021 *People at the heart of care*

White Paper includes £150 million of investment, over three years, 'to drive digitisation across the sector; and unlock the potential of caretech innovation that enables preventative care and independent living' (DHSC, 2021b). Wales and Northern Ireland have invested in telecare and note its importance to future care systems, although Wright (2020) observes that the Welsh Government has been more cautious than elsewhere, calling for incremental rather than rapid growth. There has been recent enthusiasm about the scope for using data collected by digital devices in a proactive way as part of a broader preventative approach (Welsh Government, 2015b; Health and Social Care Board, 2016; Scottish Government and COSLA, 2021).

There is clear convergence between the four nations in relation to the prevention focus, recognising its potential 'win-wins' in improving people's quality of life and wellbeing while reducing reliance on state services. Nonetheless, as we discuss when considering policy successes in Chapter 5, it has been hard to keep focused on prevention at a time of fiscal pressures (particularly in England), and the challenge of evidencing progress on prevention remains significant.

Integrate with health

People who use social care often also use primary, community and acute health services. The NHS and local authorities that purchase and provide care services share a number of goals: keeping people well in their own homes for as long as possible; improving system efficacy; and promoting a more person- (or patient-)centred approach. However, the experience of using both NHS and care services can often be fragmented, frustrating and sometimes detrimental to wellbeing. For instance, people may find themselves in hospital unnecessarily due to insufficient coordination between hospital discharge and local authority assessment processes for social care. Integrating these services to provide a more coordinated service has been a key policy goal for all four nations for at least two decades.

There have been a number of different approaches to this challenge. These include pooled funding and the joint planning and purchasing of services, as well as merging organisations, colocating staff and centralising information systems. Miller et al (2016) differentiate between micro, meso and macro forms of integration. Micro integration describes the interactions of practitioners, for instance home care workers and district nurses. Meso integration describes joint teams of practitioners from different organisations or the development of targeted services such as integrated discharge teams. Macro integration describes the systems-level integration at play in joint boards and shared policy-making across localities. Across the UK, recent integration policy has mainly focused on macro-level changes: systems-level

funding and strategies for particular localities, with meso and micro initiatives greatly varying from place to place (Miller et al, 2016).

Northern Ireland has had structural health and social care integration for much longer than the other nations. In 1972 a Health and Personal Social Services Order established joint health and social care bodies in the province. Despite its longevity, integration remains an incomplete goal of the Northern Irish system, as evidenced in the 2011 review *Transforming your care*: 'Services provided by different parts of the health and social care system should be better integrated to improve the quality of experience for patients and clients, safety and outcomes' (Health and Social Care Northern Ireland, 2011: 40). Responding to the recommendations of this report, Northern Ireland established Integrated Care Partnerships (ICPs) that identify high-intensity users and attempt to design 'wraparound care' led by clinicians (Malone and Hayes, 2017). The 2020 Northern Ireland Executive *New decade, new approach* statement (following re-establishment of power sharing in Northern Ireland) noted that policy proposals relating to integration needed to be implemented (Reed et al, 2021: 23).

In Scotland, the government has taken a more direct legislative approach to integration. The Public Bodies (Joint Working) (Scotland) Act 2014 placed a duty on NHS organisations and local government to delegate health and care functions and budgets to new integrated authorities, with a view to making these new authorities the joint commissioner of health and care. Five years on, recognising limitations in what had been achieved through this approach, the 2021 National Care Service (NCS) consultation document put forward further structural reforms:

> [W]e propose that IJBs [Integration Joint Boards] will become Community Health and Social Care Boards (CHSCBs) and will be the local delivery body for the NCS, funded directly by the Scottish Government. This will be the sole model for local delivery of community health and social care in Scotland. The functions of CHSCBs will be consistent across the country and will include all community health and social care support and services that the Scottish population requires. (Scottish Government, 2021: 90)

In Wales, in 2009, Health Boards were established to coordinate health and social care across regions, but stopped short of full integration:

> We are not persuaded that some social services should transfer to the NHS. This would undermine the integrated support, protection and inclusion for the vulnerable provided by the local government family. There are faster and less disruptive ways to address the issues encountered at the interface between health and social care. We recommend that

social services and social care for adults and children should remain a local government responsibility. (Independent Commission on Social Services in Wales, 2010: 7)

The Social Services and Well-being (Wales) Act 2014 established a legal duty on local government to promote integration, implemented through seven Regional Partnership Boards (RPBs). The Well-being of Future Generations (Wales) Act 2015 established 19 Public Service Boards (PSBs) that are required to promote wellbeing in their local areas (Heenan and Birrell, 2018). Although the RPBs and PSBs are expected to work in coordinated ways, in practice there has been confusion about their operational distinction (Reed et al, 2021: 43). In 2021, the *Rebalancing care and support* White Paper proposed to put RPBs onto a legal footing, enabling them to employ staff, hold budgets, undertake commissioning and shape markets (Welsh Government, 2021b: 19).

