Current challenges to the quality of social care services for people with intellectual disabilities in the UK

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Abstract

As the effects of the financial recession begin to bite, there is a danger that the quality of social care provision for children, young people and adults with intellectual disability in the UK will significantly decline. This article explores some of the factors contributing to this anticipated deterioration: (1) the commercialisation of social care; (2) the expansion of the 'for profit' private sector at the expense of the 'not for profit' voluntary sector; (3) the uncertainties occasioned by frequent changes in regulatory structures; (4) the move to self-regulation of care services; and (5) the neutering of the power and influence of advocacy services.

Keywords: Advocacy, commercialisation of care, deprofessionalisation, market forces, quality of life, self-regulation

Introduction

The reforms implemented following the 'commercialisation' of care which followed the National Health Service and Community Care Act (1990) brought about far-reaching changes to the provision and financing of health and social care in the United Kingdom. Market forces received an enormous boost, 'for-profit' organisations became increasingly active, notions of 'best value' became increasingly relevant within funding formulae, and users of services were more likely to be involved in decision making (Knapp & Kavanagh, 1995). Market ideals as a key principle of public service provision continued to be an acceptable feature of the neo-liberal agenda pursued by New Labour. Initially, there was the establishment of a 'quasi-market' within the public services and the 'not-for-profit' sector occupied a much more level playing field with the 'for-profit' sector.

It is clear that in the UK the provision of social care services is being increasingly opened up to market forces. The National Workforce Group for the Social Services in Scotland has reported that over the last 10 years there has been an adjustment in employment in the sector, with the 'for-profit' and the 'not-for-profit' sectors expanding while local authority employment has remained at the same level as ten years ago. The growth in the 'for-profit' sector has been particularly noteworthy in Scotland (Scottish Executive, 2006).

This trend continues apace despite the acknowledgement, in one of the first comprehensive reports on social care, that care services run by the 'for-profit' sector in England are consistently out-performed by those run by the 'not-for-profit' sector (Commission for Social Care Inspection, 2005a). With the passage of time, competition is likely to favour those 'for-profit' companies that are able to maintain their competitive edge by keeping costs low. Pollock (2005) has argued that this is likely to be achieved by the recruitment of poorly paid, inadequately trained and under-motivated staff. The implication of this is that 'not-for-profit' organisations may be squeezed out, leaving commercial companies to dominate the market.

Bakan (2004) has provided evidence to support the notion that a 'care corporation' is a contradiction in terms. He has pointed out that the legally-defined mandate of a corporation is to pursue its own self-interest. If a corporation is caught breaking the law, it can pay the large fines and continue doing what it did before. The fines and the penalties paid by corporations can be trivial when compared with its profits, especially if the corporation is large. In the opinion of Milton Friedman - Nobel Laureate in Economics - corporate executives have but one 'social responsibility' and that is that they must make as much money as possible for their shareholders. This is a moral imperative. Those executives who place social and environmental goals over profits - in other words who try to act morally - are, in Friedman's judgment, immoral. Friedman contended that there is only one instance when corporate social responsibility can be tolerated and that is when it is insincere. In other words, the executive who treats social or environmental values as a means of maximising shareholder's wealth is committing no wrong (Friedman, 1979).

Pollock (2005) has drawn attention to a comparable situation in the National Health Service, also faced with increasing privatisation:

> *In the past, doctors were free to speak out – in fact they were under a moral obligation to do so – if they felt it was in the interests of their patients. In a business culture, however, loyalty is said to be due above all to the shareholders.* (Pollock, 2005, p.213)

Stone (2000) has argued that there is a fundamental clash between care and business ethics:

> *Once care is contracted out to a 'for-profit' managed care organisation, the ethical situation becomes problematic. Every rationing decision has an impact on the caretaker's own personal bottom line.* (Stone, 2000, p.391)

While the 'for profit' sector continues to expand, there is increasing evidence that the 'not for profit' sector is struggling to compete. One of the largest providers of care for adults with intellectual disability in Scotland - Quarriers - has threatened to make all its 2000 staff redundant if they fail to agree to cuts in their sick pay, night shift allowances and payments for holidays (Unison, 2009).

