

## “But can things only get better?” Older people’s social care before, during and after austerity

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### Abstract

*In 2006 the then Labour Government published a significant, two hundred plus pages, White Paper, ‘Our Health, Our Care, Our Say’. Endorsed by Prime Minister Tony Blair and backed by the Secretary of State Patricia Hewitt, it was designed to outline a new and lasting approach to improving community-based health and social care services. In particular, it recognised the need to better manage the increased demand for care based on the anticipated growth in the numbers of older people within the UK population. Fourteen years later we still await that ‘new and lasting approach to community-based health and social care’. This paper explores why the aspirations of that original White Paper remain to be achieved and what strategic direction social care for older people should take in the future.*

**Keywords:** social care, older people, health care, policy, prevention

### Introduction

With its key themes of integration, prevention and consumerism, the 2006 White Paper, *Our Health, Our Care, Our Say* was designed to tackle long term issues in the health and social care system. As the Secretary of State argued in her Foreword to the White Paper, the need was for legislation that could address ‘years of under-investment, widening inequalities, soaring waiting lists, critical staff shortages, inflexible and unresponsive services’ (Department of Health, 2006, p.3).

If the problems sound familiar, then so do the solutions. Change was to be achieved through a series of interventions, such as practice-based commissioning, shifting resources into prevention, more care to be undertaken outside hospitals and in the home, better joined up services at a local level, encouraging innovation and allowing different providers to compete for services.

Since then there have been two further White Papers, four public Consultations, two policy papers, the Dilnot and Barker Commissions, a House of Lords review and the Care Act 2014. Yet despite this abundance of intent, social care remains trapped in a ‘Groundhog Day’ of immobility, where the same problems and solutions get endlessly repeated, whilst how to fund care stays locked in the ‘too difficult to solve’ box. As one civil servant was quoted<sup>1</sup>:

*I’ve had a ringside seat for every effort to reform social care funding in the past decade. I’ve drafted Green Papers and White Papers and even got legislation passed, but not one reform has ever been implemented.*

(Warren, 2019)

This stagnation can be illustrated in **Table 1** by putting the aspirations from the DH White Paper alongside the Care Quality Commission’s (CQC’s) 2018 report *Beyond Barriers – How Older People move between Health and Social Care in England* (Care Quality Commission, 2018a).

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<sup>1</sup> <https://www.kingsfund.org.uk/blog/2019/07/social-care-funding-reform>  
(Accessed: 06.02.2020)

**Table 1.** DH/CQC aspirations for improving community-based health and social care services.

	<b>DH White Paper 2006</b>	<b>CQC Beyond Barriers 2018</b>
<b>Commissioning</b>	'At the moment too much primary care is commissioned without integrating with the social care being commissioned by the local authority. There will be much more joint commissioning between PCTs and local authorities' (p.9).	'Future system working will need to include aligned performance measures, aligned oversight and regulation, and funding to incentivise joint commissioning across health and social care' (p.47).
<b>Prevention</b>	'We must reorientate our health and social care services to focus together on prevention and health promotion. This means a shift in the centre of gravity of spending. We want our hospitals to excel at the services only they can provide, while more services and support are brought closer to where people need it most' (p.9).	'As a starting point, there should be greater emphasis on keeping people well at home. Investment in preventing health problems and keeping people out of hospital where possible will be better for people and for the health and care system. Bed occupancy in hospitals is higher than ever' (p.4).
<b>Integration</b>	'Access to high quality primary healthcare has a vital role in helping people to live longer and healthier lives. Integration of these services with other community and social care services helps to ensure better coordinated support and care for each individual, better management of chronic disease, and reduced need for costly and avoidable hospital care' (p.57).	'Health and social care organisations should work together to deliver positive outcomes for people and ensure that they receive the right care, in the right place and at the right time... Nationally, there is a need to create the right incentives for integration and joint working in local systems' (p.4).
<b>Consumer control</b>	'Individual budgets will put far more control in the hands of people who use social care services... Recent national surveys show that we still need to do more to empower people with long term health and social care needs through greater choice and more control over their care' (p.110).	'Personal budgets and direct payments are a mechanism to allow people to have choice and control over the support and services they receive... Nationally, personal budgets and direct payments for social care and health are not widely accessed' (p.24).

So, if these four elements have remained the same over a twelve-year period, why might this be?

