DOING CARE

Differently

Contents

Doing Care Differently requires thinking about care differently

Social care was given an unprecedented high profile in the 2017 General Election campaign. Independent Age wanted to move the debate on from just plugging the gaps in the system and fixing the current 'crisis', to setting an ambitious new vision for funding and delivering care to make it truly fit for now and the future. Independent Age set out to stimulate rich discussion from across the care sector and with policymakers and parliamentarians by hosting a series of blogs from external contributors on the theme of doing care differently.

We invited contributions from a wide range of sources, both from within and outside the care sector. We challenged contributors to make the debate as wide-ranging as possible, covering topics that look to the long term, and examining what all of us in England need to do to prepare for and deliver care differently, in a time of huge demographic shift.

We were delighted with the responses we received, and our *Doing Care Differently* series enjoyed a high level of readership as well as considerable discussion and debate on social media.

This report examines six themes dominating discussions on social care right now – demand; funding and responsibility; quality; integrated care; technology; and sustainability.

Together with Independent Age's own thought leadership in these areas, our report weaves in ideas, suggestions and questions raised and examined by our blog contributors.

Independent Age hosted roundtable events at both Labour and Conservative party conferences in autumn 2017, with discussion topics based on strong themes and questions raised by our bloggers. This enabled further rich debate and exploration of the long-term options and reforms needed to ensure that the social care system can sustainably deliver high-quality care to all older people who need it.

Throughout this report, we have included (anonymised) quotes from attendees at our party conference events.

Independent Age extends a special thank you to all our blog contributors for sharing with our readers their bold ideas and new suggestions on this crucial topic.

You can read our blog series in full at www.independentage.org/policy-and-research/doing-care-differently

Foreword

Professor Paul Burstow, Chair, Social Care Institute for Excellence

In launching the *Doing Care Differently* blog series, Independent Age has helped to illuminate the challenges and opportunities facing our ageing society.

Care is not free and never has been in England. We don't have a state-funded system – we have a state-subsidised safety net. While many of us are vaguely aware of this, most of us prefer to avoid thinking about it, let alone planning ahead.

Clarity on the level of taxpayer support for the state-subsidised system and how the risk of care costs is to be shared is essential but that alone is not sufficient.

How we pay for care was a flashpoint of the 2017 General Election. The reaction to Conservative proposals to include the value of a person's home in the means-test for their home care was predictable. However, for many in this country their housing wealth is the foundation for securing any income beyond the state pension.

Yet while awareness may now be a mile wide, understanding remains millimetres deep. That must change. If the government is unwilling or unable to reach a decision on how care is to be funded, it must make people understand the need to plan ahead and the consequences of not doing so.

But however we pay, what are we paying for? More of the same or something different? What should 21st century care and support look like? What does a good later life look like?

As this report makes clear, there is no one-size-fits-all solution. Ageing is more than a physiological thing; it is a state of mind too.

Doing Care Differently requires us to reframe the debate. It's less about services and more about having meaning and purpose in our lives. Across our lifespan, we can all do more to bolster our resilience, stay strong, in control and socially connected.

The language of ageing must become more aspirational and empowering. Ageist practices may have been outlawed by Act of Parliament but ageism and stigma, including self-stigma, remain rife. Any strategy that's serious about improving the quality of social care must address these attitudes.

While many contributors to *Doing Care Differently* point to the need for greater integration between health and care, others rightly challenge this as too narrow. Meaning and purpose in life won't be found in the confines of a sickness service and care of last resort.

I believe that the Care Act offers a better paradigm. It enshrined a new organising principle for adult social care, the promotion of individual wellbeing. This principle could underpin the rapprochement needed to realise the goal of greater integration within and across health and social care and beyond.

If *Doing Care Differently* is to mean anything, then the role of housing and the voice of the housing sector must be to the fore. Housing has a crucial role to play in meeting people's aspirations for their later lives. Well-designed and well-built homes can make a significant contribution to preventing and postponing the need for health or social care services.

Across the world, technology is creating new industries and remaking others, yet health and care systems have been slow to change. While in most of our lives, we expect smart intuitive design and a seamless end-to-end service, health and care feels clunky by comparison.

Technology-enabled care remains stuck in endless small-scale pilots and demonstrators rather than the ambitious scaling that is required.

As domestic technology gets smarter and more connected, consumers will increasingly make their own choice to meet their needs for connection, support and care.

This report rightly highlights the need to reform how we pay for care for the current generation. Offering some protection from catastrophic costs would be a start, but this is not enough. There is also a need to lay the foundations for the solutions needed to fund the care of today's millennials and Generation X.

By taking the long view, the government could create a savings and risk-pooling system that generates the funds necessary to meet future care costs, while also creating financial incentives for us all to be more literate and engaged about how we age.

'The debate about social care needs a new narrative.'

In this report, Independent Age has started to craft it. Being aspirational, building on people's strengths, challenging stigma and ageism, promoting wellbeing – these are just some of the ingredients.

The Treasury orthodoxy that care is a deadweight cost must be challenged too. Social care is an engine of economic growth; its value to our economy is significant and growing. A failure to recognise this and act accordingly runs the real risk that social care becomes a brake on growth.

So, my challenge to colleagues in the sector is to make the case for doing care differently by locating care and support as integral to policy debates about family life, economic growth and what sort of UK we want to be post-Brexit.

1 Meeting future demand

The media rarely tire of new stories about the pressures facing England's social care system. But for all the many warnings we read and hear about on the news, we still haven't fully prepared as a country for future growth in the older population.

We have known for many years that demographic trends point to many millions more of us living for longer, not necessarily in good health and more typically than in the past, with multiple, chronic health conditions.

In 2018, the number of people in England with three or more long-term conditions could grow to 2.9 million from 1.9 million just a decade before. This is according to estimates by the House of Lords Committee on Public Service and Demographic Change, which may even be too cautious[1].

65%
of people over 65 and

82%[2]
of people over 85 are living with two or more long-term conditions.

1   Ready for Ageing? - Select Committee on Public Service and Demographic Change, UK Parliament. https://publications.parliament.uk/pa/ld201213/ldselect/ldpublic/140/14012.htm, 2013.
2   Musculoskeletal conditions and multimorbidty, Arthritis Research UK, August 2017.

And research from the University of Newcastle has shown that with increasing life expectancy, the numbers of added years where older people experience substantial care needs is growing. The rates doubled between 1991 and 2011 and there is nothing to suggest future trends will see anything other than increased numbers of older people living with illness and disability[3].

It is fundamental then for us to 'do care differently'. We first need to think through who care and support will need to be available for in future decades and in what numbers.

What type of care or support might future generations need or desire? And will this always be personal care, or as PA Consulting and the Telecare Services Association (TSA) ask, will it increasingly be technology-enabled care, using new devices to help us keep healthy, fit and well?

Just as important, with projected growth in the numbers of older people who themselves provide care, Carers UK and Age UK estimate there will be over 200,000 carers aged over 85 by 2030[4]. So we also need to identify the additional support older people might need as they look to balance their own wellbeing with caring responsibilities.

Professor Peter Beresford OBE, in his contribution on reimagining social care, surely speaks for many when he argues that to do care differently in future, we will also need to think about it differently. He talks less in terms of 'caring', and more in terms of the 'support' people will want to lead purposeful and independent lives.

Sara McKee, Founder of Evermore, was not alone in reflecting that the connotations of the word 'care' can make people feel vulnerable, like they are approaching death rather than embracing life. No amount of advertising, she argued, 'will ever get people to plan for care'. So McKee suggests a paradigm shift: let's help people to plan for life instead, and tackle the challenges that are stopping older people from enjoying a good old age and contributing to their community.

But whatever language we choose, the numbers make for stark reading. There's much to do – and not a huge amount of time in which to do it.

No timebomb, just steady growth

Jeremy Porteus, at the Housing Learning and Improvement Network (Housing LIN), hints at one of many challenges when he focuses on the current build rates of specialist retirement housing (1% of all housing stock) and the momentum we need to construct more. Over a quarter of our population is aged over 65 so Porteus calls for a shift in housing policy, to better serve today's older population and future generations too.

'There is inconsistency in social care policy and practice across local government. We are not always getting the basics right.'

---

3   Extra 71,000 care home places needed in eight years, study warns, Newcastle University. http://www.ncl.ac.uk/press/news/2017/08/cfasresearch/ 15 August 2017.

