



# **WE NEED TO TALK ABOUT ADULT SOCIAL CARE**

**IT'S JUST NOT WORKING  
– BUT IT CAN BE FIXED**

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# IT'S JUST NOT WORKING...

Adult social care simply isn't working for anyone. Firstly – and most importantly - it isn't working for those who need support. Some people manage to get into the 'system' but too often find it unresponsive.

*'Ella is in her thirties; she's never had a job or lived a life with predictable routines of any kind. She ricocheted from one crisis to the next – arguments with neighbours, frightening outbursts of violence from her son, her youngest daughter wasting away, her middle daughter sixteen and pregnant. She was angry, aggressive, terrified and desperately needed help. Seventy three professionals had been involved but they just seemed to be another noise from which she needed to escape. After decades of sanctions, referrals and further meetings, Ella would like the welfare state to walk away'*

Others leading lives diminished by frailty and isolation can't get into the system at all.

*'Stan is imprisoned in his flat by his loneliness and physical frailty. On the day of his ninetieth birthday he had not spoken to anyone; this was not unusual. Agnes in the same neighbourhood is a former athlete now in her eighties and crippled by osteoarthritis. She doesn't trust her balance enough to go out, so passes most of her days alone. Ellen used to be a hotel receptionist, now she is bedridden'*

These examples are taken from Hilary Cottam's recent analysis of how the 'welfare state' is [losing touch with the people it was intended to support](#). They encapsulate the dual dilemma of current arrangements – assessment processes seemingly designed more to keep people 'out' than welcome them in, and inflexible and unresponsive support for those who do get 'in'. Alex Fox puts it well in his new book (subtitled 'Escaping the Invisible Asylum') where he describes [resource-starved people and families and resource-starved front-line practitioners both expending time and money they can ill afford on a fruitless battle with each other.'](#)

Official figures and other estimates amply demonstrate that fewer and fewer people are able to access support of any kind. There is now overwhelming evidence of the harmful impact of austerity on social care services and support; big annual budget cuts since 2010 have resulted in an estimated funding gap that will reach almost [£6bn pa by 2020](#).

Demand for help is also higher in [more deprived areas](#) but the councils in these areas have suffered the most from central government cuts and are least able to raise extra funds locally. To take one example, meals-on-wheels - at one time a standard offer - have now been entirely removed by [over half of local councils](#). This widespread denial of access to support has in turn resulted in the unplanned growth of people paying for their own care ('self-funders') acting as 'consumers' and using their own capital and savings. Again this simply isn't working. The Competition and Markets Authority has reported problems of poor information, lack of understanding and a litany of sharp practices in the [care home sector](#). In short, people do not think of themselves as consumers when it comes to social care, and are unlikely or unable to shop around.

And it's not just the people who need some direct help. The system isn't working for those who work in the sector as carers, either paid or unpaid. The largely privatised workforce is now characterised by [low pay and insecure working arrangements](#) with resulting problems of recruitment and retention. In 2016/17 the annual turnover of all care staff was 27.8% and the vacancy rate 6.6%. [Care Act guidance](#) states that local authorities should encourage training and development of care staff but the companies providing services are not formally required to offer development opportunities to staff. Meanwhile annual surveys reveal a long-standing and widespread lack of support for informal carers and a heavy toll on their [personal health and wellbeing](#).

**This massive policy failure simply can't go on.**

OF COURSE  
IT'S ABOUT  
MONEY...

Whatever the form and model of support, more and fairer funding is a prerequisite. The relentless cuts to local authority budgets have to be reversed. The National Audit Office has recently shown that the point has been reached where councils are now under existential threat as a result of the 49.1% real terms [cut in funding between 2011-2017/18](#).

but is unlikely to be the last. Alongside this failure to support local funding from the centre there is also the long-standing failure to determine a sustainable model for sharing the cost of long-term care between the state, individuals and families. A largely tax-funded national care service putting adult social care on the same footing as the NHS would probably be no more expensive than restoring access to 2009/10 levels. It would also ease the problem of integrating health and social care by removing the problem of trying to align a means-tested system with one [free at the point of use](#).