### Commissioning

In the same year as the White Paper (2006) I wrote an article for *Research, Policy and Planning* (Kerslake, 2007) exploring how the Government's aims might be implemented. The article proposed a different approach to commissioning and, in particular, that the procurement of social care, as the original diagram (**Figure 1**) illustrated, whether by individuals or organisations, needed to be intelligence driven. Underpinning the White Paper was the assumption that purchasing would not be dominated by local authorities but by individuals who, if state funded, would be allocated an individual budget (later called a personal budget) to spend on the care of their choice. With a growing older people's population and more self-funders, the market would expand and reflect the diversity of demand that people presented. Individuals or local authority commissioners would use the best knowledge available to achieve a set of desired outcomes through flexible and responsive service provision. However, for these

objectives to be fulfilled required one final assumption, that funding would continue to increase as it always had done in the past. What of course happened was that whilst demand increased, funding did not. In 2016 there were nearly 12 million people aged 65 years and over in the UK; 25 years' before that there were just over 9 million, and in 25 years' time it is estimated there will be 17 million, with the fastest growth being in the oldest population aged 85 or more (ONS, August 2018). Yet currently nearly half of that post 65 life span is spent in ill-health (Swerling, 2019), with around two-fifths of NHS spending being on that age group (Obineau, 2016). For those aged 85 and over the numbers of people with high dependency needs will have doubled between 2015 and 2035, and the number with comorbidities will similarly increase substantially (Kingston *et al.*, 2018).

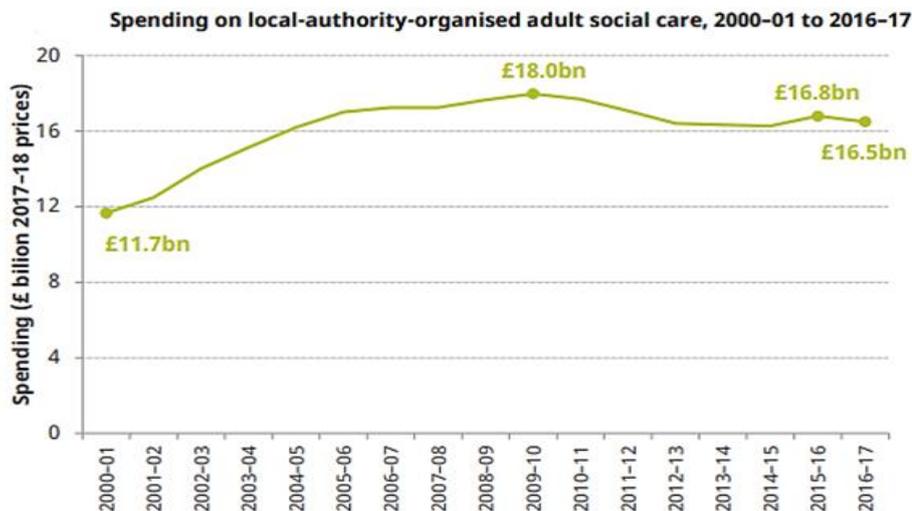
Interestingly, in 2006 expenditure was not perceived as an issue, as social care spending consistently rose year on year. Since the recession that has not been the case, as the Institute of Fiscal Studies chart (Simpson, 2017) shows in **Figure 2**. In the nine years from 2001 spending grew by £6.3 billion, as compared to a drop of £1.5 billion over the following seven. The impact of this drop is then even greater if inflation and the overall growth in the older people's population is taken into account.

Figure 1.



Source: Kerslake, 2007, p.106.

Figure 2.



Source: Institute of Fiscal Studies (<https://ifs.org.uk/publications/9185>)

One effect of this has been to distort the care market. In a normal market, if demand outstrips supply, prices will rise until new suppliers find it advantageous to enter the market. The increased supply will then cause prices to fall. In this way markets maintain equilibrium. However, the social care market does not function in this way. In those areas where it is the dominant purchaser then the local authority in effect becomes monopsonistic<sup>2</sup>, controlling the market through the price it chooses, or can afford, to pay. If it is not sufficient, then providers who wish to continue to operate their business will have to find alternative finance to survive by gaining greater economies of scale, increasing debt, finding cheaper labour, or reducing the quality of the service they provide. The consequences of this have been extensively reviewed by the Competition and Markets Authority, who point out that:

*... About a quarter of care homes have more than 75% of their residents LA-funded, and that these are the ones most at risk of failure or exit because of a funding shortfall. We estimate that LA-fees are currently, on average, as much as 10% below total cost for these homes, equivalent to around a £200 to £300 million shortfall in funding across the UK.*

(Competition & Markets Authority, 2017, p.13)

The conclusion they draw from this is that:

*The current model of service provision cannot be sustained without additional public funding; the parts of the industry that supply primarily local authority (LA)-funded residents are unlikely to be sustainable at the current rates LAs pay. Significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs.*

(Competition & Markets Authority, 2017, p.6)

## Prevention

Central to the DH White Paper was the role of prevention.