The voluntary sector in the UK, which is largely comprised of organisations with charitable status, is facing a number of critical challenges for a number of reasons:

- there has been a downturn in individual and corporate giving to charities;
- falling asset values for the funds held by charities is affecting investment income;
- a number of charities were among those institutions who had deposits in failed Icelandic banks; and
- a freeze on local tax, coupled with greater autonomy given to local government in its spending, means that those sectors, like social care which are seen as low priorities, are suffering.
(Outram, 2009, p.1)

A further consequence of the marketisation of social care has been the growing marginalisation of professional workers (e.g. social workers, educational psychologists, clinical psychologists, GPs, etc.) in decision-making processes related to assessment and placement. Decisions are increasingly being taken by local authority commissioners for services (Care Service Improvement Partnership, 2008). Thus a process of deprofessionalisation is occurring in which the role of those with relevant knowledge, expertise and experience and who are well placed to make informed

decisions concerning the individual needs of clients are being sidelined. These changes appear to be driven by cost and not quality of life considerations. There is a certain irony in the fact that those charged with this responsibility are called Quality Commissioners.

Regulation

Over the course of the last two decades there has been a succession of major crises in child care in the UK which has produced a series of enquiries and reports indicating profound concern about the working of the child care sector (Utting, 1991; Skinner, 1992; Waterhouse, 2000). In April 2004 the Labour Government set up the Commission for Social Care Inspection (CSCI) with the aim of modernising the system of regulating care services. In November 2004 the CSCI published its first performance ratings of all councils with social services responsibilities. However, in 2009, only five years later, responsibility for regulating and inspecting adult social care and health care has passed to the Care Quality Commission which represents a merger of the CSCI, Healthcare Commission and the Mental Health Act Commission.

In its final report in 2009 the CSCI noted that services for those with complex needs were being impeded by poor strategic commissioning, lack of person-centred care and 'marginalisation' of human rights (CSCI, 2009; Latchem, 2009). It also drew attention to the fact that some service users had little if any choice about their services and councils relied on inappropriate out-of-area residential care (Ahmed, 2009).

For its part the former Labour Government made clear that the Care Quality Commission would continue to focus on reducing its operating budget. Early indications suggest that this means a reduction of 40% on the budgets of the three predecessor organisations. Closely linked to the budget reduction is the decision to

continue the deregulated inspection methodology practised in the CSCI which was termed 'proportionate risk-based inspection'. When translated this means fewer inspections. The previous statutory requirement to inspect care homes twice a year has been abandoned. Now the minimum requirement is for care homes and homecare providers to be inspected once every three years and inspections are to be replaced by 'Annual Service Reviews' which are paper exercises based on provider 'self-assessment' and any other intelligence received (Unison, 2007).

Unison, the principal trade union representing social care staff in the UK, is campaigning to highlight the effects of these changes on the safety and quality of care provision. Union members are reporting that the new regulatory system, with its reduced staffing, is failing because of lack of time: (1) to target its resources on those providers giving a poor service; (2) to follow up on concerns and complaints or detect problems in the early stages; (3) to impose and follow up on enforcement measures; and (4) to spend time in the field talking to service users. Unison has pointed out that inspectors are 'too thin on the ground' and that the situation will be further exacerbated by planned redundancies (Samuel, 2009a).

The outgoing chair of the Commission for Social Care Inspection, Dame Denise Platt, went out of her way to warn about the ability of the CQC to be an effective social regulator. She stated that it would struggle to balance its health and social care responsibilities because the focus of public attention would be on health care which meant that failings in adult social care were unlikely to attract much attention. She highlighted the fact that the CQC lacked people with social care expertise at senior level, as many CSCI managers had not transferred to the CQC. She also questioned the ability of the CQC to shape social care policy in the way that the CSCI had done through the publication of its annual State of

Social Care reports. She further observed that the focus on social care policy was likely to be diluted in a body which had been set up to look at both health and social care (Samuel, 2009b).