Integration has been a policy goal in England for several decades, but structures have not had a legal basis comparable to that in the other nations (Reed et al, 2021: 3). In England, the Better Care Fund, established in 2013, sought to transform local health and care systems using a joint pot of money spent on shared priorities. These local priorities are agreed and signed off at local Health and Wellbeing Boards – another macro integration intervention (enshrined in the Health and Social Care Act 2012) to develop joint health and care strategies. In 2015, NHS England announced a range of pilots to explore organisational alignment between different aspects of health and social care services. These 'vanguard sites' sought to develop new models of care based on new contractual structures, payment regimes and joint organisations (Miller et al, 2016). Since 2015, these new organisations and partnerships have developed 'place-based' approaches: collaborations that seek to manage demand into acute services and promote wellbeing and the prevention of ill health. NHS England developed these loose partnerships into 'Sustainability and Transformation Partnerships' and more recently into more formal 'Integrated Care Organisations' (Miller et al, 2021). In yet another development, in 2021 the Department of Health and Social Care introduced proposals for Integrated Care Systems, which are legal structures, bringing England into line with the other nations (DHSC, 2021a).

Professionalise the workforce

High staff turnover and rising vacancy rates are symptoms of problems within the social care workforce. Skills for Care data shows a pattern of growth in staff vacancies over time, with figures for England in 2020–21 showing vacancies at around 105,000 at any one time (Skills for Care, 2021). The

report also showed that turnover rates were highest for people on zero-hour contracts. An All-Party Parliamentary Group (APPG) report on social care covering the four nations noted that half of care workers leave their job within the first year. A care provider giving evidence to its inquiry reported:

> There are simply too few people wanting to join and stay in adult social care roles. Despite regular efforts by government, Skills for Care, and employers, including a recent national recruitment campaign in England, the tide has not been turned whilst the demand for care continues to grow. … The inability to access enough qualified, motivated and values-based carers and nurses is the biggest single threat facing the sector. (Quoted in Hayes et al, 2019: 17)

Key issues reported to the APPG were low pay, availability of easier jobs in hospitality and retail, lack of training and career development and Brexit uncertainty. These point to clear problems for service user outcomes:

> The lack of funding, training and professionalisation evident across much of the social care workforce is clearly a major factor in negative service user experiences, and during the course of this inquiry, we have heard accounts of the use of multiple care workers to support someone, and the associated unfamiliarity with people, insufficient time allocated for care duties, a lack of continuity of care, and indeed a lack of any kind of care worker at all. (Hayes et al, 2019: 33)

New Labour's 2010 White Paper, *Building the National Care Service*, indicated its intention to introduce a licensing scheme for all social care workers (encompassing residential care, homecare and personal assistants [PAs]) (HM Government, 2010). The change of government later that year meant these changes never happened. In 2011, the coalition government Health Minister Andrew Lansley announced:

> The risk to service-users and the general public posed by groups of unregulated health and social care workers is not considered to be such that regulation of individual workers is necessary ... the Government does not believe that the extension of statutory regulation to all workers in the health sector across the UK and the social care sector in England would be a proportionate response. The emphasis should be on employers of unregulated workers to take responsibility for the quality of services provided. (Cited in Hayes et al, 2019: 31)

A decade on, the 2021 White Paper, *People at the heart of care*, appeared to revive earlier plans, and included proposals for a voluntary 'skills passport'

that would be used for 'establishing a foundation for registration of staff in the future' (DHSC, 2021b: 76).