*Finally, throughout this White Paper we have been clear that the focus on greater prevention, and on greater activity in primary and community settings, is crucial to delivering an NHS that is high quality, that focuses on health and wellbeing, and that is cost-effective in the medium term. Unless this White Paper strategy is pursued – and the consequent service reconfigurations take place – some local financial imbalances may never be corrected.*

(Department of Health, 2006, p.150)

Despite two major national funding initiatives, the Partnership for Older People Projects (POPP) and the Better Care Fund (BCF), neither can be said to have delivered the aspirations of 2006 (Steventon *et al.*, 2011; National Audit Office, 2014) though both offered some benefits. For example, in the case of the Better Care Fund, although gains occurred in relation to delayed transfers of care (DETOC), they have been subject to the law of diminishing returns, i.e. the more money you put in, so the marginal impact on delayed transfers declines (Forder *et al.*, 2018). So, why has prevention been so difficult to achieve, given that financial limitations might have been expected to drive alternatives?

### **A lack of focus**

Prevention can cover a myriad of interventions: from broad based community programmes, to recovery and rehabilitation from conditions, to avoiding readmission to hospital.

- **Low level preventative interventions** As the Kings Fund (Curry, 2006) pointed out, these may well be valued by older people, but there is a lack of evidence about their long term preventative or diversionary benefit, and hence whether they are cost-effective.

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<sup>2</sup> The opposite of monopoly, i.e. one or few buyers to many sellers.

- **Preventing hospital admission** Reducing hospital admissions and preventing readmissions has been a key aspiration of prevention, yet despite many initiatives and a pressing demand for bed spaces, older people still experience over-extended stays and unnecessary admissions. The consequences, as the NHS reports, are serious:

*35% of 70-year-old patients experience functional decline during hospital admission in comparison with their pre-illness baseline; for people over 90 this increases to 65%. Extensive use of audit tools has shown 20% to 25% of admissions and 50% of bed days do not require an 'acute' hospital bed.*

(NHS Improvement, 2018, p.2)

- **Avoiding inappropriately induced conditions** Many older people have a number of co-morbidities, yet in hospital enter a world mainly focused on single treatment modalities, e.g. orthopaedics, cardiology, etc. As a consequence, a poor intervention in one area may increase demand in another, e.g. the over-use of catheterisation post fracture could lead to an older person being readmitted for a urinary tract infection (UTI) (NHS, 2018; Ramanathan & Duane, 2014).
- **Care not seeing its role as ill-health prevention** A recent study from The Health Foundation (Walters *et al.*, 2019) showed that not only are there high levels of hospital admissions from care homes for preventable conditions, but also that those from residential homes were higher than those from nursing homes. Therefore, it might not be the type or severity of condition that prompts admission but the ability of staff to cope with or manage it.

### ***A failure to mainstream***

Many preventative initiatives have been small-scale, seen as temporary, rather than from the outset being designed to scale-up. Although the social care literature on organisational inertia is limited, the question has to be asked: why, even where success has been achieved, have preventative interventions not been universally adopted? Possible answers:

- **Restrictive practices** The National Audit Office (NAO) suggested that 'differences in working culture, professional entrenchment and different terms and conditions across the health and local government sectors remained barriers to integrating and developing the workforce' (National Audit Office, 2017, p.47). This was in a report that only mentioned prevention four times within its 52 pages, despite this being an area where the need for integration is probably at its greatest.
- **Inertia** Most managers at some time will have encountered staff or colleagues for whom stopping change seems to be their primary goal. As Coiera states:

*Humans apparently favoured culturally static organisations—perhaps, because they were believed to be more reliable or accountable. Unfortunately, static organisations become increasingly out of step as the surrounding environment changes.*

(Coiera, 2011, p.27)

- **Lack of permanence** Many preventative initiatives are set up as experiments, projects or pilots. Whilst the intention may be to test whether something works, it often means that funding is time-limited and such projects can seem artificial, divorced from the day-to-day realities of practice. Equally, if the only route to funding is via one-off bids, then the temptation is to move to the next new idea rather than consolidate the old.