4   Carers over 85 more than double in a decade – but numbers getting support are down, Carers UK https://www.carersuk.org/news-and-campaigns/news/carers-over-85-more-than-double-in-a-decade-but-numbers-getting-support-are-down, 30 April 2015.
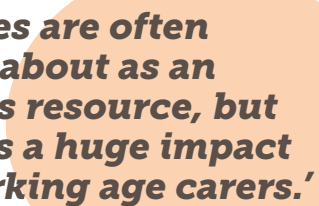
There are of course many other significant challenges. The Alzheimer's Society has highlighted that if trends continue, and no action is taken, by 2025 we could be looking at over 1.1 million people living with dementia in the UK[5]. However, they also make clear this doesn't represent a 'demographic timebomb'. This term is too commonly used and hardly helpful language when we should be celebrating, not fearing greater longevity. It is more accurate, says the Alzheimer's Society, to describe this level of population change as steady, 'not dramatic', growth[6].

Health and social care services certainly need to gear up to support people with conditions, like dementia, that are more prevalent in old age. But what about the change that still needs to be engineered to 'do care differently' for individuals who historically haven't been front of mind – and yet – demographics tell us will also grow in number over the coming decades?

Ian Green, at Terrence Higgins Trust (THT), paints a worrying picture when he reveals that THT research shows a quarter of respondents saying they would have no one to support them if they ever needed support with daily tasks. Their research report, Unchartered Territory, shows that 83% of over-50s living with HIV are concerned they wouldn't be able to access care they need and 88% haven't made financial plans for their future care needs. Many people who live with HIV can now expect to live a full life expectancy, but Green points out that with 54% of people with HIV in the UK projected to be aged over 50 by 2028, there will be new challenges both for individuals and care services too.

The care gap

A principal challenge will be who steps in to provide support when formal care is hard to access. And worse still, what will happen when there are no other obvious sources of help?

'Families are often talked about as an endless resource, but there is a huge impact on working age carers.'

Kirsty Woodard, from Ageing Without Children, explains that many of our expectations about how we are going to serve increased numbers of older people are based on outdated assumptions. She reminds policymakers that just because the pensioner population is growing, it doesn't follow that the army of family members willing and able to step in to provide unpaid care will likewise grow in the same numbers.

There are already 1 million people over the age of 65 who have never been parents which she estimates will double to 2 million by 2030.

The Institute for Public Policy Research (IPPR) has previously estimated that by 2030, we will be looking at a social care 'gap'.

5   Dementia UK Update, Alzheimers Society.
     https://www.alzheimers.org.uk/download/downloads/id/2323/dementia_uk_update.pdf, November 2014.
6   Demography, Alzheimers Society.
     https://www.alzheimers.org.uk/info/20091/what_we_think/93/demography, September 2014.

For 230,000 older people in England who need care of more than 20 hours a week, this could translate into high levels of unmet need and no family being available to help[7]. In fact, the IPPR first estimated that in 2017 the number of older people in need of care would outstrip the number of family members able to provide unpaid care[8].

Woodard explains that with these sorts of projections, we can't possibly continue with the same models of providing care. If current experience is anything to go by, we could be looking at older people without children entering residential care sooner than the rest of the population. But is that fair? And just as pertinent, is it even workable? Recent research published in The Lancet predicts that an extra 190,000 care home beds might be needed by 2035[9]. Other analysis from Which? suggests different numbers, but they share a common narrative, arguing that 9 in 10 councils in England won't have enough care home places in five years' time[10].

Whatever we choose to do, Woodard concludes that, 'As a society we must plan care around the population we have now and will in the future, not one from the past.'

From a workforce to a care force?

But if we can no longer rely on the same models of care that, for good or bad, have served us in recent years, which models of care will emerge in their place and can these prove effective?

Historically we would typically turn to care bodies and skills agencies to come up with some of the answers. However, Professor Paul Burstow, Chair of the Social Care Institute for Excellence and former Minister for Care, gives us all a jolt with his reminder that what we are actually faced with are acute workforce shortages. Just ploughing on won't do.

Professor Burstow claims that even if funding questions are resolved, business as usual in the social care sector is 'unsustainable'. In 20 years' time – so in 2037 – it has been estimated that the care workforce will be between 400,000 and 1.6 million workers short depending on how attractive the care sector is.

'We can't keep having consultations and commissions which don't go anywhere – we must just get on with reform.'

7   The generation strain collective solutions to care in an ageing society, Institute for Public Policy Research. http://www.ippr.org/files/publications/pdf/generation-strain_Apr2014.pdf, April 2014.

8   The generation strain: Collective solutions to care in an ageing society, Institute for Public Policy Research. https://www.ippr.org/publications/the-generation-strain-collective-solutions-to-care-in-an-ageing-society, 24 April, 2014.

9   Is late-life dependency increasing or not? A comparison of the Cognitive Function and Ageing Studies (CFAS), The Lancet, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(17)31575-1/fulltext, 7 October 2017.

10   Care home provision to hit crisis levels in most council areas within this Parliament, Which? https://press.which.co.uk/whichpressreleases/care-home-provision-to-hit-crisis-levels-in-most-council-areas-within-this-parliament/, 4 October 2017.

The UK's exit from the European Union will perhaps have one of the strongest impacts. In 2016, workers from the European Economic Area (EEA) made up the majority of migrants coming to work in the care workforce in England[11]. And yet, between July 2016 and April 2017, statistics from the Nursing and Midwifery Council revealed the number of nurses from the EU registering to work in the UK had dropped by 96%[12].

Elsewhere, analysis from Independent Age and think tank, International Longevity Centre-UK (ILC-UK), concludes that demand and recruitment difficulties could lead to a near doubling of the 'care ratio' of care workers to older people, from one worker per seven older people today, to one worker per 13.5 older people in 2037[13].

Although the introduction of the National Living Wage and more promising career pathways may all help tackle large vacancy and turnover rates, we are still looking at a struggling sector. Research for the BBC suggests that in 2016, 900 paid professionals left the workforce every single day[14]. And the Nursing and Midwifery Council now believe the numbers leaving the nursing profession may be outstripping the numbers joining.

> *'The third sector should be doing more to increase the level of noise on the problems in social care and the need for urgent action.'*

It is in these challenging circumstances that John Bryant, from Torbay Council, questions whether we need to think more creatively about how we plan for the future. He asks if we should rely less on plugging workforce gaps and instead, mobilise a new 'care force' based on the contributions all citizens could make. The alternative, he baldly puts, is finding an extra 339,000 people each year when the care sector struggles to compete with other employers.

But Dr Eileen Burns poses an altogether different sort of challenge. It is premised on the view that rapidly increasing numbers of older people with frailty, dementia and long-term conditions will require multi-disciplinary working. She asserts that those who care for older people will need to 'have the right skills, training and specialist knowledge' in the future to meet their increasingly complex needs. One has to wonder where these workers might come from.

11 Brexit and the future of migrants in the social care workforce, Independent Age. https://www.independentage.org/sites/default/files/2016-09/IA-Brexit-Migration-report.pdf, 2016.

12 New data show 96% drop in nurses from EU since July last year, The Health Foundation. http://www.health.org.uk/news/new-data-show-96-drop-nurses-eu-july-last-year, 12 June 2017.

13 Nearly 80,000 care staff could be at risk as Brexit fuels uncertainty about status of EU workers, Independent Age. https://www.independentage.org/news-media/press-releases/nearly-80000-care-staff-could-be-at-risk-as-brexit-fuels-uncertainty, 21 September 2016.

14 Social care system 'beginning to collapse' as 900 carers quit every day, BBC. http://www.bbc.co.uk/news/uk-england-39507859, 11 April 2017.

Needs must be met

Dr Margaret Blake, from Ipsos MORI, gets to the heart of the matter when she posits that individuals may have more of a responsibility to plan for their older age and future care needs. Their research, together with the National Centre for Social Research, confirms what a number of other studies have also shown: unmet needs are widespread. They are often hidden. And to be real about the challenges ahead of us, with mounting pressures on services, we need to do what we can now to minimise the risk that future generations of older people go on to experience difficulties. These include problems with daily living, getting out-and-about, and critically, social isolation and loneliness.