Dame Denise could not conceal her exasperation that the decision to abandon the CSCI appeared to have been made out of ignorance: "there was really a big misunderstanding in central government about the nature of our role. People think social care is the mirror image of health. It isn't" (Davies, 2005, p.1). She pointed out that their values might be similar but the underpinning policy assumptions were different, not least because users have to pay for social care. "Many of the things the Chancellor wanted to achieve around burdensome regulation can be achieved by changing the regulations, not necessarily by changing the institutions" (Davies, 2005, p.2). Not only had the Government succeeded in creating one of Europe's biggest regulators but also there was an increased fear that the move heralded the long anticipated 'takeover' of social care by the health service. When asked if the Chancellor had been badly advised, Dame Denise pointedly and crisply replied: "the level of ignorance in the Department of Health about how social care as a sector operates should not be underestimated" (Davies, 2005, p.2).

Self-regulation

The rapid privatisation of the care sector over the past five years coincided with the decision by the CSCI to transfer greater responsibility for the assessment of care standards to care providers. Thus, within a short time of the CSCI having been established, self-regulation was accorded a high priority. In November 2004 the CSCI published a consultation document *Inspecting for Better Lives (Modernising the regulation of social care)* in which it proposed that self-assessment be introduced for care providers (CSCI, 2004). The

Commission indicated that it expected care providers to be honest about the strengths of their service and explain what they were doing to improve it. It went on to state that it would take a tough line on misleading self-assessments and view them as a sign that the service was not being well managed. In a follow up document, published in July 2005 entitled *Inspecting for Better Lives - Delivering Change*, it was acknowledged that there were some who believed that the adoption of a self-assessment system could be open to abuse (CSCI, 2005b). Notwithstanding these reservations the CSCI made clear its determination to introduce what it described as 'provider self-assessment' which it viewed as an essential part of its new ideas.

Given the scale of the problem facing the CSCI, in terms of seeking to raise care standards, it was all the more surprising that it proposed to cut its own workforce by 25%. These changes, which were a direct result of the Government's policy of devolving powers in the public sector and its commitment to reducing public sector expenditure appear to be built upon the naive assumption that if care providers take part-ownership of the regulatory process that they will do so in a responsible manner. However, as Bakan (2004) has convincingly demonstrated, for-profit companies operating in deregulated systems invariably act in an aggressive, exploitative and self-interested manner. Are there any grounds for believing that care corporations will act differently?

Market leadership

It is instructive to look at the performance of one of the market leaders in social care which is listed on the London Stock Exchange. The accuracy of the company's claim to being a market leader was recently assessed by examining the inspection reports on 24 of their premises which had been published by the Commission for Social Care Inspection. It was found that

one quarter of the premises run by the company had to meet at least six or more statutory requirements. In other words, a quarter of the premises were deemed to be in breach of their legal obligations. Three areas occasioned the Commission particular attention:

1 *Overuse of agency staff*: The inspectors drew attention to the need for the company to review recruitment procedures to ensure that more was done to employ permanent staff teams thus reducing the use of agency staff. A further matter noted was a failure to obtain satisfactory clearance for agency staff and to produce evidence that they were appropriately qualified.

2 *Staffing levels*: A recurrent issue noted by inspectors was a failure by the company to employ a sufficient number of staff to meet the needs of residents, particularly those requiring 1:1 attention. It was pointed out that if demands for 1:1 staffing were not met then this could lead to restricted choice for other residents thus increasing the risk of neglect and abuse. Insufficient staffing also meant that opportunities for social, educational and recreational experiences for residents were limited.

3 *Failure to implement Commission requirements*: The Company failed to implement the statutory requirements repeatedly identified by the Commission. In one case the registered manager had been required to ensure that suitably qualified, competent and experienced persons were working in the home at all times and in such numbers that were appropriate for the health and welfare of residents. This requirement had been made on no fewer than three previous occasions.