### ***A failure to incentivise providers***

Given their large workforce and community base, the main providers that should be central to prevention are home care agencies. Yet as Opus Restructuring and Company Watch reported in 2017, the sector loses £11.66 per client per year, with total losses of £10.5m, prior to the implementation of the National Living Wage; and 27% of domiciliary care providers accordingly fell within the Company Watch Warning Area (Opus Restructuring and Company Watch, 2017). Even large providers are in difficulties. Mears, for example, was losing £3m a year on its home care business, saw its share price halve over the last two years (London Stock Exchange, 2019) and in the end has sold the business (Homecare.co.uk, 2020). As CQC confirmed:

*The adult social care market remains fragile, with providers continuing to close or cease to trade and with contracts being handed back to local authorities.*

(Care Quality Commission, 2018b, p.4)

In such an environment it is little surprise that providers have often been reluctant risk-takers in developing preventative approaches. Within the author's work for CQC on market stability (Institute of Public Care, 2014) the following were all advanced by providers as reasons why investing in prevention was problematic.

- 'Preventative initiatives involve risk. Why take them if your business is already vulnerable?'
- 'Nobody is going to invest in prevention, unless there is some guarantee of funding continuance and a belief it is possible to get a return on that investment?'
- 'If you spend time and money developing an innovative approach then why would you share that with your competitors if that is a requirement of the contracting process. After all, they have taken none of the risk?'

### ***A failure to invest in measurement***

There are two key elements to measuring the impact of preventative interventions. The first is establishing a clear link between cause and effect, i.e. 'is the anticipated or actual outcome a result of the intervention?' Secondly, moving away from measuring success by input or take-up to measuring the outcomes the intervention is intended to achieve.

In understanding the relationship between cause and effect, social care has long had measurement difficulties. Its interventions do not lend themselves to control groups and double-blind testing, given that it would be hard to deliberately leave someone without care in the interests of good measurement. Equally, effective outcome measurement takes time and skill to develop, requires shared aspirations between commissioners, providers and service users (Allcock, 2015), with a willingness to change practice if interim results are not as expected. This lack of a focus on outcomes can be illustrated by the quality of some reporting on the Better Care Fund (Ministry of Housing, Communities and Local Government, 2019). It either measures process (the allocation of funding to x or y) or in its local metrics self-reported anecdotes of success.

These problems with measurement tie into organisational inertia. I recently spent time working with an information team that straddled health and social care. Over and above compiling statutory returns and answering members' queries, most of the data captured remained unanalysed. A lack of time or managerial motivation were described as the reasons for this. When the data were reviewed it became apparent that some people were being admitted to hospital from care homes for preventable conditions. Yet from both health and social care perspectives, there was an inevitability about such admissions. Despite the potential for resource saving, it seemed too difficult to alter people's practice, roles and functions so that this outcome could be avoided.

## Integration

If prevention was seen as important in 2006, then integration of services was one of the mechanisms by which it might be delivered cost-effectively. Yet, like prevention, there has frequently been confusion about what integration means: a single budget, shared commissioning, common management, staff transferability, or a single health and social care body that combines all of the above? The Nuffield Trust (2018) explored the potential of different arrangements:

*Organisational integration requires a lot of time and dedicated resources to create the necessary infrastructure. Progress towards integrated working on the ground can be made more quickly via service level integration, but organisational integration can bring other benefits, such as helping all members of staff to understand the entire health and social care pathway. It is important to be very clear about exactly what it is hoped will be gained from integration.*

(Holder et al., 2018, p.4)

What should be inside or outside an integrative model for older people's care is open to question.

- Should it include housing (Buck & Gregory, 2018) or learning disability (currently part of social care, but a sector that spent decades trying to move away from a health-based model of provision) (Brend, 2008)?
- Should public health and social care, both part of local government, become single departmental entities?
- What are the accountability structures, given that social care is enmeshed in the funding, governance and management systems of local authorities, whereas health is not (and after all, health care provision can run at a deficit whereas social care cannot)?
- How do we manage the difference between private and state funded provision, bearing in mind the vast majority of social care provision is delivered by the private and voluntary sectors?

Therefore, it is of little surprise the National Audit Office concluded that:

*Nearly 20 years of initiatives to join up health and social care by successive governments has not led to system-wide integrated services... The Departments have not yet established a robust evidence base to show that integration leads to better outcomes for patients... There is no compelling evidence to show that integration in England leads to sustainable financial savings or reduced hospital activity.*

(National Audit Office, 2017, p.7)

## Consumerism

The 2006 White Paper was intended to create a new breed of care consumer. Individuals would either be self-funders or personal budget holders, with the market responding to their diversity of demand with an equal diversity of supply.