Dr Blake makes an interesting point when she argues we need to prepare for population ageing by looking beyond traditional care and support services. In many cases this will mean individuals maintaining and extending their social networks and building their own personal resilience. She accepts it won't always be easy.

Danail Vasilev at think tank, REFORM, strikes an especially sobering note when he explains that on current trends, by 2066-67 public social care expenditure will have doubled as a percentage of GDP, reaching £40.1 billion. The needs of the over-65s will account for a rising proportion of the care bill. Without changes to the current model, he adds, 'The extra tax burden will fall on a young generation hit by a decade of subpar growth and rising house prices.'

This poses yet further tricky questions about intergenerational fairness and whose role it will be to take responsibility for delivering and paying for care, as explored in the next chapter.

> **By 2066-67 public social care expenditure will have doubled as a percentage of GDP, reaching**
>
> # £40.1bn

In the end, any analysis of future demand for adult social care has to come back to the basic point that people need high-quality care and support, and however we plan for this, meeting these needs is paramount. With the number of people aged 80 and above projected to more than double by 2037, Mike Adamson, at the British Red Cross, urges us to bring different parts of the system together, 'not only for the individual but for our system as a whole'.

2

Determining responsibility and funding

The most fundamental questions about doing care differently are: who does the caring and who pays for it? The two questions are of course linked and they are also the ones we struggle with most.

Should it be the individual's responsibility to plan and pay for their care as they grow older or their family's? Is it instead the role of the state? And what is the role of partners, friends, neighbours and communities?

'The public need more certainty on care and we must tackle catastrophic costs.'

Around the world, different countries and cultures approach the issue differently. (These are of course very broad generalisations but they do help to frame the debate.) Some northern European countries like Sweden, place greater responsibility on the role of the state to provide comprehensive care and support for people as they age.

In countries like the United States, the responsibility is placed firmly on the individual and the market, with only those with the lowest assets receiving any form of state support. In southern Europe, there's greater emphasis on the family, with the state providing a supportive role in countries like Italy. And the family has also traditionally been the source of care in many Asian countries, where the concept of 'filial piety' places responsibility on the eldest son (and very often the daughter-in-law) to care for his ageing parents.

As societies come to terms with increasing longevity, however, some of these approaches are having to change. In China, for example, the exodus from villages to cities by adult children has left many older people without the first-hand support they might have expected. The state has also had to step in – both legislating for families to retain responsibility and to start implementing a more comprehensive care and support system.

Our *Doing Care Differently* contributors addressed many of these themes. Most obviously, Kirsty Woodard points out that, as more people age without their own children, families cannot always be the main source of support. 'More older people than ever before are living longer but are not and will not be in a position to rely on family support.' Others make the point that older people may not want families to provide hands-on care, either because they find it undignified or, as Professor Burstow notes, because they do not want to be a 'burden'. It is also true that hands-on care becomes harder for children who now live further away from their parents and are often working.

Supporting those who care

In addition, we shouldn't lose sight of the reality – made forcibly by Carers UK – that millions of families do want to look after their relatives and put in thousands of hours of time doing so. One key question in *Doing Care Differently*, then, is how we identify and support the millions of family carers already performing that role.

Here, employers surely have a wider role to play. Although many employers do offer carers leave and flexible working, many do not. A strong nudge from the government – or even statutory rights to carer leave, as in Germany – would help the many family carers who are desperately trying to juggle work and caring.

The Conservatives' 2017 General Election manifesto set out a commitment to a new statutory entitlement to carers' leave, but little has been said since about how this will be introduced.

The role of an individual's wider circle of friends and community is another strong theme discussed widely by our contributors. Ewan King, from the Social Care Institute for Excellence (SCIE), talked strongly about no person being an island, while Martin Routledge argued persuasively for a model of community circles to support individuals. In a similar vein, Samantha Clark and Ralph Broad outlined the concept of local area coordination, while Simon Bottery enthused about the potential of 'virtual villages' being developed in the UK as in the United States.

Our contributors often cite international examples as effective in getting people to think about smaller, household-type models of provision. These place 'the emphasis', as Sara McKee described it, on 'people and relationships over care'. She quoted two of the better known examples in social care circles that many in England are keen to emulate: The Green House Project in the United States and De Hogeweyk Dementia Village in the Netherlands.

An important theme of all these contributions, though, was that the role of friends, neighbours and community is not to take over and provide care but rather to support the individual themselves to find the support they need. 'They walk alongside any community members who want to connect or take practical steps to make a change in their lives,' say Clark and Broad.

This is a powerful and intuitively attractive approach, recognising that everyone has strengths and abilities that can be drawn on, that resilience can be built and friends, neighbours and communities can rally round, whether formally or informally. Support for this model should surely be a part of our approach to an ageing society.

> **'We should focus on community models and urgently tackle loneliness.'**

Developing formal support schemes, of course, does not come free. And no one is arguing that essential social care services (including help with washing, dressing, and going to the toilet) can or should be provided by the community or, in all cases, the family. How then do we fund the increasing care and support needs of an ageing population?

Professor Peter Beresford OBE, makes an important point in this debate. He says care and support should not be seen simply as a 'costly, financially burdensome policy'. Rather it should be seen as an investment that allows older people to live the best lives possible without reliance on crisis interventions and family carers.

Who signs the cheque?

But even if we accept this argument, there remains the issue of who pays the cost of this 'investment'. It's an issue that is addressed by many of our contributors, who tease out the choices we have about who 'signs the cheque'.

For example, should it be:

- The state collectively or the individual?

- The generation that needs care now or the generation that is currently working?

- Homeowners?

- Those who use the most care?

The state versus individual split is a classic one which, in the case of social care, is now hopelessly confused. People do not know or understand where responsibility lies. Imelda Redmond, at Healthwatch England, speaks for many when she argues for a system where 'the balance between public and personal provision is clear'.

A simple way of achieving this would be to make the state entirely responsible. Dr Anna Dixon, at the Centre for Ageing Better, cites King's Fund research from 2007 in which most people thought social care should be funded in the same way as the NHS, from general taxation. This is also picked up on by Professor Beresford, who argues that users of social care services also want it put on the same financial footing as the NHS. He cites 2009 research in which service users felt that funding contributed to the 'false divide' between health and social care, with almost all wanting it funded through general taxation and free at the point of delivery.

The main argument against such an approach is, of course, the costs of providing social care in this way as health services. In the past, these have been estimated at just under £30 billion, albeit spread over a 10-year implementation period – to help set up a 'comprehensive' social care system, free-at-the-point-of-use[15].

Even more fundamentally, if this system were to be funded through income tax/national insurance, it would essentially require the young and middle aged to pay the costs of the old. As the large baby boomer generation increasingly ages and needs care, it creates a significant additional responsibility on a proportionately smaller group of younger taxpayers. While that is a situation we have long accepted with health services in particular, older generations (looked at in terms of income growth) have been less affected by austerity than younger households. This will make consensus-building tricky.

Other forms of taxation are of course available. The US state of Hawaii even explored the possibility of funding social care through a sales tax (30% of which in Hawaii is paid by tourists, so you can see the attraction to lawmakers!). While that never made it through the legislature, it demonstrates the willingness – perhaps desperation – to find alternative ways of funding social care other than income-based taxation.

That is one reason why the potential of housing wealth to pay for care is an attractive approach for some of our contributors.

People over 65 hold
43%
of all housing wealth, compared to just
5%
for under 35s[16]

Using housing assets: yes or no?

The over 65s now hold £1.42 trillion, or 43 per cent of all equity held by owner occupiers. These are the benefactors of a housing market that took off in the 1980s.

Around **75%** of older people own their own homes[17]

Danail Vasilev, from Reform, makes the case that 'equity locked in old people's estate… can be used to finance care fairly.' Certainly housing wealth is a tempting target for policymakers as they struggle to find ways to pay the rising costs of social care.

15 Impact Assessment of Care and Support White Paper, Building the National Care Service, (2010), HM Government.

16 Savills plc, http://www.savills.co.uk/_news/article/72418/213407-0/1/2017/uk-homes-worth-a-record-%C2%A36.8-trillion-as-private-housing-wealth-exceeds-%C2%A35-trillion

17 Garrett H, Burris S, (2015) Homes and ageing in England, BRE Bracknell, IHS BRE Press Analysis for all people aged 55yrs and over.