In Scotland, worker registration is mandatory in some care settings. The Scottish Social Services Council (SSSC) has a remit for adult day care and residential care, care at home and housing support services. The majority of the social services workforce must register with the SSSC within six months of starting work. Workers are not required to have a relevant qualification in order to register, but must acquire one within five years; most are paid the Scottish Living Wage, and are entitled to travel time, holiday and sick pay and sleepover payments (Hayes et al, 2019). The Resolution Foundation found that Scottish care workers were the best paid in the UK (Cominetti et al, 2020). As one of the interviewees working in the third sector in Scotland put it:

'[W]e now have the bones of an adult social care reform programme, which is going to tackle all of these things that I've been talking about in the workforce. Living wage, sustainability, different service models, they've accepted, totally, that is where they should be focused. I'm kind of moaning about how terrible everything is, but actually, in policy terms, it's pretty bloody good! Actually, it really is, it really is, comparatively.'

In Scotland, as elsewhere, the PA or directly employed workforce is unregulated and operates outside state visibility:

'So I guess we didn't really know how big our PA workforce was until Covid happened and we tried to pay them the £500 payment or get their ID card and their PPE. We realised, oh we don't really know where they are and what they do or how they're trained.' (Scotland, civil servant)

The National Care Service consultation in Scotland (Scottish Government, 2021: 130) is looking at whether a register and national minimum employment standards for PAs should be introduced.

The Northern Ireland Social Care Council is the regulator for the social services workforce there. People working in social care in Northern Ireland have been required to register with the Council since the end of 2017. Registration in Northern Ireland covers residential care workers and is being extended to home care workers. No qualifications are required to join the register. Given the relatively high proportion of in-house staff in social care, an issue for Northern Ireland is the pay differential between care staff employed by a Trust and those employed in the private sector, as discussed in Chapter 3.

In Wales, social care staff in domiciliary and care home settings are required to register with Social Care Wales. To be eligible for registration,

they must have suitable qualifications and agree to abide by professional standards. The Welsh Government describes registration as 'serving the dual purposes of professionalising and raising the status of the social care workforce, and reassuring service-users and their families that workers have the qualifications and skills required to perform their work professionally' (Hayes et al, 2019: 20).

England is, therefore, alone among the four nations not to have mandatory registration (beyond professions such as social workers and nurses). Oung et al (2020) point to the difficulties of introducing registration in England:

> One of the biggest challenges with the professionalisation of the English social care workforce is its size, as well as the vast number of settings in which the workforce operates. Developing mandatory registration as a first formal step in professionalising the workforce would require large amounts of planning and resources, especially if registration is to increase the attractiveness of working in the sector. (Oung et al, 2020)

A further complexity arises where staff work across the England–Wales or England–Scotland borders and would become subject to separate registration frameworks. The APPG report called for recognised compatibility standards between England, Wales, Scotland and Northern Ireland (APPG on Adult Social Care, 2019: 12).

Many of the interviewees made the case for professionalisation, seeing it as crucial to increasing the skills and prestige of the sector:

> 'I want also some proper remuneration recognition for social care staff, because these people are dealing with very complex people and very complex issues and they should not be seen as people who do a minimum wage job. They are people that should be on a career pathway, because they are professionals, they should have acknowledgement of that. They should also have the qualifications for that. And also I think registration would help with the status because it would also help us to be really clear about the support that is offered to the worker, but also the worker's responsibility and accountability for the quality of the service they provide.' (England, provider representative)

For many it was also an important way to acknowledge and recruit for the level of expertise required. Comparisons to other parts of the NHS were common:

> 'I want proper career pathways and escalators for social care, just as we have them in other parts of the system around the NHS.' (England, provider representative)

> 'You can go in, now, and start working in a nursing home or for a domiciliary care provider. Maybe you're looking after people who are terminally ill, for example. You maybe worked in a garage the week before. ... They're put through training and stuff once they start but if you compare that to what someone who wants to be a GP or a doctor has to go through, it's two completely different things. Then we're surprised when people complain about the standard of care in the nursing home or they refuse domiciliary care because it's not good enough.' (Northern Ireland, third sector)

Professionalising care workers is about more than just registering them. The title of an APPG on Adult Social Care (2019) report on care workers in 2019 identified three strands: elevation, registration and standardisation. Hayes et al (2019: 3) note that addressing aspects of professionalisation and sector reform cannot be done effectively if this happens piecemeal: "Training, occupational registration, concern for safeguarding, terms and conditions of work and funding are intricately connected and improvements must be made on all fronts to recognise and reward the skills and professionalism of care workers."