**But although nothing much can change in adult social care until it is better funded, it's not enough to just complain about a failing model. We need to enthuse about a better one.**

## IT'S ABOUT MUCH MORE THAN MONEY...

Nothing much can change without better funding, but simply investing in the model we currently have will not serve the interests of people needing support or those who work in the sector. Adult social care has been through two major changes in the fifty years since the publication of the [Seebohm Report](#).

The period roughly between 1970 to 1985 consisted of a virtual monopoly of provision by local authority social services department, but this was followed by the gradual dominance of a market model characterised by a multiplicity of competing providers, mostly private companies. Now this model too is under challenge from fresh thinking that explores the ways in which the views of those who need support, and who work in the sector, take priority. In particular the [Social Care Future movement](#) has become an important focus for organising and promoting this challenge.

What we now need is something radical and far-reaching; something that addresses the following five components:

1. New administrative structures
2. A new focus on ethical behaviour
3. Rein in and reshape the care market
4. Commissioning for innovation
5. Supporting change to make it happen

None of this will happen spontaneously. Change of this nature will disturb and challenge many of the current 'taken-for-granted' assumptions about where decisions should be taken and by whom. Despite the huge policy significance of the shift to a market model, it has been the subject of remarkably little debate; rather, over three decades, it has gradually shifted the way the sector is structured and understood - the marketisation of social care has become 'the new normal' and 'consumerism' the mode of exchange.

Moving towards a radically different model for the way support is structured, commissioned and provided inevitably represents a challenge to the current distribution of power. It asks difficult questions on how decisions are made, where, by whom and with what [level of accountability](#).

## NEW ADMINISTRATIVE STRUCTURES

Any reference to 'public administration' is guaranteed to elicit a yawn, yet it is anything but insignificant; it is the key means by which we put into effect the values, principles and policies that we have collectively decided should shape our lives. Local government used to have a huge role in shaping and delivering a beneficial civic life but is now largely powerless as an independent source of power and legitimacy - of every £1 raised in taxation 91p is controlled and [allocated by central government](#). This is a degree of centralisation unseen anywhere else in the western world. For any sort of change at local level to be transformative, local government needs a better source of independent funding such as local tax revenues topped up by increased ring-fenced grants for priority areas (like social care) alongside additional redistributive no-strings funding that allows councils to set their own priorities.

But new funding also needs to be matched by new structures. There is now a multiple patchwork of structures at local, sub-regional and regional level covering traditional local councils alongside combined authorities, metro mayors and influential external bodies such as Local Enterprise Partnerships. The administrative dilemma here is that increasingly ambitious policy goals have outstripped the capacity of existing structures and processes to respond. In social care these high-level goals are contained in concepts such as 'wellbeing' and 'independent living'.

These goals in turn require an administrative system capable of focusing on 'place' rather than on separate – and often competing – organisational

priorities; an administrative structure capable of ensuring strong organisational coordination at the right level for different tasks, and building strong relationships between local government, civil society, local businesses and people, [around a shared interest in place](#).

Current funding flows act as a significant block to any such system change, particularly where they are designed to solve specific problems like [bringing down waiting lists](#). Place-based commissioning requires single or integrated commissioners holding the 'place' to account, whether that 'place' is at regional, sub-regional, local, or neighbourhood level. This is important. New models of care need a new administrative infrastructure otherwise they will always be struggling against the grain.

**This has far reaching implications beyond social care and would require a joined-up approach to governance at national, regional and local levels that has not hitherto been evident.**

## A NEW FOCUS on ETHICAL BEHAVIOUR

The place of ethics in human services seems to have got lost. Where debate does occur it tends to be on the back of sporadic (if alarmingly frequent) high level scandals that attract media attention. Ideas about restoring ethical behaviour into public services and public life need to be about more than some marginal tweak to the scoring systems of competitive bidding. They are essentially about the kind of society in which we wish to live and how we should lead our lives. Those working in the sector are (or certainly should be) active moral agents guided by ethical principles and emotions such as sympathy, empathy, sensitivity and responsiveness, yet as Julia Unwin has tellingly pointed out, kindness, emotion and human relationships have become the ['blind spot' in public policy](#)

**Two things could make a difference here: making commissioning decisions about more than money; and commissioning services from ethical care providers.**