However using housing assets to finance care graphically highlights one of the main problems of the current funding system: the inability for individuals to guard against the catastrophic risk of requiring very long-term residential care. At its crudest, if someone develops dementia, they may well lose their family home paying costs that can run into hundreds of thousands of pounds. Nor is there any way to protect yourself – it is, says Royal London's Steve Webb, 'the last big uninsured risk'.

Dr Eileen Burns, at the British Geriatrics Society, calls for funding to be structured on a basis that 'equitably shares risks and costs', which does not 'unnecessarily penalise older people if they have a long-term condition'.

For Reform that is not achieved by simply requiring people to sell their homes if they need care. Instead they argue for 'risk pooling' measures such as property taxation or government-backed equity release. Similarly, Webb makes the case for 'some form of social or private insurance' to allow pooling of that risk. Stephen Lowe, at Just Group, has a further take on this approach: a 'home equity pledge' that would allow individuals to commit a proportion of their housing equity to meet any future care costs. And of course there is already one proposal on the table to do this; Andrew Dilnot's plan for a 'cap' on the costs of care is still, in theory, due to be implemented in 2020. However, Independent Age's report *Will the Cap Fit?* recommends a higher cap, which covers all costs incurred, including the often overlooked 'hotel costs' of care.

Insuring against risk

There is another problem with using housing to fund care, as Reform pointed out: whether it will be effective in 30 years, given falling levels of home ownership. So funding solutions will need to be future-proof. At the very least, the government needs to be agile enough to adapt when – as seems inevitable in England – future cohorts reach old age with lower levels of housing wealth to draw on to meet care costs.

Reform's proposal is to spend time implementing a more sustainable approach that in the longer-term requires young people to save into a fund to cover care costs. Such a scheme is already the basis of social care funding in countries including Germany and Japan, with the latter weighting the costs towards older generations by requiring contributions only from the age of 40.

However, as these schemes have matured and so too have the people making contributions, the pressures have intensified on people having to pay higher premiums.

Where such approaches work, they are legal requirements rather than voluntary schemes. The costs of social care are risks that we seem very reluctant to even consider when we are younger let alone pay premiums out of our hard-earned income to cover some future, little-imagined liability. Even in the United States, in a heavily market-oriented health and care system, and with a cultural emphasis on individual responsibility, the private social care insurance market is a small one.
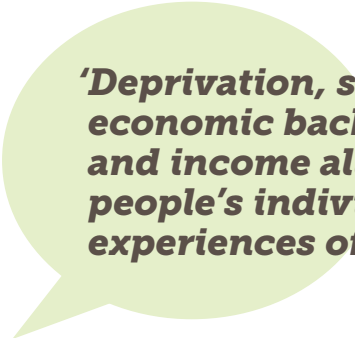
Lowe, at Just Group, is right to call for a campaign of greater awareness of our care cost responsibilities. However, there is no reason to believe that this will fundamentally change our desire to focus on our immediate plans rather than consider our future liabilities.

The danger of focusing too heavily on individual responsibility and individual wealth to pay for care costs is that many people do not have sufficient funds when they reach retirement. Although 75% of older people may own their own homes, that leaves a quarter who do not. And the average private pension pot is around £30,000 which – even when supplemented by the state pension – gives an income that is barely sufficient to pay the bills, let alone pay for costs of long-term care. So one of the questions we need to ask of 'risk pooling' proposals is whether the funds generated are intended to also contribute to the care of those who do not have assets.

But an even more fundamental question is raised in a comment by Webb. In almost any conceivable system, he says that the state is likely to be 'a provider of last resort', providing a safety net for those who do not have assets or outlive the ones they do have. This begs a question: how could we ensure that this 'last resort' social care is good enough to ensure a decent old age for people who need it – while also, presumably, not making it so good that there is no incentive for individuals to save for their own care?

It is an uncomfortable question that takes us back to where we started – talking responsibility – and demonstrates how hard it may be for us to design a funding system that genuinely meets all of our demands for affordability, quality and fairness.

'Deprivation, socio-economic background, and income all impact people's individual experiences of care.'

The power of quality care

What do we mean when we talk about quality social care? We may know quality when we see it and when we experience it – but quality is highly subjective and describing or defining it, especially for anything other than an individual case, is hard to do.

Views on quality differ widely from one person to another depending on their needs, sources of support, levels of resilience, as well as individual preferences and expectations. As Dr Margaret Blake, at Ipsos MORI reminds us, 'The same adaptation or source of support which may give independence for one person, may be insufficient for another… A third person may feel the same support would take away their independence.'

Perspectives on quality also differ within the system – a fact acknowledged by Quality Matters, the new CQC-led commitment, which recently set about establishing a shared, sector-wide understanding of high-quality care.

For most, quality social care is recognised as being more than simply meeting basic care needs such as washing, dressing and eating. It is about 'making lives meaningful' says Professor Paul Burstow and this requires more than 'merely making lives safe'.

Yet, if we accept that quality is highly individual, supporting a person with their basic care needs – in a sensitive and caring way – may well be high-quality care. And ensuring basic needs are met is a good starting point, especially given the reality that over a million older people in the UK don't receive all the support they need on a daily basis.

'There is inconsistency in social care policy and practice across local government. We are not always getting the basics right.'

Good quality care can transform lives

The importance of high-quality care is universally recognised. Dr Anna Dixon, from the Centre for Ageing Better, speaks for many when she states that 'Being able to access high-quality care and support when you need it in later life is essential if we are to enjoy a decent quality of life… and to die with dignity'. The significance of good care to quality of life and dignity is compounded by a prevailing fear of needing care. This may be a fundamental fear of helplessness, but it also taps into our perception of care being generally poor quality.

Claudia Wood talks about the findings of a Demos poll in which 'three quarters of the public said they wouldn't consider moving into a care home in old age. 54% of these said this was because they feared the risk of neglect or being abused.'

But quality care can and does transform lives. With the right support, people who receive and give care can regain independence, participate in activities they enjoy, improve their quality of life and extend their lives.

We know from Healthwatch England, that the majority of people who receive domiciliary care have positive things to say about it, in particular that it enables them to remain in their own home and maintain as much independence as possible.

For our contributors to *Doing Care Differently*, quality is strongly associated with person-centred care, protecting dignity and enabling agency. ILC-UK's George Holley-Moore observed, first-hand, the positive impact of giving people living with dementia opportunities to undertake meaningful tasks. Participating in shopping and cooking and even doing paid tasks within the community, Holley-Moore noticed that people's mood changed when they were involved in a task. He said they became 'more talkative and relaxed', showing evident 'pride in being valued by society' and 'doing a good job'.

The critical role played by those delivering care is a strong theme among our contributors. Claudia Wood, focusing primarily on residential care, talks about the importance of 'meaningful relationships' with staff and includes 'having personalised and relationship-centred support' as one of her five features of good quality care.

If social care is personal care then quality depends on the person delivering the care, their capabilities (attained through training, experience and supervision) and their caring approach (sympathy, patience and compassion).

Of course, caring and capable staff alone does not equal quality care; staff must have the time and resources to carry out the work required, and they need to work in a system in which problems can be escalated and responded to.

'We need to better incentivise the good or penalise poor performance in health and social care.'

Needs not deficits

How do we ensure that social care is high quality? A good place to start is by examining our understanding of 'needs'. Several of our contributors describe the way in which a wellbeing or asset-based approach considers the individual as a person rather than a set of needs or 'deficits'.

'What does your good life look like?' is the starting point for Local Area Coordination Networks as described by Samantha Clark and Ralph Broad. This question, they tell us, changes the conversation, moving the focus from people waiting for ever-decreasing services to 'a discussion of what helps people to stay strong, in control, and valued within their local communities'. 'Get a life not a service' is the Derby Network team's slogan.

Similarly, Mike Adamson reflects on how Red Cross volunteers and staff initiate a new relationship with a service user: 'We ask them what they want us to help them achieve. Most want help managing day-to-day activities or improving social networks and friendships.' Adamson encourages thinking beyond 'clinical interventions' in social care and argues that non-clinical, voluntary roles could be undertaken in hospitals including taking people home who need a little bit of support but do not need to be in hospital. These roles could help prevent older people staying in hospital for longer than they need to, which we know can have a detrimental impact on their mental and physical health.