*Choice means people will increasingly determine what services they want, and where. Providers that offer these services will thrive; those that do not won't.*

(Department of Health, 2006, p.157)

Some of the original assumptions about the way consumers would behave were flawed. Care is not a 'good', unlike many consumer goods, that can be easily returned to the vendor. For example, once a care home 'purchase' has been made it is hard for an older person to return home, move to another establishment or find an alternative provider. Equally, whilst there was

an initial growth in the use of direct payments and personal budgets, as finance diminished, older people who were more likely to buy traditional services (National Audit Office, 2016) were disadvantaged; because if they were only funded to purchase at the same price as the LA, a provider was always likely to prefer purchasing from a bulk purchaser with contractual security. That of course assumed in a market with limited choice that the personal budget holder could even find a service they wished to purchase.

Some diversity did arise through the development of personal assistants, although it is not clear how much that created new jobs as compared to diverting home care staff or paying previously unfunded carers. Yet even this trend seems to be slowing. As Skills for Care reports (Skills for Care, 2019), the personal assistant workforce of around 140,000 has remained fairly static in recent years, with over half of those employed being people who were already known as either family or friends of the care recipient.

Therefore, the consumer driven market has never really developed as envisaged for older people. Instead they have ended up with a system more akin to the Soviet economy of the late 1980s: money to buy but little choice, queues for what there is, which when purchased isn't really what you would have desired, but you buy it because that is all that is available. Even older self-funders, the group that might have been expected to use their financial muscle to drive diversity, have ended up being the very people who have kept traditional residential care afloat. As the Competition and Markets Authority states:

*Many care homes are relying on higher prices charged to self-funders to remain viable, even when providing the same services... Our assessment based on larger providers is that self-pay fees are now, on average, 41% higher than those paid by LAs in the same homes. This represents an average differential of £236 a week (over £12,000 a year).*

(Competition and Markets Authority, 2017, p.14)

### The way ahead for funding

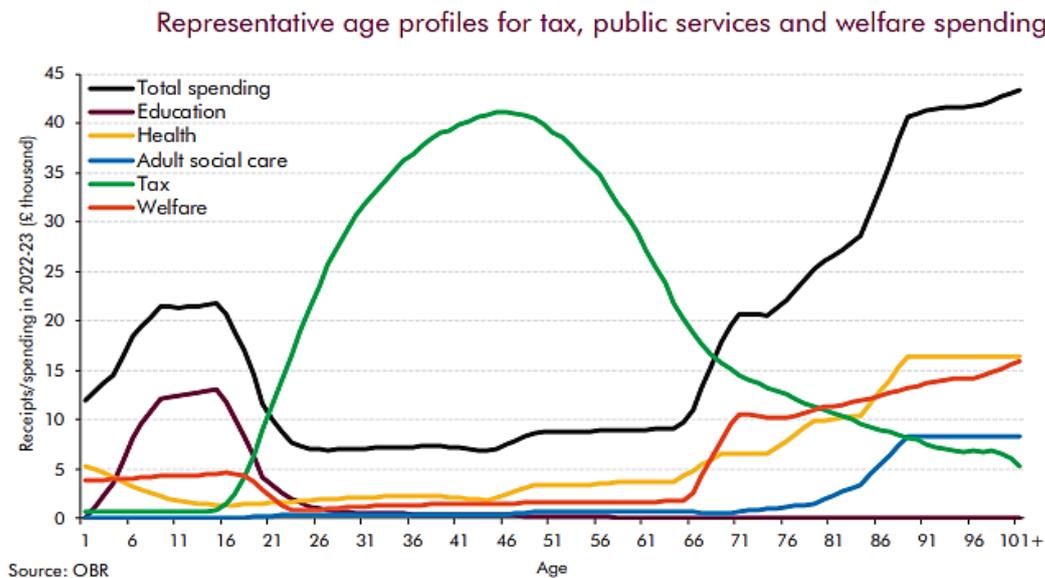
So, as austerity eases, are the unfulfilled aspirations of 2006 likely to be delivered? It is interesting to consider the two main political parties' 2019 election manifestos as a policy benchmark for social care. At least between them there is consensus: it's all about the money. For one party (Conservative and Unionist Party Manifesto, 2019) it's about how much they have spent and how much more they will spend in the future (2 out of 3 text references). For the other (Labour Party Manifesto, 2019) it's about how much finance has been cut and how much of that will be reversed (8 out of 9 text references). The implicit assumptions of both are that funding can keep pace with demand, that demand is irreducible, and that the current configuration of services must be worthy of continuance, given that they wish to spend more on them.

Funding is of course a matter for political will; and hence it is questionable whether a more youthful, poorer population will in the future wish to increase spending on their more affluent but dependent seniors. That pessimism may also be detected in the 'coded' cautions from the Office for Budget Responsibility (OBR). As their chart shows in **Figure 3** (Office for Budget Responsibility, 2018, p.73), older age drives a rapid increase in state spending per individual, whilst revenue from the same population diminishes.