*Commissioning for Social Value*

Currently the main legislative basis in England for prioritising anything other

than financial efficiencies in the awarding of public services contracts is the Public Services (Social Value) Act 2012. This legislation, somewhat lamely, requires those commissioning public services to 'think about' how they can also secure wider social, economic and environmental benefits. Despite the best efforts in some [localities like Greater Manchester](#) there is little evidence that this measure has been effective. Research has found that only 24% of local authorities have a social value policy; that only around a third routinely considers this in their procurement and commissioning; and that even when included for consideration, social value only amounts to between 5-10% of the [contract scoring system](#). The Government seems to be alert to these difficulties. Cabinet Office minister, David Lidington has recently said he wants more charities, social enterprises and mutuals to bid for public services contracts and that he will extend the Social Value Act so that contracts are awarded not just on value for money but also on ['company values'](#).

Whilst this is an interesting recognition of the importance of ethical care, it is unclear how robust any change will be. Stronger obligations on social value exist elsewhere in the UK. In Wales the 2017 Code of Practice for Ethical procurement (developed in partnership with unions and public service employers) requires all public sector organisations, businesses and third sector organisations in receipt of public funding to sign up to a code of practice that promotes decent jobs, a living wage and protects against blacklisting and other forms of exploitation. The Procurement Reform (Scotland) Act 2014 goes further in requiring all public bodies to have a procurement strategy in place that supports community benefits, the living wage and the economic, social and environmental wellbeing of the local area.

We need to know more about how the Scottish and Welsh legislation is working and whether stronger measures might be required. These additional measures might include replacing 'social value' with stronger measures such as 'social impact' focused upon [measurable outcomes](#), ['public value'](#) and looking at the case for a new [Companies Act](#) that would make a commitment to ethical practice a condition of company formation.

### *Commissioning from Ethical Care Providers*

Commissioners need to be able to distinguish between the business and workforce practices of different providers and to prioritise those acting as 'ethical employers'. These considerations could cover both specific employment practices and evidence of a wider ethical mission.

Criteria could include:

### *Staffing Levels:*

There is clear evidence of worsening [staff-user ratios](#); consideration could be given to requiring a minimum staff-user ratio as a condition of access to public funding along the lines already [in place in Belgium](#).

### *Living Wage:*

Consideration could be given to making payment of the Living Wage – a level designed to meet the costs of living rather than just the government minimum – a requirement for access to public funding. This should also cover any sub-contracted workers – it is estimated that although 24% of local authorities pay the Living Wage, 75% of these do not make the same [requirement of their suppliers](#).

### *Collective Bargaining:*

The social care sector is characterised by [low levels of unionisation](#). Commissioners could require contractors to encourage staff to join a union and require them to engage in collective bargaining that is conducted freely and in good faith. This could also include an obligation to consult with union representatives and affected staff before the submission of bids or tender documents that would require [changes to staff terms and conditions](#).

### *Governance Sharing:*

Ethically compliant companies could be required to demonstrate [shared governance arrangements](#). The recent comprehensive report from the IPPR, for example, suggests that companies with more than 250 employees should have at least two elected workers on both the [main board and the remuneration committee](#).

### *Compliance with Ethical Codes:*

Attempts have been made, most notably by Unison, to codify an '[ethical care charter](#)' with around thirty local authorities already having signed up. This commits them, amongst other things, to ensuring home care workers are not on zero-hours contracts or going unpaid for travelling time between appointments. Compliance with extended codes of this nature could again be made a prerequisite for accessing publicly funded contracts.

# REIN IN and RESHAPE the CARE MARKET

**Revisiting the role and place of a 'market' in adult social care is a complex undertaking. There are three complicating factors: penetration, fragmentation and fragility.**

## *Penetration:*

The provision of adult social care is effectively privatised. Early talk of a 'mixed economy of care' with local authorities, private companies and the voluntary sector competing on a 'level playing field' has long since evaporated. In 1979, 64% of residential and nursing home beds were still provided by local authorities or the NHS, by 2012 it was 6%; in the case of domiciliary care, 95% was directly provided by local authorities as late as 1993; [by 2012 it was just 11%](#). This shift in ownership has required investment by non-statutory providers, especially in the case of residential facilities. The care industry estimate is that cumulatively this investment amounts to [around £30 billion](#) and although this figure might be an overestimate it does raise the issue of compensation costs should a future government wish to consider some model of nationalisation.