This wellbeing approach is a marked change from current practices. It also requires some shift in perspective on the part of older people too. Professor Burstow describes how overcoming the 'self-stigma' of thinking of our later life as a time of decline and decreasing participation in life is an important hurdle to tackle in improving quality of life. The power of a positive attitude should never be underestimated. Professor Burstow cites the Irish Longitudinal Study's finding that frail elderly people with positive attitudes towards ageing had the same level of cognitive ability as their non-frail contemporaries.

A new lease of life

Peter Durrant wrote to Independent Age with his own perspective. He explains that 'us oldies' (as he puts it) may live alone but having had to cope with the problems of loneliness and isolation, have space left over 'to make a valued contribution to the common good' through their life experiences and skills.

The Eden Alternative, a care home concept originating in the United States, has a philosophy based on a sort of deficit-model but with a refreshing twist. They believe that boredom, loneliness and helplessness are the three 'plagues' responsible for the bulk of suffering among older people. Eden Alternative care homes are run on the basis of alleviating these three conditions. They prioritise close relationships with staff members, providing genuine choice and control and offering a wide range of opportunities for meaningful activity. These include maintaining their home through gardening and decorating, as well as social activities. Similar models of care are becoming more common, including outside the United States.

UK-based movements such as My Home Life and the Evermore project were referred to by a number of our contributors. As Wood points out, they 'prove there are ways to ensure care can offer a new lease of life and sense of identity and autonomy in sociable surroundings'. Sara McKee from Evermore – putting this philosophy in her own words – states, 'People don't want to buy care or be cared for as that implies they are giving in… By starting a conversation about later life by mentioning care or care needs, we instantly define a person by what they can't do.' Her proposed antidote? To think about older people as individuals who need connections in their life. Only that approach, concludes McKee, will lead to 'true innovation'.

Studies show that embedding approaches similar to that of the Eden Alternative is a powerful way to improve quality of life and quality of care for those living in long-term care. Older people report having more control over their daily lives and less need for taking medication.

What does dignity mean to you?

These approaches recognise the importance of valuing and protecting a person's dignity, and chime with the Dignity in Care campaign which is working to change the culture of care services with their 10 'Dignity Dos'. As well as enabling people to remain independent through choice, control, confidence and self-esteem, the campaign also stresses the vital role of privacy.

> **How many of us would feel dignified when people we barely know (and given turnover of staff may never have met before) must help us wash, dress and go to the toilet? Can a care home really feel like your home if you do not have a private space in which to meet with your visitors and relatives? How do we give a person privacy while also ensuring their safety? How do we feel about cameras in care homes? Even if they help to identify poor care, is the lack of privacy worth it?**

Ian Green, from Terrence Higgins Trust, cites a case with a shocking disregard for privacy, while talking about some of the challenges facing the first generation of people with HIV as they age. He has dealt with cases where 'care providers reveal their resident's HIV status to family or friends without any consent from the resident themselves'. Importantly, this reveals a complete lack of understanding of a person's right to privacy.

To protect dignity and create a culture in care provision where dignity is prioritised, Dignity in Care emphasises communication: listening to people express their needs and wants and engaging with family members and carers as care partners. They cite best practice examples where dignity and 'what dignity means to each person' is discussed among staff, residents and families.

Small but meaningful changes are made – napkins used at mealtimes instead of bibs intended for children or support to use the bathroom rather than being expected to use a commode in a bedroom.

Mervyn Eastman, of Change AGEnts, asserts that 19th century attitudes to care still prevail: 'Deserving and undeserving need, benevolence, othering, paternalistic and patronising predispositions abound'. And this connects with Holley-Moore's thought-provoking reflections on the balance between living a meaningful life and accepting an element of risk. A risk-averse approach to care may deny a person agency and diminish their independence. How should we strike a balance between the two when striving to deliver quality care? Wood's view is that an ambitious 'can do' approach is the one most likely to enable meaningful activity and a sense of purpose – risk management, rather than risk minimisation.

How realistic is quality care as a goal? It is certainly going to be difficult to provide quality for all on current levels of public funding, as highlighted in the previous chapter on responsibility. It depends, of course, on how we define quality. Dr Eileen Burns from the British Geriatric Society makes a strong point that 'this isn't some sort of utopian vision – it is about meeting basic needs and it is within the gift of society.'

But what about a vision of quality that goes beyond basic care needs and builds a person's resilience and connectedness? 'It is not too idealistic' argues Adamson, from the British Red Cross, whose vision of quality care is one that is person-centred, preventative and integrated.

'The Red Cross has been providing health and social care services since before the NHS was established and has witnessed much bigger transformations.'

It is also relevant to consider that quality doesn't have to be more expensive. 'Prices [of care homes] don't necessarily bear any relation to quality' points out Dr Dixon. This is something that Independent Age's own analysis has shown; some of the most expensive care homes have been rated as 'Requires Improvement' and 'Inadequate'.

We know that the role played by care staff in delivering quality care is critical. John Bryant, of Torbay Council, urges greater efforts on retention of staff, highlighting that nearly 1,000 people leave the social care sector every day and that retention 'costs less, with better results' than recruitment. A perpetual crisis in social care means that the focus naturally settles on recruitment to fill the gaps and maintain service, but sustainability will only come with better retention – having engaged people to provide care, we cannot afford to lose them.

So what's on the wish list? A living wage, 'licenses to practice, recognised and transferable accreditation to allow great staff to move around the system… carers need to be trained and get paid fairly, like any other profession' argues Wood. The matter of valuing caring staff goes beyond higher wages. Consider the role of a social care worker compared to an NHS-employed healthcare assistant (HCA).

The two roles are broadly similar, but the HCA receives better pay, pension and benefits than the care worker as well as something less tangible but equally crucial to retention: a feeling of being valued by society.

Models of care have an important influence on staff morale. Studies on the Eden Alternative show improved levels of staff satisfaction and retention. And asset-based approaches such as Local Area Coordination, which focus on meaningful and long-lasting relationships between service-users and staff members, have markedly better turnover rates than the social care average.

How will we know that we have the care system older people deserve? Anecdotes of poor care have become so routine that policymakers and service providers almost seem to take for granted these tales of failure, suggests Andrew Harrop of the Fabian Society. We will know quality care is in place 'only when cases like this are the rarest of exceptions'[18]. In a similar vein, Wood stresses that to 'fundamentally challenge public perceptions of what care homes are… [we need to be] celebrating good practice with the same dedication as we weed out instances of neglect and abuse'.

18   Andrew Harrop, 'Helping people before they reach crisis point, The Fabian Society',
      http://www.fabians.org.uk/helping-people-before-they-reach-crisis-point/

Achieving integration in care

When we talk about integrated care, most of us will think 'health and social care' and it might start and end there.

Some may consider the roles that housing, community and voluntary services or the police play. Others might identify transport (both public transport and adapted private transport) as a crucial component. A well-informed minority might also suggest social security is a vital part of an integrated system, as Andrew Harrop from the Fabian Society does.

If integrated care is person-centred care, then should an integrated approach be one that includes some or all of the above aspects as well as the individual's personal situation and goals? Dr Margaret Blake from Ipsos MORI thinks so and recommends that 'education courses, sports and social clubs and gyms' should also be considered and that to provide a properly integrated response to the needs of older people, none of these elements should be left out of the equation.

Healthcare — Voluntary services — Police — Social security — Housing — Transport — Social care — Sports & social clubs — Education courses

> *'We need the NHS and social care to be properly integrated at a system level.'*

The key is not just in the components of, but also the degree of integration. The need to achieve an approach that addresses fragmentation of services through better coordination and greater continuity of services is particularly relevant for older people's care. Older people are more likely to have multiple needs and needs that blur the boundaries between health, social care and other services. This is a point Mike Adamson, from the British Red Cross, is keen to stress: 'As we live longer with increasingly complex conditions, it's becoming more difficult to distinguish between "clinical" and "social" needs.'

These blurred boundaries, along with the fragmentation of service provision, are part of the reason that navigating each system can be incredibly complex, confusing and time-consuming. Imelda Redmond from Healthwatch England, Dr Eileen Burns from the British Geriatric Society and Independent Age's Janet Morrison are in agreement that a properly integrated response is needed to remove the need for older people and their families to try and navigate the 'hugely complex web' of health and social care services. And Gwynne Hemmings, one of our contributors speaking from personal experience, gives a moving account of the time and effort involved in arranging her mother's care.

Integrated care was a subject touched on by well over half of all our blog contributors. So what can we learn from them about doing integrated care differently?