Hayes et al (2019) also highlight that other changes in care systems, such as the trend towards personalised or self-directed support, have implications for the workforce that need to be considered. As the *Domiciliary care workforce review* for Northern Ireland (2016–21) put it: 'In line with the principles of personalisation, the role of the professional and the care worker within SDS [self-directed support] will become less about being a "fixer" of problems and more about being a co-facilitator of solutions working in collaboration and co-production based on power sharing and mutual respect' (DH, 2018: 30).

There is also a need to recognise how diversity across the four nations in relation to affluence and diversity and urban and rural factors affects workforce availability and the sorts of issues that are required to attract staff. Interviewees in Scotland emphasised the challenge of getting sufficient providers and staff in rural and remote areas:

> 'Attracting providers into some remote and rural areas is quite challenging, because of the problems with actually recruiting the workforce and all the issues around about things like travel time. ... Some of the island communities in particular have issues in attracting providers, and quite often have to pay additional subsidies in terms of hourly rates.' (Scotland, local government representative)

Similarly, interviewees in Northern Ireland highlighted the rural and urban divide:

'If you're in the city … [it's] not the most stable of workforces, but providers would tell us that they find it easier to get the staff to work in the cities. There is the turnover, but you can get the people. In rural areas, obviously the pool that you're recruiting from is shallow, but also there are additional difficulties. The contract price, particularly for domiciliary care, is low and a lot of providers squeeze their staff in terms of payment of travel time, or travel expenses, mileage. Now, that's less significant if you're able to work by walking to and from a dozen streets, surrounding the street you live in. But if you have to have a car and you have to drive to your clients that becomes an issue.' (Northern Ireland, civil servant)

It can be particularly hard to find social care staff in areas where wages are high and there are plentiful alternative forms of employment. One of the local councillor interviewees from England noted that the lack of this dynamic in their area made recruitment easier: "The fact that we have a low wage–base economy means that we can afford to keep [social care] going pretty well, actually, when compared to some other places."

In Wales, the Welsh language is an important aspect of staff recruitment, particularly in the areas where Welsh speaking is most prevalent. The right to speak Welsh was added to the definition of wellbeing in Wales in 2017 (Hamblin, 2019), but, as has been pointed out, 'just 16 percent of staff working in regulated services and 10 per cent of staff working for commissioned care providers can communicate effectively through the medium of Welsh' (Hayes et al, 2019: 15). This may in part be because Welsh speaking is unevenly distributed across Wales (Jones and Lewis, 2019). One of the interviewees from the NHS in Wales commented:

'I don't get a double decker bus arriving in [the local town] with 16 [occupational therapists] on it who can speak Welsh. So you've always got to be thinking outside the box. You've got to have good links with the universities, offer placements for students, encourage people when they do go away to train that they're more than welcome to come back.'

Addressing workforce challenges requires recognition of these different aspects of diversity, and the ways in which different levers will be required in different localities.

Assessing progress

As is evident from the range of issues discussed in this chapter, reforming the care system is a daunting task, equivalent to the foundational work that went into constructing a comprehensive welfare state in the UK after the

Second World War. We identify two groups among the four nations: those with a wide-ranging care act (a 'big bang' approach, adopted in England and Wales) and those that have reformed their care system in more gradual way (Scotland and Northern Ireland). England had a large set-piece Act – the Care Act 2014 – which was the most wide-ranging care legislation since the National Assistance Act 1948, codifying over 50 years of care policy and guidance (Spencer-Lane, 2011). The breadth of the Care Act 2014 has been seen by some people as a disadvantage. As an English civil servant in our study put it, "The Care Act is quite kind of aspirational in its drafting and therefore probably is going to be true for all time that if you ask user representative charities, do you feel that the Care Act has been beautifully delivered over the country, they're always going to say no".

In England a new Health and Care Act was passed by Parliament in 2022 to further progress integration between health and social care and give the Care Quality Commission the power to inspect local authority commissioning (DHSC, 2021a).