## *Fragmentation:*

The sector is characterised by a multiplicity of fragmented, competing providers. The care home sector supports around 410,000 residents across 11,300 homes from [5500 different providers](#) whilst the situation in home care is even more diverse, with almost 900,000 people receiving help from over [10,000 regulated providers](#). Nor is it any longer the case that the state is even the dominant commissioner of these services. The privatisation of care alongside tighter access to local authority funded care has resulted in a rise in self-funding 'customers' accessing support that is exclusively or largely dependent upon their fees - indeed in some wealthier parts of the country, self-funders constitute the majority of the care market. The sheer size and complexity of this market means that strategies that might work in more simply structured sectors, such as empowering the state to take a foundation share in private companies and appointing non-executive directors to their boards via a Public Benefit Company model, [would be difficult](#).

### *Fragility:*

The third complicating feature of the social care market is fragility - the prospect of significant market failure and the impact of this on highly vulnerable people. This is not so much a question of small individual providers failing to meet regulatory standards and being deregistered; rather it is the prospect of one or more major provider covering thousands of service users exiting the market. As larger operators have begun to populate the sector, the potential for a large scale market failure has increased. The first major casualty was Southern Cross in 2011 - a large national care home provider which had 9% of the market nationally but a much greater share in certain regional areas. Not the least of the problems here was the remote ownership of the company – a complex mix of [creditors, property investors, bondholders, banks, shareholders and landlords](#). Much of the Southern Cross provision was eventually taken over by another major provider, Four Seasons, which is itself now at high risk for [much the same reasons](#). Either through financial collapse or strategic withdrawal, the market model is now even said by the regulator – the Care Quality Commission - to be at [‘tipping point’](#).

There are nevertheless several ways to regulate the market and incorporate a more ethical approach:

### *Transparency:*

There is remarkably little transparency about the ways in which private companies in receipt of publicly funded contracts deliver on their agreements - a member of the public would find it hard to locate and read most contracts for public services. A ‘transparency test’ (incorporating an extension of the Freedom of Information Act) could stipulate that where a public body has a legal contract with a private provider that contract must ensure full openness and transparency with no ‘commercial confidentiality’ outside of the [procurement process](#). It could be further stipulated that the public, via staff groups, user groups and trade unions, must be involved in both the specification and management of a contract.

### *Tax Compliance:*

The ownership of all companies providing public services under contract to the public sector should be available on the public record. At the same time a new taxation test could require private companies in receipt of public services contracts to demonstrate that they are subject to UK taxation law.

The investigative organisation [Corporate Watch](#) claims that some leading private providers have set up corporate structures that allow the avoidance of tax on millions of pounds of profits by making use of corporate entities in the British Virgin Islands, Luxembourg, Jersey, Guernsey and the Cayman Islands. These companies include some of the biggest private providers of health and social care services in the UK, It cannot be ethical for companies that avoid tax to simultaneously complain that the taxpayer needs to pay them higher fee levels.

### *Profit Capping:*

Debt-financed businesses have a particular problem since they need high profit margins to be able to afford their huge debt interest – an expectation that is completely inappropriate. Social care is a stable market on which low returns on investment should be expected since demand does not fall or vary, and taxpayers cover the cost on half of all beds. An appropriate maximum return of, say, 5% on investment would be an acknowledgement of the fact that social care is a low risk sector and that both inflation and [borrowing rates are very low.](#)

### *Renationalisation:*

The final option is some form of 'renationalisation'. This would not be a simple undertaking. Decisions would have to be taken on the nature and extent of such a measure. For example:

- Would it apply to all non-statutory providers, private and not-for-profit alike?
- Would it apply to large rather than small or medium sized companies?
- Would it apply only to those multi-national companies using debt-financed models?
- What would be the estimated cost – and opportunity cost - of the compensation associated with any such measure?
- How could continuity of care, stability of provision and protection of the workforce be assured?
- Could it lead to an undue focus on sectoral ownership at the expense of high quality care?