*In the short term, the Government has responded to the pressures on the sector by increasing funding directly and giving local authorities the ability to increase council tax further. But ASC (Adult Social Care) spending remains well below pre-crisis levels in real per capita terms. Current policies could return spending to previous levels and our long-term projections assume that these short-term fixes persist, but further pressure for the Government to increase publicly funded provision of ASC and to enhance integration of health and social care appears likely.*

(Office for Budget Responsibility, 2018, p.155)

Figure 3.



The Competition and Markets Authority is more pessimistic when it looks at provider-side financing:

*Our assessment, however, is that the sector is not able to attract the investment required to meet the future increase in demand to serve LA-funded residents.*

(Competition and Markets Authority, 2017, p.15)

Therefore, given the likelihood of increasing demand from more people, with less funding per head, surely the logical policy is to focus on demand; in the case of older people, how can the period of ill-health or morbidity experienced prior to death be reduced? To explore this, it is worth returning to the four themes proposed by the original 2006 White Paper, i.e. commissioning, prevention, integration and consumerism.

### The way ahead for commissioning

Kerslake (2007) suggested that commissioning needed to be more knowledge-driven, a statement that feels as relevant today as it did then. However, this is not just about the acquisition of knowledge but about how it is used, which to have impact calls into question where the commissioning function sits in health and social care and what power it exercises. Joint commissioning, striving to achieve shared outcomes, should mean commissioners being able to cut across health and social care boundaries, not that one or another is a 'no go area', or that one function is subservient to the other. Commissioning must be a strategic function, able to go beyond the role of purchasing, because whilst this might be one element of commissioning, in straightened financial times there is a tendency for it to be seen as the only element.

Consequently, commissioners need to be able to undertake three activities:

- to quantify demand over time without being limited in their thinking by the services currently on offer,
- to be able to evaluate existing supply in terms of how well it is able to meet that demand now and in the future, and

- finally, where there are gaps in supply, or where current supply does not meet what older people say they want or need, then to explore how such provision can be developed at what cost and from whom.

Even if evaluating demand and supply in this way is not possible, then at the very least there should be some explicit assumptions made about the minimum volume and range of service provision for any given population, e.g. across 10,000 older people, what volume of care home beds, home care provision, extra care housing, carer support, community dementia services, physiotherapy, occupational therapy, handyman and housing move services should be available.

Following such an evaluation, 'selling' the results to managers, providers, Government and, critically, the public, is then required: which in turn demands leadership. Scott *et al.* (2003) see this as one of the key elements in delivering change, both through reward and cognitive change in behaviour. Whilst improving people's status or giving higher pay or more holidays may act as incentives, people also need to integrate change into their behaviour, to 'buy into' the vision. For example, they argue that if you wish to deliver a patient-centred model of care then this:

*...is not just about modifying familiar behaviour, it is also about radically redefining participants' interpretations and experiences of health care.*

(Scott *et al.*, 2003, p.116)

Although the funding and legislative intent needs to come from central government, the impetus for change must be led by local health and care communities (Ham, 2012), including convincing the public that change is essential and desirable.

### **The way ahead for prevention**

Whilst ill-health and its aftermath are the major drivers for care, as a number of authors (Institute of Public Care, 2010; Taylor *et al.*, 2010; Gawande, 2014) have pointed out, decline in older age is not a smooth path. Instead it is more a series of steps, where critical incidents such as the death of a partner, a fall, or a stroke, can produce a sudden loss of functionality. At each step, restorative or rehabilitative interventions may take an individual back to a pre-critical state, yet as CQC points out, access to such services is limited:

*Access to reablement and rehabilitation services can make a significant positive difference for people – there is wide variation in access to these services. Of those older people who received these services following discharge from hospital in 2016/17, 82.5% were still at home 91 days later. However, only 2.7% of older people discharged from hospital received these services in the first place.*

(Care Quality Commission, 2018b, p.28)

Yet the issue is not just about access, but about how we target interventions at those key moments of decline. There are three elements to this: what do we know, when is the optimum point of intervention, and with what?

In terms of the first of these elements, joint commissioners need to understand what their data are telling them is happening and why. At a minimum there must be the capacity to interrogate and align health and social care information (perhaps with assistance from Public Health). For example, are there patterns in who goes into hospital for preventable conditions? Who is getting readmitted post hip fracture, and why? Which populations look to be most vulnerable to UTIs?