It might be reasonably expected that a responsible service provider would pay attention to requirements or recommendations made by the CSCI and seek to implement the changes needed as expeditiously as possible. In the view of the author, the apparent failure of the company to appoint sufficient permanent and appropriately qualified staff to meet the needs of residents would seem to imply some unwillingness to invest adequately in staffing. The evidence from these inspection reports could be interpreted to suggest that running costs were being deliberately kept down through the use of agency staff and by maintaining low staffing levels.

E-auctions or reverse auctions

Whilst the impact of self regulation is a matter of concern, a more recent market-oriented development has occasioned alarm. An increasing number of commissioners of services in the UK have been making use of e-tendering or reverse auctions. A wide range of benefits have been claimed - tangible and intangible - for this process. Tangible benefits comprise process efficiencies - time savings and reduction in overhead costs incurred during the tendering process. E-tendering solutions automate or eliminate some of the repetitive routine administrative tasks such as document preparation and distribution; assessment and evaluation of tenders. Process automation frees up time for buying staff to focus on 'value-added activities' such as negotiating better contracts. The overhead costs of tendering will also be reduced where the main elements of costs are printing, copying, paper, postage and stationery.

One of the intangible benefits of e-tendering is that, by managing the e-tendering solution centrally, tendering requirements can be controlled and co-ordinated. All documents for a particular tender can be held in a logical structure for ease of retrieval. E-tendering solutions also reduce the time spent analysing numerical information by

having parts of the responses already in spreadsheet format ready to manipulate and compare and provide a secure history of each tender from advert and tender creation to contract award. This history provides a full audit trail that encourages openness and integrity in all contractual decisions. It is also claimed that quoting performed in real time via the Internet results in dynamic bidding which helps achieve rapid downward price pressure; something which is not normally attainable using a traditional static 3-quote paper-based bidding process.

However, the prices that buyers obtain in the reverse auction reflect the narrow market which it created at the moment in time when the auction is held. Thus, it is possible that better value - i.e. lower prices, as well as better quality, delivery performance, technical capabilities, etc - could be obtained from suppliers not engaged in the bidding or by other means such as collaborative cost management and joint process improvement. There is a paradox here for at a time when so much emphasis has been placed by the Government on the personalisation of services for clients with intellectual disabilities strategies are being put in place which have the effect of depersonalising them. Care is simply a commodity.

Because of increasing concern at the use of reverse auctions in Scotland, a motion was put before the Scottish Parliament on the 30th October 2007 that:

> ... *Parliament deplores the practice of reverse auctions ... it is morally repugnant for such a system to be used for the provision of social care services in Scotland.* (Scottish Parliament, 2007)

Then, as a result of a BBC Panorama programme screened in May 2009 - *Britain's Homecare Scandal* - the Local Government Committee of the Scottish Parliament undertook to look at the practice of using online bidding auctions.

Undercover filming for the BBC programme revealed carers rushing between appointments, with some clients being missed entirely. Hidden camera footage revealed the case of a 78-year-old man who received care from the private company that was successful in the e-auction. He was fed mainly on a diet of crisps, had not had a bath or shower in six months and received visits from carers lasting only a matter of minutes (East Kilbride News, 2009).

Advocacy

One might have expected that some of the problems identified above would have been picked up and addressed by advocacy services representing people with intellectual disabilities. However, the problem here is that most advocacy schemes in the UK are dependent on statutory sector funding from health authorities and/or social work departments. Although this financial support is welcome and serves to provide stability and security to local advocacy projects, there are inherent dangers in relying too heavily on such funding. A particular concern is the trend for advocacy schemes to be funded through contracts rather than grants. In other words, the provision of advocacy services has also been impacted by the process of marketisation.