The third pillar of integrated care

It was refreshing to see housing mentioned as an essential part of integrated care by four of our contributors. Also pleasing is that three of these authors were not from the housing sector. Of course, Jeremy Porteus, from Housing LIN, advises readers that housing 'is the third pillar' of integrated care and outlines the crucial role that well-designed specialist accommodation can play in improving the lives of older people. It is encouraging that others echoed this view – namely Professor Burstow, Dr Blake and Alyson Scurfield from the Telecare Services Agency (TSA). So what can the housing sector contribute to an integrated care approach?

Increasingly, we are hearing about innovative housing models, led primarily by housing associations, that promote the specific needs of older people. Housing is designed to support people with increasing mobility needs or cognitive impairment, from preventing falls through to removing hazards.

Other options include step-down services for people leaving hospital who cannot immediately return home, 'housing with care' or 'extra care' housing (any form of housing where care services are provided or facilitated) through to new approaches such as Evermore in the UK. This is where older people live in small households with a mix of private and shared facilities, with universal workers on site and the ability to buy in additional care packages, meaning older people do not need to move into a care home as their needs increase. Housing options such as these can help overcome social inclusion for residents and some models include specific in-reach approaches to further tackle loneliness and social isolation.

The body of evidence on the benefits of extra care housing is growing, in particular the benefits of reducing the need for use of health and social care services. Porteus cites the example of the ExtraCare Charitable Trust's model of integrated housing, health and social care. He notes that social care costs per resident were £1,222 (or 17.8%) lower than those for older people with similar needs across the community. This figure rose to 26% lower costs for people receiving higher levels of social care. In his blog, Porteus also describes how similar housing models can delay admission to (more costly) residential care homes. Professor Burstow goes so far as to state that housing organisations are becoming 'integral to emerging accountable care systems where the goal is to get up stream and manage population health'.

Porteus tells us that promoting independence by 'supporting older people to live independently for as long as possible' as well as tackling loneliness and social isolation, are unique strengths of the housing sector and are significant factors in reducing use of social care services. This is echoed by Professor Burstow's belief that evidence of housing's contribution is now sufficiently acknowledged by health and social care leaders who recognise the right model can 'promote autonomy and wellbeing' among the older population.

Scurfield also reminds us of the value that housing can provide the 'design, development and integration' of technology-enabled care services, creating housing purpose-designed for older people. For instance, they might have in-built telecare solutions or safety and security features, helping people to stay safe and well in their own homes for longer.

And Dr Blake mentions housing as one of the many less-traditional sources of care and support for older people.

But our contributors are clear that while the evidence is solid, the current contribution is small-scale and localised. There is much to do differently before housing is part of a mainstream integrated care approach. Only 0.6% of over 65s live in housing with care and, as we saw in Chapter 1, Porteus informs us that 'just 1% of new housing built in the UK each year is specialist accommodation for older people – yet 27% of our population is aged over 65'.

More mature retirement housing markets exist in the USA and Australia where over 5% of over 65s live in housing with care. As he concludes his blog, Porteus states that, 'There is no doubt that housing can be part of a comprehensive new approach to an integrated health and care economy, but first we need to make older people a comprehensive and trusted housing offer.' This, combined with a mandated seat for housing at the Sustainability and Transformation Programme (STP) table, would make a real difference at a local level.

27% of the UK population is aged over 65, yet just

1% of new housing built each year is specialist accommodation for older people

The only bit of the system that works?

If housing is the third pillar of integrated care, what is the fourth? Harrop believes a strong but overlooked contender is our social security system, while recognising that 'social care experts often don't think of it as part of the system'. From personal experience of caring for an older relative, he found that 'the only bit of the system which did work was social security'. In Harrop's experience, Housing Benefit and Attendance Allowance 'played a vital role in enabling our relative to stay independent, by paying for sheltered housing and a fantastic home help'.

So how can social security be designed differently to maximise its contribution to an improved more integrated approach for older people?

As well as expressing concerns over recent proposals to these benefits, Harrop also considers if a further step is required and whether 'social security in the future [should] play an even larger part in supporting disabled older people'. He points out the inconsistency whereby Attendance Allowance and housing benefit can be used by residents to help pay for extra care housing, but cannot help fund a care home place. And he proposes relieving pressure on cash-strapped councils by 'allowing care home residents to claim the two benefits'. Independent Age has long argued that there are a number of quite simple steps that could be taken. At the very least, for example, information on Attendance Allowance claimants could be shared more effectively with social services departments so they can target universal information, advice and other forms of preventative support at those already recognised as having additional support needs.

Does integrated health and social care have to mean a single system?

Earlier we noted the 'hugely complex web' of health and social care services and the difficulty experienced by older people and their families in navigating this web. Care cannot be person-centred until some of the barriers to achieving quality care are removed. Redmond calls for better information and signposting of services and how to access them 'whatever the shape of future services'. She also suggests a cultural shift away from 'a world where eligibility criteria are tightened in ways people aren't aware of until they need a service', towards clarity of responsibility between personal and state.

Unsurprisingly, a number of our contributors commented on the current policy context for health and social care integration, given that sustainability and transformation plans (STPs), new care models and vanguards loom large right now. Adamson believes that while STPs aim to escalate integration, 'more needs to be done to define and reap the benefits of integration'. He poses the question everyone has considered at some point: 'Do we need to bring our separate systems together as one?'

And Dr Burns, while accepting that STPs 'have shortcomings', supports the vision behind them and urges greater investment from central government to ensure the process can be truly transformative. But to achieve real transformation, she rightly calls for a reality check on 'the time and cost involved in overcoming cultural, as well as financial barriers, in the journey towards integration' – not an easy path, even with STPs and the Better Care Fund now in place.

Adamson's question of whether a single health and social care system is the solution (as called for by the Barker Commission in 2014) was addressed by the Labour Party's 2017 manifesto commitment to a National Care Service. However, Labour isn't proposing that social care mirrors the NHS entirely – there is no commitment to it being funded fully and from general taxation or free at the point of access. But then that isn't a prerequisite for a single system. A single health and social care system would require some alignment of funding, organisation and entitlement but could still incorporate payment or co-payment for some (both health and/or social care) services.

Adamson refers to the legislative framework in Scotland combining health and social care systems into one, and considers whether England could benefit from similar legislation 'not least to prevent health further overshadowing [social] care'. With a blog emphasising the importance of prevention in health and social care, Adamson advocates full integration of health and social care budgets to 'incentivise both local authorities and the NHS to properly invest in prevention'.

While successive governments have been clear about the need for integration of health and social care for some time now, the exact vision has never been made clear. The lack of a clear articulation of what integration should look like, beyond *feeling like* a single service, makes it hard to judge when integration, even incremental integration, has been achieved.

Care home residents in particular can benefit from more integrated care

Care home residents have complex needs. Two thirds are immobile or need assistance. Four out of five have dementia or other cognitive impairments. Two thirds live with incontinence. Each resident has an average of eight prescribed medications and most suffer recurrent falls[19]. This is a group of people who are most in need of integrated, joined-up care not fragmented, episodic care.

Given that the blurred boundaries between health and social care are often most keenly felt in this population group, the vanguard for Enhancing Health in Care Homes (EHCH) is to be welcomed. The six sites for EHCH show that while previously, services for older people, especially those in care homes, were in the shadows, now there is a concerted policy focus on this issue. The 'out of sight, out of mind' culture that Redmond describes as responsible for social care's low profile – as well as disconnecting residents of care homes from their communities may be on the way out.

This is all the more encouraging given that the vanguard programme now sets out a vision for joined-up primary, community, secondary and social care to residents via in-reach services. The challenge with the vanguards will be how to help the 'rest' learn from the 'best' when the drive and additional resource provided through the NHS Five Year Forward View comes, perhaps to a – shuddering – halt in the next couple of years.

19   Enhancing health care in care homes: integration in practice, The King's Fund, 2015.

Professor Michael Escudier, of the Royal College of Surgeons, uses oral health as an example of how health and social care can work together to better serve older people. Discussing what works well, Professor Escudier cites programmes where dental trainees provide oral health training to care home staff and calls for similar training for all health and social care staff who have regular contact with older people. While this may be a niche example, the philosophy can be extended to many other health and care needs where specialist awareness or training can have an impact – dementia, mental health or arthritis, for instance.