If, as stated above, decline is not constant but occurs through a series of critical incidents or events, then there is a need to focus resources at the point where they are most likely to have maximum impact. Intervene too early and it is hard to prove that the benefit arises from the intervention, intervene too late and it may become impossible to restore a person's functionality. Whether it is falls prevention or carer support, or any other of the myriad of preventative initiatives, the question should always be: what is the optimum intervention point in order to achieve maximum cost benefit? That determination should also include when the recipient is most likely to be motivated to change and be receptive to the intervention.

If defining 'when to intervene' is important, then so is 'with what'? If in the past prevention has developed on a basis of let a 'hundred flowers bloom', then now is 'harvest' time; for bringing together the best of what is known, ensuring it is routinely available and implemented across the country, maybe with some kind of cost / benefit scoring. At least there is no shortage of information about what works and what doesn't, either in terms of routine clinical data, as the Nuffield Trust points out (Neuburger, 2016), or from the reports on the many pilots and experiments that have been conducted. For example, just a quick review shows there is good information about how to lessen A&E admissions from care homes (Lloyd *et al.*, 2017), reduce the level of UTI based hospital admissions (NHS, 2018), improve recovery from stroke (Clark, 2019; Dragert & Zehr, 2013), lessen the likelihood of falls (Public Health England, 2016), improve frailty (Holland *et al.*, 2015), and increase food intake through better oral health care (Public Health England, 2018).

### The way ahead for integration

As the NAO argued (National Audit Office, 2017) there is a need to understand which models of integration work best and/or achieve most and put people at its heart, not systems or organisations. If integration is simply seen as a process for bringing health and social care together then, as stated before, it is unlikely to deliver the desired benefits (Georghiou & Keeble, 2019). If, as suggested above, the focus of intervention shifts towards reducing demand and onto those optimum points when poor outcomes might be diverted, then that will almost always require integration. For example, if it is recognised that there are sound predictors of falls amongst older people (Todd & Skelton, 2004), then lessening risk might require structured exercise programmes, housing adaptations, dietary change, sight checks, and changes to drug regimes, not forgetting someone encouraging the older person to change their own behaviour. This does not require a single service, but it does require integration across planning and delivery, not least in the end user's experience of what is on offer.

The NAO established that there are some important hurdles to overcome in pursuing integration (National Audit Office, 2017). Firstly, establish the evidence base, then address the following three barriers:

- **Misaligned financial incentives** Changing a tariff system that incentivises hospitals to recruit patients,
- **Workforce challenges** Overcoming issues such as differing working cultures, professional restrictive practices, employment terms and conditions, and recruitment,
- **Reticence over information sharing** Ensuring there is clarity over the sharing of patient information at a national and local level.

There are also other obstacles, such as how to align services that are free with those that are means tested / charged for or, in terms of information-sharing, how to overcome problems not only between organisations but within health and social care, given the plethora of systems they use. Finally, as others emphasise, the primary beneficiary of integration needs to be the service user.

## The way ahead for consumerism

As self-funders indicate, social care consumerism is not about who holds the money, because if there is little choice, limited availability and services are not desirable, then you are forced into being a recipient rather than a consumer.

### Choice

Most older people say they want to remain in their own home, including specialist housing, until death (NatCen, 2013). Yet only 20% of the population aged 75 and over achieve this, whilst nearly half die in hospital and 30% in residential care (Public Health England, 2019, Section 4, Table 2: Proportion of deaths by place of death for people aged 75 years and older in England in 2017). In the case of the latter, it is often a decision which many older people feel they have little choice over, and one which is made at a time of crisis or ill-health. Few of us know what outcomes we expect residential care to deliver, what constitutes good care or even whether one care home really differs from another. Even the information that is available via the CQC, as the Kings Fund points out, is often not well used.

*Providers and patient and public groups told us that awareness of CQC and use of CQC information in the context of choice still seems quite low among the general public and service users when compared with, for example, sectors such as education.*

(Smithson et al., 2018, p.24)

Although choice is often couched in terms of choice of services, as funding has fallen, the very things that people say they want to have a choice over are more likely to become restricted. Which person delivers my care? How much time do they have for me? What choices do I have over what they do? Do they know who I actually am? These are all issues frequently raised by older people. After all, there can be few things less desirable than being washed or dressed by someone you don't like.

Overall, there is a need for a much wider discussion about how we ensure choice, not only between services but also within them. Some of this is about enhancing the role of the regulator to genuinely inspect against a higher standard, and some is about paying for services to spend more time with older people. As the ICDC stated eight years ago, a lack of choice often starts from assumptions that people make about older age and what older people need (Independent Commission on Dignity in Care, 2012, p.5). This is not helped by a public perception that older people can only be a problem, never an asset.