As early as 2001 the Scottish Executive had noted that the tendering process was not a creative way to achieve the effective provision of advocacy and for a number of reasons (Scottish Executive, 2001). It requires the commissioners to specify in considerable detail what is to be provided, when a better picture of what people need most from advocacy emerges more clearly over time. A purchaser-supplier dynamic is set up, where the advocacy scheme is expected to see itself as delivering a service on behalf of the commissioners, not in response to the people who need advocacy. This compromises an agency's independence. It encourages advocacy

schemes to be dependent on the funding provided by the commissioners, so that the advocacy only happens if this funding continues to be provided. By definition, advocacy means a continuing commitment to people over time and not abandoning that commitment in difficult times. This tends to encourage the choice of the larger, national advocacy agencies which can present bids, demonstrate a track record and negotiate contracts which makes it harder for advocacy to become genuinely rooted in the community.

One development in England has given particular cause for concern (Gould, 2003). In the face of widespread opposition the (then) government decided in 2003 to abolish Community Health Councils, the long established voice of the health service user, and replace them with a bewilderingly complex bureaucratic edifice comprised of:

- Patients' Forums which are based in every primary care trust and National Health Service trust. They are funded by the Commission for Patient and Public Involvement in Health and monitor and review services arranged or provided by the trust. They seek the views of patients receiving services, inspect premises and make reports and recommendations to trusts.

- Patient Advice and Liaison Services (PALS) are provided in every trust to resolve problems on the spot; provide information to patients, carers and families; put people in contact with local support groups; and tell them how to access the complaints procedure.

- Patients' Forums also provide an Independent Complaints Advocacy Service (ICAS) to enable anyone to make a complaint about NHS services. ICAS offers free impartial confidential support, information about complaints procedures, assistance with letter writing, support at meetings and has a brief to listen and act on the patient's behalf. ICAS also helps and guides a complainant through the whole process from local resolution to formal investigation.

- The operation of the Patients' Forums and ICAS is monitored by the Commission for Patient and Public Involvement in Health (CPPIH). It is the funding body for Patients' Forums and ICAS and submits reports to the Secretary of State for Health on how the system of patient and public involvement is working.
(Jackson, 2005)

The problem here is that the advocacy element in this arrangement is owned by the hospital trusts it exists to monitor and challenge. The high profile adoption of this model hinders rather than helps the development of an independent advocacy culture since it gives a tacit nod to other large service organisations which would be only too happy to create 'in-house' advocacy for their users and to dispense with the rigours of independent scrutiny. Market principles when combined with an emphasis on clinical outcomes inevitably lead to a form of advocacy that does not differ significantly in its mode of operation from the service that it is monitoring. The neutering of advocacy services in this way communicates a damaging image to both public and professional audiences of the integrity, value and purpose of advocacy. Such an image is likely to act as a deterrent to any potential user considering approaching such a service. Recruitment of advocates, too, is likely to be adversely affected by this negative image (Jackson, 2005).

A further example of the way in which advocacy schemes can be absorbed into the statutory system is provided by the introduction and implementation of the Mental Health (Care and Treatment) Act

2003 in Scotland (Jackson, 2005). The primary objective of the Act is to ensure that people with mental disorder – defined as covering mental illness, personality disorder and developmental disability – can receive effective care and treatment. This Act enshrines the right of access of a 'patient' to advocacy. It places a duty on each local authority and health board in Scotland to ensure the provision of independent advocacy services to any person with a mental disorder within their area. In other words, a local authority or health board has a statutory obligation – a legal duty – to involve an advocacy service and the advocacy service has a duty to respond. If representation is sought then there is an expectation on the part of the local authority, health board and client that the advocate appointed is thoroughly familiar with:

- all the principles, roles and responsibilities involved in the implementation of the Act;
- the range and nature of the powers relating to compulsory treatment and detention;
- the law concerning people with a mental disorder who enter the criminal justice system; and
- knowledge of a person's rights and safeguards in accessing mental health services.
  (Jackson, 2005, p.26)

If for any reason an advocacy scheme is not able to offer representation then this could lead to the withdrawal of funding because of the failure by the service to meet its obligations. Representing a 'patient' may result in the advocate making an appearance before a Mental Health Tribunal where the advocate is likely to be 'opposed' by a professional who is familiar with the legislation or has been briefed by legal officers from either the local authority or health board. If 'patients' are not to be disadvantaged then advocates need to be thoroughly grounded in the relevant law

which means that some form of specialist legal training is required. It is open to question whether there are many volunteer advocates who would have either the competence or confidence to act in such a capacity.