The Social Services and Well-being (Wales) Act was seen by Welsh interviewees as the key legislation, albeit alongside other Acts that established new approaches:

'We had new legislation with the Social Services and Well-being (Wales) Act. That was all about the design of the system, if you like, the expectations, more voice and control, more collaboration. Looking at early intervention, focusing more on safeguarding, so that was the policy principles. The sister Act was RISCA, Regulation and Inspection of Social Care. That established new responsibilities for [the] Care Inspector of Wales. That's the service regulator – and new responsibilities for us as the workforce regulator.' (Wales, regulatory/oversight body)

The Well-being of Future Generations (Wales) Act 2015 was also seen as important legislation, supporting and taking further the Social Services and Well-being (Wales) Act. A Welsh civil servant described it as a 'top of the tree' Act in terms of shaping the context for other policies. However, another respondent noted that the links between the legislation were not always clear:

'So you've got the Future Generations Act. … Then you've got *A healthier Wales*, which is just a sort of policy document, but that's the road they want to go down. And you've got all these people then working in Welsh Government, in their different little silo departments, not understanding these other policies, and these other pieces of legislation, might actually fit into the future sort of direction of their

work. So you've got departments there who don't talk to each other.'
(Wales, carers' organisation)

Scotland has no equivalent to the wide-ranging Acts in England and Wales, but has pursued an iterative approach to care reform, developing a series of new laws for different issues in the care system. In contrast, Northern Ireland has lacked legislative change in social care. As one interviewee put it: "Legislation is a blunt tool but, well, we don't have an adult safeguarding bill … and every other part of the UK does. … We haven't got the care bill or any equivalent" (Northern Ireland, regulatory/oversight body).

There is a sense of 'playing catch up' (Chapman, 2018). As another Northern Irish interviewee from the Health and Social Care Board put it: "It is very outdated, the legal framework underpinning the delivery of social care [in Northern Ireland]. It was in the '72, '73 order here … and to support there has been circulars produced by government with particular 2010 circulars that everyone kind of still relies on."

In Northern Ireland, the 2020 power-sharing agreement re-establishing the Executive indicated an intention to implement the proposals in the *Transforming your care* and *Power to people* reports (Northern Ireland Executive, 2020). In January 2022, the Department of Health announced that it was consulting on its response to the *Power to people* report (DH, 2022a). Proposed actions by the Executive included the introduction of comprehensive legislation on social care and a review of charging arrangements, although it remained a draft consultation framework rather than a clear plan for change.

Conclusion

In this chapter we have set out the six mechanisms that have been used to advance care reform in the four nations, noting areas where they are converging and diverging in decisions being made. Much as we found when looking at care values in Chapter 2, the broad goals of reform across the nations are very similar. All six of the mechanisms we have looked at here are being attempted, although the tactics through which this has been done are different. Scotland is the nation that has made most progress on care reform. We can summarise the findings presented in this chapter in the following way:

Active: Scotland has pursued an iterative approach to care reform, developing a series of small pieces of legislation for different issues in the care system. It has: introduced free personal care for over-65s, later extending it to working-age adults; introduced care worker registration and improved pay and conditions; developed a more centralised

infrastructure for integration than exists in England; and brought in a standard national fee rate for care homes.

Emergent: Wales had weaker powers than Scotland following devolution and had to overcome public ambivalence about the new institutions. This led to delays in pursuing a distinctive social care agenda from England. The Social Services and Well-being (Wales) Act 2014 was a large and ambitious piece of legislation. It introduced new rights for carers, a maximum weekly charge for home care and an increase in the means test threshold. Wales has also introduced mandatory care worker registration.

Symbolic: the wide-ranging Care Act 2014, applicable to England, was seen at the time as a new settlement for care, equivalent to the National Assistance Act 1948. However, it has only been partly implemented. Successive prime ministers have talked about the importance of reforming care spending, with a particular focus on protecting people's homes (a bigger issue in England than elsewhere, due to higher levels of self-funding). An adapted version of the care cap model from the Care Act 2014 has also been passed into law in the Health and Care Act 2022 but its implementation has already been postponed from 2023 to 2025.

Stalled: much of Northern Ireland's care settlement was shaped by its structural integration of health and care in the 1970s (itself in part a response to the political violence of that era). As a result of this long history of integration, it has some features that other parts of the UK are seeking to emulate, for example, *de facto* free personal care at home; registration of the workforce; and a strong civil society. However, its lack of policy capacity over the last 25 years (with repeated suspensions of the Northern Ireland Assembly) has prevented progress on key issues such as carers' rights. Much of its legislative framework for care is still derived from the National Assistance Act 1948.

In the next chapter, we focus on how reforms in each of these areas have fared, in order to understand the practice and results element of convergence and divergence (Pollitt, 2002). We explore this through the lens of outcomes, starting by discussing the growth of an outcomes orientation in all four nations, and then looking in detail at outcomes for the six mechanisms discussed in this chapter.