# COMMISSION for INNOVATION

## **Rediscover Commissioning with a Purpose**

The adult social care sector is big and more should be made of its clout - one recent estimate puts the total direct, indirect and induced value of the sector at 2.6m jobs and [£46.2bn in 2016](#). Regardless of whether the purchaser-provider split continues, there will need to be confidence that the services and support that are commissioned, contracted and provided meet the needs and requirements of those who rely upon them. In social care, the skills and capacity to commission, contract and monitor have all been diminished by years of austerity and there seems to be no strategy to harness the commissioning of public services to some strategic direction; rather the end product seems to be simply market diversification in pursuit of greater 'cost-effectiveness'.

This isn't good enough. We need to draw on the [ideas of Mariana Mazzucato](#) with her proposal for 'mission-oriented' public investments, where the task of the state is to determine the direction of change by 'transforming landscapes and creating and shaping markets'. [She notes](#) that such missions require capacity and leadership; new organisational capacities and capabilities will be needed within public organisations. In particular the roles of commissioning and procurement officials will need to be strengthened and professionalised. The Cabinet Office and its partners have already developed the Commissioning Academy for senior leaders from all parts of the public sector, while Skills for Care offers a certificate in Principles of Commissioning and Wellbeing. Much more of this is needed, probably on a compulsory basis.

## **Commissioning to Retain Local Wealth**

The concept of [Local Wealth Building](#) is also relevant here - a growing movement in Europe and the USA based on the principle that 'places' hold significant financial, physical and social assets of local institutions and people. The key is local 'anchor' institutions (public, social, academic and commercial) and their procurement role in supporting the local supply chain. This approach will involve opening markets to local small and medium enterprises rather than looking to national and international chains. These local suppliers will encompass employee owned businesses, social enterprises, cooperatives and other forms of community ownership. Procurement of this type is locally enriching because such businesses are more likely to support local employment

and will have a greater propensity to retain wealth and surplus locally. Some localities are already demonstrating achievements along these lines, for example in [Preston](#), [Manchester](#), [Barnsley](#) and elsewhere.

## **Commissioning Local and Small**

Commissioners tend to gravitate towards bigger companies providing larger sized services as a way of avoiding the complexity of developing relationships with a multiplicity of [smaller providers](#). Much of this occurs beneath the public radar, such as bringing together sets of smaller contracts into large single tender opportunities that favour larger bidders. Similarly, pre-qualifying questionnaires can be littered with pass or fail questions that undo a prospective bid from smaller organisations; and although many local authorities are signed up to a local Compact with the voluntary sector, when it comes to challenging a procurement decision the Compact will tend to have [little force](#).

Alongside the commissioning preference for large providers there is the trend towards larger scale provision, especially in the care home sector. The trend here is for small-scale operators to be replaced by large provider chains with more than fifty care homes. [Industry estimates](#) indicate that as care homes grow in size they become more profitable, with the highest margin for those with over a hundred beds. The paradox here is that while the market is moving towards large-scale provision, the evidence from the social care regulator is that smaller facilities tend to receive better ratings for [quality of care](#).

The models which most closely align to what people want are those which can operate at human scale; and the people most likely to design them are front-line workers and the people and communities with whom they work. This implies the need to look afresh at the potential roles that could be played by 'civil society' in its widest sense - informal networks, community groups, cooperatives, registered charities, social enterprises and a [hybrid of all of these forms](#). The bulk of providers are already small and local but many of them are under existential threat. A recent annual survey (<https://localgiving.org/local-charity-and-community-group>) of 686 local charities found just 47% 'confident they will survive beyond five years' and reported that the sector is in 'an increasingly precarious position' due to increased competition for grants and contracts, cuts in spending, an inability to diversify income streams and a growing demand for services.