There are those who believe that the provision of training runs the risk of 'professionalising' the role of the advocate and transforming their identity to that of a quasi-human services worker (Peters, 2000). It has been argued that one of the main strengths of advocacy is the independence of representation provided by advocates to their clients. In representing their clients advocates are asked to act as 'free agent' citizens unencumbered by significant conflicts of interest. However, if advocates undergo training it is possible that the content of the training – whether intended or not – can serve to control their actions. The training may impart knowledge of a highly prescriptive nature which can discourage advocates from exercising common sense, initiative and flexibility – the essential qualities sought in the ideal advocate. Peters (2000) has argued that the case against the provision of advocacy training is that it is incompatible with, and even destructive of, the identity of advocacy.

In any event the life span of advocacy schemes may be shortened for other reasons. It has been suggested that advocacy schemes have an ephemeral existence passing through a four-stage life cycle (Gray & Jackson, 2002, p.19):

- *Initial phase*: a short period characterized by general enthusiasm for the idea of advocacy;
- *Awareness phase*: when statutory services begin to realize the potential threat that independent advocacy poses;
- *Containment phase*: when efforts are made 'to rein in' advocacy schemes as the performance of local authorities and health boards funding the schemes

comes under increasing critical scrutiny; and

- *Final phase*: when the integrity of advocacy schemes is progressively subverted either through their absorption into the statutory structure or through the imposition of contractual arrangements that limit operational freedom.

The failure of advocacy schemes to recruit sufficient volunteers to sustain a viable advocacy network, coupled with increasing evidence that other kinds of formal advocacy are being slowly absorbed into the statutory system, may explain why increasing attention has been directed to the role of self-advocacy, which has been described as a process of development through which individuals acquire the skills and confidence to voice their own views and concerns. However, it can also refer to the activities of groups of people who have come together to voice their collective concerns. Whilst the growth of a vibrant self-advocacy movement over the past few decades has generally been welcomed, some reservations have been expressed. In Wolfensberger's opinion, the adoption by the People First Movement of the ideology of radical individualism and self-determination threatens to antagonise and alienate those whose support is vital if appropriate services are to be developed (Wolfensberger, 2003).

Conclusion

The economic recession should have taught us that nothing can be taken for granted. Who would have anticipated a situation where the Government in the UK would be forced to bail out the banks and in the process nationalise them? This point is made because the 'for profit' care companies, many with extensive property holdings have seen a precipitous and precipitate depreciation in property values - in some cases of the order of 30%. And in order to grow their businesses they have

been heavily reliant on banks providing large loans. It is evident that some of the smaller 'for profit' care companies are finding it increasingly difficult to compete and as a result are being swallowed up by the larger companies which recognise that only by pursuing an aggressive policy of acquisition can they secure increased dividends for their shareholders. It may not be too long before commissioners of care services in certain parts of the UK are presented with a situation where there is only one competitor for a tender as that company commands a monopoly position.

The 'nuclear scenario' would occur if monopoly providers found themselves financially overstretched and as a result subsequently collapsed. Will local or central government be forced to step in to re-nationalise the social care service? This scenario may seem far-fetched until one recalls Dame Denise Platt's strongly voiced concerns about the ability, capacity and willingness of the newly created social care regulator - the Care Quality Commission - to monitor effectively developments in the social care field. It should also be noted that it was, in part, a failure on the part of the Government established financial regulator - the Financial Services Authority - to see the danger signals in the financial market and to take appropriate and timely remedial action to prevent or in some way mitigate the effects of the market crash.

There may be those who feel that the general argument advanced in this paper is unjustifiably doom laden. What cannot be in doubt is that the quality of care services for children, young people and adults with an intellectual disability is under serious threat.

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