### Availability

As discussed earlier, there has to be unused capacity in the market for choice to work, so equally there needs to be a funding mechanism which allows home care services and care homes to have spare capacity, as well as the funding to expand the scope of their provision. Even though this might seem impossible, farmers have been paid for years to leave land fallow! Equally, given that older people incur higher health costs, use services more, and stay in hospital longer, there is a need for them and their carers to be able to fast-track health care. Although older people are the group most satisfied with health services, overall satisfaction with primary care, such as GPs, is in decline.

*Public satisfaction with general practice dropped by 7 percentage points in 2017 to 65 per cent, the lowest level since the survey began in 1983... patients (are) finding it harder to get through to the surgery on the phone, harder to see their GP of choice (which affects continuity of care, something that we know is key to keeping patients healthy and out of hospital) and rating their overall experience of the surgery more negatively.*

(Robertson, 2018)

However, 'availability' cuts both ways. Government wishes to develop more family housing, yet in 2011 nearly 40% of all three, four and five or more bedroomed properties owned outright were occupied by those aged 65 and over (ONS: CT 0802\_2011 Census, May 2018). Some older people will of course wish to remain in their family home as they age, yet it is estimated that up to a third of older people want to move but many feel unable to do so (Wood & Vibert, 2017; Nationwide Building Society, 2019). Some of the reasons for staying put are poor health, the physical exertion of sorting, packing and unpacking possessions, and the difficulties of buying and selling. Government could do more to offer incentives to older people to move, such as lowering stamp duty, better mortgage systems for older people, providing a national help-to-move service and through stimulating self-help, such as encouraging developments like co-housing:

*There are fewer than 10 existing cohousing developments designed specifically for older people... The Netherlands record approximately 230 senior cohousing communities.*

(Quinio & Burgess, 2018, p.10)

### **Desire**

Regardless of how many people might need care, few of us actively want it; yet that shouldn't mean it has to be undesirable. My father, when in his late eighties, was asked if he might like to consider moving into an extremely well-funded alms-house in his hometown, he scornfully replied that they were for old people, not him. Anyone with parents of a similar age might well have experienced similar responses. It is hardly surprising, given the negative attitudes to old age (Royal Society for Public Health, 2018).

Ageism not only discriminates against older people but acts as a powerful disincentive to receiving age specific help or services. It is noticeable that adverts for aids and adaptations, such as stair lifts or continence products, typically feature younger people who don't look to be suffering from any of the conditions for which the advertised product is intended. Equally, products ranging from alarms to raised toilet seats do little in terms of their design to lessen discrimination.

Finally, it is important to make recovery and rehabilitative interventions desirable. Bennett & Winters-Stone describe a range of behavioural interventions to encourage older people to engage in exercise programmes, rather than simply having them on offer (Bennett & Winters-Stone, 2011). Recovery from hip fracture (Sims-Gould *et al.*, 2017) and stroke (Rapoliené *et al.*, 2018) often requires considerable motivation, particularly where, in the case of stroke, the effect on the brain may in itself be to lessen motivation.

### **Conclusion**

The argument in this paper is that little has changed in terms of policy towards older people's social care over the last fourteen years, from the 2006 White Paper to the present day. A number of reasons can be advanced as to why this is true.

- Whilst finance has undoubtedly played a part in limiting social care innovation, it is not the sole reason why change has not occurred.
- The increased focus on how to finance social care over this time period has moved attention away from whether what is being purchased is appropriate or desirable.
- There needs to be a refocusing of the social care debate onto how demand for both care and health provision can be reduced.

- The commissioning function across health and social care needs to use research and local data analysis better in order to understand and predict demand, fuel evidence-based prevention and to target interventions. Public Health should be encouraged to support this activity.
- At a national and a local level there needs to be a greater emphasis on how good prevention outcomes are then mainstreamed.
- Given that the bulk of social care is provided by the private sector, if better and greater preventative provision is to be available, then that sector has to be better engaged, supported and incentivised.
- It should not be supposed that all integration is good; but it should be judged on whether it delivers replicable cost benefits and will lead to better provision for care consumers.

Overall, there has to be a significant shift from how we can fund greater supply, based on an increasingly ageing population, to how we reduce demand. Failure to achieve this will inevitably mean a deterioration in services as less money per head will be available. Politically, it may also become untenable to ask a poorer, younger, working population to fund such provision.

Instead the aim should be to reduce the period of ill-health that older people experience prior to death, through enhanced rehabilitative and recovery services that can target the optimum points in older age when maximum benefit may be achieved. Alongside this should be a much greater emphasis on provision that encourages and supports individual older people's own health and wellbeing. Currently we spend far too much, far too late, on health and care services that escort us to the grave, without making sure that the journey is as good as it could be.

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