**Any ideas of the spontaneous flowering of 'community' remains wishful thinking; only a strategic mission to shift the default setting of commissioning activity can do this.**

There is also a need to encourage and support community businesses. Early evidence on the value of small scale [micro-enterprises already exists](#) and further evidence is being gathered through the work of [Power to Change](#). Public procurement law already exists to facilitate the use of small and medium-sized enterprises. The Public Contracts Regulations 2015 are intended to make public sector procurement more accessible for small businesses, for example by removing Pre-Qualification Questionnaires for low value procurements. Similarly the Small Business, Enterprise and Employment Act 2015 allows the government to place duties on public sector contracting authorities, setting out how they conduct public procurement, and places the Mystery Shopper scheme (which investigates procurement practices) on a statutory footing. These could both be strengthened and extended. However, smallness and locality can't be uncritically fetishised – we also need confidence in their ability to deliver the right sort of support. Not all smaller enterprises will want or be able to be part of the change.

## **Commission Personally**

The notion of 'personalisation' has become a prominent feature of the policy and practice landscape of adult social care, but there is a tendency to equate it solely with holding a personal budget. There are wider considerations that were well encapsulated by the now forgotten [Putting People First strategy](#) of 2007 which sets out four dimensions:

- Individuals having choice and control over their services through personal budgets
- Widely available low-level support to help people avoid a debilitating crisis
- Universal access to the information needed to make new choices and plans
- Work to building more inclusive and supported communities

Of these four, two have been virtually eliminated by austerity – widely available low-level support and the building of inclusive and supported communities. The personal budget/personal health budget model is one that can and does work for [some people](#) though some see it as a step towards further degrading of a collectivist model and a cover for budget cuts. Even supporters tend to acknowledge there are ongoing problems to be addressed such as support in making choices and decisions; receiving Information and advice; understanding allowance and spend; budget management, monitoring and review; and risk management and contingency planning. Underlying these barriers is a cultural disposition on the part of local authorities to control activity and spend. Even if this sort of support for personal budget-holding was forthcoming there remains the problem of a receptive market offering a choice of appropriate alternative suppliers.

## Co-Productive Commissioning

Implicit in all of this is the need for care and support to be co-produced. Definitions and understandings of the [concept](#) abound but all point to the need for a relocation of power and control, through the development of new user-led mechanisms of planning, delivery, management and governance.

Interest in the concept has been around now for at least a decade and there is no shortage of suggestions for what it could look like in practice. The Social Care Institute for Excellence, for example, emphasises that organisations must change at every level (from senior management to frontline staff) and that meaningful participation should become part of daily practice, not be a [one-off activity](#).

The stage has now been reached where co-production is no longer simply being explored conceptually or discussed in general policy terms. Rather there is now growing evidence of successful implementation with positive results, for example with [small community businesses](#), [local area coordination](#), and [asset-based community development](#). The first national gathering of the Social Care Future movement in Manchester in [November 2018](#) in effect became a celebration of these and many other initiatives. Indeed, perhaps the key question now is not so much whether these new models can work but rather how can they best be supported to flourish.

# SUPPORTING CHANGE to HELP IT HAPPEN

There is no shortage of ideas for changing the current failing model of adult social care, but transformational change has no qualities of spontaneous growth or self-perpetuation. There is a need to think of ways in which a new approach could be effectively promoted, regulated and supported. Possibilities might include: an implementation support model along the lines of the 2014 Care Act implementation support programme; a new and more robust role for the Committee on Standards in Public Life in spreading ethically-based culture and practice; extending the role of the Care Quality Commission to cover commissioning and not just providing; reinventing the Audit Commission to have an overview of 'place'; and offering ongoing support to those tasked with putting change into effect, perhaps along the lines of the prematurely scrapped Care Services Improvement Partnership and the Change Agent Team. The Nesta 'People Powered Results' model has already demonstrated the importance of support to make change happen and the ways in which it might be [put into effect](#).

# CONCLUSION: MARKETS, MORALS and POWER

In the realm of personal care and support there is a view that markets have become too detached from morals – indeed it offers a good example of the argument put forward by the popular philosopher, Michael Sandel, who argues that without any real debate there has been a drift from having a market economy to being a market society with markets and market values penetrating into spheres in which they [do not belong](#). However the dissatisfaction with the old 'take it or leave it' model of much previous local authority provision and the challenges to that model from the independent living movement [largely remain unmet](#).