What would make your life better?

Ewan King from the Social Care Institute for Excellence, Mervyn Eastman from Change AGEnts, Martin Routledge from Community Circles and Samantha Clark and Ralph Broad from Local Area Coordination describe the benefits of asset-based approaches in their blogs. If integrated care equals person-centred care, then an asset model is a good place to start. When the opening question is, 'What would make your life better?', as described by Clark and Broad, it does not presuppose a set of needs that neatly align to health care or social care or housing. For instance, 'I'd like to get out of the house more often' could mean: being mentally or physically well enough to leave the house; having someone to accompany you; aids or adaptations that make getting out and about easier; suitable transportation or where you live (what is available nearby or how safe you feel outside your own home).

Not one of our contributors questioned the value of integration or suggested we forget about the integration agenda. Our blog authors reflected the dominant view within the care system that (further) integration of care is essential to providing person-centred care for the needs of today's population. Yet, it wouldn't be wholly surprising to hear the other side of the argument – that joined up or integrated care shouldn't be a priority when evidence is not yet conclusive on clinical outcomes or value for money, with some studies suggesting it is, at best, cost-neutral[20].

We await more detailed findings from the EHCH and other vanguards piloting multi-disciplinary and integrated approaches to care and health provision. Yet there is strong reporting of improvements in patient and service-user experience[21]. Is this enough? Should integrated care be the goal simply because it is the right thing to do? As Redmond says, 'The prize of a care system that is part of and supports people's lives, rather than a separate service outside the life of a community, is worth striving for.'

20 EY and Rand, Evaluation of Integrated Care Pilots, 2012.

21 Ham C and de Silva D (2009), Integrating Care and Transforming Community Services: What works? Where next? (Policy paper). Health Service Management Centre, University of Birmingham.

Technology: Enabling or replacing quality caring?

It is hard to turn on a TV (or, these days, open an app on a tablet) without being bombarded with news and opinions about new technology, its benefits and sometimes drawbacks. But perhaps technology has not caught our imagination in social care in the way it has in healthcare and certainly in our everyday lives.

With a few exceptions, technology did not feature strongly in many of the blogs we received about how to do care differently. Although there were strong contributions from the Telecare Services Association (TSA), PA Consulting and references in other contributions, on the whole it was the dog that did not bark.

The positives, first, though. Alyson Scurfield, at the TSA, makes a pitch that technology has 'the potential to maintain our health and wellbeing, as well as keep in contact with people that can add value to our lives'. She says that technology is available now that allows 'a rapid response to a home emergency, with the ability to order care on demand via an app or video link with a doctor'. And she points out that as UK telephone systems become fully digital in the next few years, health housing and care commissioners will have to move quickly to keep up to date with its potential.

Imelda Redmond also enthuses about technology having the potential to help us crack some of the 'wickedest issues' in social care, if we use it 'intelligently, strategically and in support of the needs articulated by service users'.

Similarly, Professor Paul Burstow paints a picture of a future in which 'everyday household appliances, mobile technology, cloud computing, machine learning and 3-D printing' will be harnessed to 'enable and enhance' people's lives.

He foresees the arrival of 'anticipatory and preventive service models driven by artificial intelligence and fuelled by data'.

There are echoes of this in other contributions. Jeremy Porteus, at Housing LIN, argues that in the digital era, the phrase 'aids and adaptations' does not just mean grab rails and hoists. Rather, he sees 'telecare, telehealth and SMART technology' as ways to maintain independent living and potentially cut care costs' and he wants housing associations to be building homes that include the adoption of SMART technology.

And for those wanting practical examples and research evidence, PA Consulting describes the partnership between Hampshire County Council and Argenti Care Technology which has, it says, 'brought real benefits to over 8,500 individuals across the county, achieved measurable efficiencies and saved the councils £4.7m in the first three years of service'.

Hear technology, think robot

Why then is technology not more of a feature in our other blogs? Perhaps part of the explanation is a milder variant of what we might call the 'killer robots' response to technology. This has two elements: firstly the tendency to hear 'technology' but think 'robot' – to reduce technology to one high profile but utterly unrepresentative element of technology. Secondly, there is the fear that it will rise up and destroy us.

This is a rich vein in science fiction that surely taps into a basic fear of technological change. And while we may not fear being destroyed literally by technology in social care, it does raise genuine concerns that our contributors – even the ones who write in support – address or at least hint at.

One concern is that technology will not in fact enhance but rather replace high-quality personal, human care. That the cost savings that Porteus refers to will not – as he and all of us would want – be ploughed back into services to improve care but rather will be banked, either by private sector providers or state-sector accountants. We may not be as convinced as we would like to be by Scurfield's belief that, 'people who will provide empathy and undertake complex tasks to support our physical and mental wellbeing will be even more in demand than they are now'. Instead, in an alternative more fearful scenario, care does not improve because of technology but, in fact, gets worse as automation and artifice replace human care and compassion.

A second concern is perhaps that technology is absolutely the right solution to many problems in social care for older people, just not yet. Certainly it is true that while older people are among the fastest-growing users of new technology, they remain the age group least likely to be active participants in this brave new world. Only around 41% of adults aged 75 years and over have used the internet in the past three months compared to 99% of adults aged 16 to 34[22].

---

22 Internet users in the UK: 2017, Office for National Statistics, https://www.ons.gov.uk/businessindustryandtrade/itandinternetindustry/bulletins/internetusers/2017

41% of people over 75 have used the internet in the past three months, compared to

99% of 16 to 34 year olds

There is also a concern about the design of new technology and, particularly, its appropriateness for older people. The feeling that products are designed by 25 years olds for other 25 year olds is pervasive and not without foundation, as anyone with arthritis in the fingers who has tried to operate a mobile phone will testify (though there are hopeful signs that this is changing).

Finally, there is a concern about the type of data that is collected as part of technological delivery of care and what will happen to it. Some fear technology being used to save money and create data to be exploited rather than enhance care and assume many older service users will struggle the most to access and engage with it.

The antithesis of person-centred care or the solution to connectedness?

If we combine all of these concerns, we get services that are the complete antithesis of the person-centred care model put forward by the great majority of our contributors. So perhaps it is not so surprising that there is only limited enthusiasm in many areas.

Yet the issues that technology might help us address are clear in many of the contributions we received. Two of the biggest problems – the 'wicked issues' of Redmond's phrase – are connectedness and prevention.

Community Circles talks about the need to combat loneliness and build community connections, while Professor Burstow cites research showing that isolation is the biggest unmet need for many older people. Ewan King talks about the need to connect people to each other and to the wider community. It would, of course, be a mistake to assume that giving people the technology that allows them to communicate with other people is the solution to loneliness. Nonetheless it is not hard to see that it might be part of that solution at least in those scenarios where, as Dr Margaret Blake observes, difficulties in getting out and about are linked to loneliness and isolation.

Even greater opportunity lies in prevention. One of the technologies on display at the recent International Association of Geriatrics and Gerontology conference was an algorithm which is able to analyse gait and, it is claimed, predict risk of falling. Home alert systems already exist that will provide an alert if the routine of an elderly person is changed unexpectedly – for example, they do not put lights on in the evening.

An example of this type of preventive technology is provided by Robert Turnbull and Steve Taylor from PA Consulting in the case of Mr H, who has dementia and is at risk of becoming lost when he leaves home. This made Mrs H, his carer, really anxious. She consequently began to go with him whenever he left the home, reducing Mr H's independence and putting intolerable strain on Mrs H.

A small device including GPS tracking however now means that Mr H can be located if becomes lost or has a fall. Door monitors also create alerts if he leaves the home unexpectedly.

However the PA Consulting contribution makes it clear that simply applying technology is not enough. It says that focusing on outcomes – what people want from it – is vital. It needs to be used to support professional judgement – not to replace it – and it must be tailored to an individual's specific needs. It is perhaps a failure to apply these lessons – or a fear that they will not be applied – that drives much of the concern about technology and care. And, of course, Scurfield is surely right to say that technology must fulfil the basic requirements of being reliable, safe and secure.

If technology is genuinely to make a more universal change to the way we do social care, what will those new products, services and functionalities be? Wider use of very common technology like GPS and sensors, as in the PA Consulting example, seems a likely starting point but what then? The current generation of contenders vary widely, from robots such as 'Mario', the companion robot for people with dementia (or another variant of it – Toyota has invested £14 million in buying the prototype of ElliQ, an 'active ageing companion').