In his classic analysis of power, [Steven Lukes](#) distinguishes between 'three faces of power': issue (power as a relation among people); agenda (subtle use of power within a complex system); and manipulation (the power to control what people think of as being right). All have been shown to habituate the landscape of adult social care policy in the UK over the past thirty years and each would be challenged under the new approach proposed in this report.

## *Issue*

This is the 'open face' of power – the ability of one person or group to achieve compliance by openly making decisions that must be observed. In the case of parliamentary legislation there is at least some basis for this in democratic consent. It is here that the marketisation of adult social care has been built up through key policy landmarks such as the 1990 NHS and Community Care Act and the 2014 Care Act. A shift away from a market model will correspondingly require fresh legislation, as would any serious attempt to shift power towards people who need support, along with promoting alternative modes of sustaining people's independence and wellbeing.

## *Agenda*

This is Lukes' 'secretive face' – the power to set the agenda and make decisions behind closed doors; a situation where it is unclear who is making decisions and on what basis. This has increasingly become the modus operandi of adult social care decision-making where critical judgements are made without taking into account the needs, views and wishes of those most affected by them. This includes organisational decisions such as tightening eligibility criteria for accessing support; professional decisions, where front-line staff exercise discretion in how rules are interpreted and implemented; and business decisions where judgements on the terms and conditions of care workers,

on loading a company with debt in order to extract dividends, and on whether or not to terminate market activity are decided in distant boardrooms. A new approach to adult social care needs to be based upon an 'open' not a 'secret' face.

*Manipulation:*

This is the 'deceptive face' – the power to shape and shift values in such a way that the decisions that create benefit and advantage to the powerful party are accepted without serious questioning. In the case of adult social care there has been a thirty year period within which to promote the concepts of markets, competition, choice and consumerism as self-evident virtues that require no further justification. Where defects in the model become apparent, these are then interpreted as failures of policy implementation rather than of misconceived policy design. The fact that the most heated policy debates are around funding rather than the model of commissioning and provision bears testimony to the force of manipulative power. The point has now been reached where there is every reason to challenge all of these normally uncontested assumptions.

The ideas in this report therefore challenge all of these faces of power. Commissioning from local suppliers would redirect resources from national and transnational companies to local suppliers and populations. Commissioning small would give preferment to human scale community businesses and not-for-profit organisations; agencies with local roots, local presence and local accountability. Commissioning holistically would challenge the orthodoxy of separate organisations pursuing different and distinct objectives and place primacy on the importance of 'place' and belonging in people's lives. Commissioning personally would replace the restrictive interpretation of a personal budget with a wider understanding based upon personal outcomes and supported, inclusive communities. And commissioning ethically would offer the opportunity to prioritise non-market values in decision making to support the social, economic and environmental wellbeing of an area.

Big picture change is never easy - as the Italian philosopher Gramsci observed, 'the crisis consists precisely in the fact that the old is dying and the new cannot be born; in this interregnum a great variety of [morbid systems appear](#)'. It will be a long game with short, medium and longer term changes. The first stage is to discover evidence that some places and people are able to show that change is possible; that new ideas have been shaped, adopted and put into effect with successful outcomes. Arguably the sector has reached this point. A milestone of sorts was reached recently when the annual conference of directors of local authority adult and children's services being held in Manchester – the largest 'establishment' gathering of the social care world in England - was paralleled by an alternative '[social care futures](#)' event focussing

on innovation, new care models and the direct testimony of [users and carers](#). Interestingly at a combined meeting of the two events the Care Minister is reported to have said that for too long adult social care has been seen as the poor relation of the NHS and that she was 'fed up with it being seen through the lens of the NHS'. The much delayed Green Paper will be the test of what this means in practice and whether there is any willingness on the part of the government to rethink the nature and purpose of the sector. Some bottom-up innovation will doubtless continue regardless of the thrust of the Green Paper, but it will always struggle if it goes against the grain of national policy. We need a future in which bottom-up innovation is promoted by top-down support along the lines developed in this report.

**We can't go on like this, playing around with small bits of the jigsaw puzzle. We need to articulate a new model for adult social care; we need to see the picture on the jigsaw box and we need to fit the pieces together. And we need a coherent and sophisticated national policy to help ensure this can happen. Adult social care just isn't working – but it can be fixed.**

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