But they also include technology that operates unseen in the background to make services more efficient or create new connections between services and users.

An example is the machine allowing Leeds Clinical Commissioning Group to integrate patients' health and social care records, or the platform that allows providers, such as Care.Com, to put people who need homecare in touch with care workers that can provide it. (This, after all, is the technology that has allowed services such as Uber and AirBnB to change the way we find taxis and holiday homes.)

But, of course, it may be that the breakthrough technology will not be in these areas. The nature of new technology is that it surprises us by finding solutions we had not thought of, often to problems we had not realised we had. Before the invention of the iPad, few people were musing on the desirability of a tablet shaped mini-computer that could be operated using your fingers. Yet tablets are usable by many older people who did not want or feel confident enough to master the PC.

There may be even newer developments in voice-activated technology that do away with even the requirement of touch-to-use technology. Or driverless cars could make a whole generation of older people mobile once again. Or there could be a hundred and one things that we have not yet imagined. The bigger question, in fact, may be whether the care sector will be ready to embrace and adopt these new solutions when they do in fact emerge.

6

A value for money solution

Perhaps one of the most important questions in any publicly-funded system of health or care provision, is how services achieve value for money. Some consider the question of efficiency to be too narrowly concerned with economics and not enough with care itself.

There is possibly a broader question still; that is how can care and support be designed in a way that is genuinely effective?

How often in England do we assess whether the care that we pay for is actually achieving what we hoped it would? How – if at all – are we measuring the 'successes' of care and support, and do we even need to?

Professor Julienne Meyer, from My Home Life programme based at City University London, wonders whether on occasion we perhaps go too far, focusing on measurement at the expense of common sense when indeed we don't need research to prove that a great deal of care is simply a 'good thing'.

The government's 2017 Queen's Speech focused on the need for a more sustainable system of care – one where variation in quality is tackled as a key priority. But how can we learn about what the most effective care looks like, and how can the 'rest' learn from the best?

The Secretary of State for Health has tasked the Care Quality Commission with looking at pathways of care and the support individuals receive across these pathways in up to 20 areas across England. One important issue the government wants to address are the significant gaps between those local authorities delivering optimal levels of social care, and the 24 responsible, as the Prime Minister sees it, for 50% of all delayed hospital discharges.

There is certainly a lot of pressure on local authorities to 'do care differently'. The money promised to them through the Better Care Fund appears to be committed many times over and new conditions have started to get attached that appear ever more dependent on them taking their share of responsibility for reducing hospital discharges. But whatever the rights and wrongs of the current efficiency drive, are there approaches to organising and delivering care and support that are generally accepted to be the most efficient, which involve the minimum amount of bureaucracy and waste?

'We should use the Green Paper as an opportunity to understand what a fully funded Care Act might look like and how local authorities might be able to fulfil their role shaping their local care markets.'

There is literature on these questions, from the likes of John Bolton at the Institute for Public Care (IPC), a former director of community services at Coventry City Council. But these are questions the contributors to our *Doing Care Differently* series perhaps grappled with least. They are serious issues nevertheless and ones we need to come back to if, as Danail Vasilev at Reform attests, we are looking at spending £40 billion upwards in publicly-funded social care by the 2060s.

Doubling the amount we spend on social care as a country will not, of course, come without added scrutiny as to what we are spending that money on. Questions will be asked about why and whether it is genuinely increasing independence and wellbeing. And yet the debate about what additional funding of social care is actually for doesn't always take off perhaps quite as much as it should, at least not in terms that seek to quantify the precise personal benefits that might then result from more money being spent.

Variation and best practice

John Bolton at the IPC has looked at different ways councils can manage demand and the regional and local patterns that help shape people's prospects of receiving one or other type of care. He notes how commissioning varies from council to council, with about half of councils in England experiencing a growth in spend in 2014/15 on (costlier) residential care, and the other half showing a reduction in their local spend.

His 2016 discussion paper for Oxford Brookes University on predicting and managing demand in social care highlights where local authorities are managing demand in a very positive way, and where indeed councils are reducing cost and improving outcomes for residents[23]. He identifies common ingredients of commissioning that reduces demand for care, which among other things include the performance of intermediate care and the availability of nurses and therapists in the community, plus the use of performance frameworks to help judge outcomes from the care system.

23   Professor John Bolton, Predicting and managing demand in social care, https://ipc.brookes.ac.uk/docs/John_Bolton_Predicting_and_managing_demand_in_social_care-IPC_discussion_paper_April_2016.pdf, April 2016.

His basic argument is that not enough local authorities use these performance measures and more could be done by some local authorities to self-evaluate their work in predicting and managing demand.

Some of our contributors were less concerned with the prosaic questions of social care finance but wanted instead to examine how we achieve 'the common good', with stronger, thriving communities. Peter Durrant highlights that we need to take a more radical approach, moving on from 'the confusion' created by 'layers upon layers of social policy and administration' and instead promote Community Development Thinking and Practice (CDTP), popular he argues in Scotland and the States.

Instead of forever obsessing about the structures of social care delivery, which he claims have simply resulted in confusion for the general public, Durrant argues that Community Development approaches apply a simple, effective principle of bringing people to work together and find common solutions to common problems. In practice, he envisages approaches not unlike those observed in New Zealand, where co-operative working sees relatives, friends and neighbours helped to 'largely resolve their own problems'. The obvious challenge in terms of whether such approaches can ever hope to address the serious needs of the frailest, or most isolated individuals, never gets fully answered, but Durrant continues to make his case that Community Development can be 'scaled up to organisational level to address major issues such as that of social care'.

Person-centred approaches: the best use of resources?

When resources remain scarce, there are those who worry that simply championing asset-based or place-based approaches frees the state of its responsibility to provide and meet older people's costs for care.

But Dr Margaret Blake argues that the most person-centred approaches to delivering care can indeed prove the best use of resources. She recognises that while 'financial constraints may lead to standardised offers' of care, in the end, more tailored approaches can prove more economic in the long-run as they are the ones that best support older people's desire to maintain independence. This is a really important point, but not one it always feels is embedded in local government approaches to commissioning publicly-funded care.

Personal budgets provide some personal control over what care or support adults assessed as having 'eligible needs' can purchase, but the quantum is always set by local authorities, which are under a duty to balance their budgets and secure value for every pound they spend. The tension, then, between tailoring a personal budget to fit around an individual's own expectations of what they want to spend their budget on, and what a local authority can deliver in terms of public resource, remains.

Professor Peter Beresford OBE, is another contributor who argues for a whole new paradigm, with social care 'at the heart of a new sustainable economy, a model for future employment, based on "looking after each other" rather than based on economistic growth'.

He wants to see far greater involvement of service users and user-led organisations (ULOs), but he worries that social care has been conceived as a costly, financially burdensome policy, 'taking money which even a supposedly rich Western society like the UK cannot afford'. He calls for policymakers to engage in a very different 'kind of number crunching'. He asks us to reimagine social care as an 'economic contributor' that harnesses the skills, contributions and wellbeing of disabled people, young and old. Conceived differently, we can support people to live the very best lives possible, but from an economic point of view, Professor Beresford argues that we can also look to do this without resorting to costly and wasteful crisis interventions, with the family breakdown that then results.

While the language of efficiency wasn't commonly used, a number of contributors to *Doing Care Differently* were nevertheless clear where the evidence points: to services and support rooted in what users themselves want and within networked communities. Samantha Clark and Ralph Broad, from the Local Area Coordination Network, were just two contributors who could point to evaluations and studies of place-based approaches. They highlight the positive impacts on both the individuals involved, and also commissioners, as local area teams expand and relieve wider system pressures in areas as diverse as Leicestershire and Thurrock.

Their approach isn't one of procurement, but instead these local coordination areas connect people with someone easy to access in their community who can assist with building a plan for their future and maintaining personal networks and friendship.

There will always be a healthy debate about what is most important to prioritise in any system of publicly-funded care. Delivering value for money and efficient care is certainly contested with far from unanimous views about what efficient care even looks like and whether indeed we should view care through this particular lens.

But as the UK population continues to age, questions will inevitably be asked about how far we can reasonably stretch not just public resources, but all the resources available within families and communities. To do care differently, we will need ever smarter ways of learning what works well so that everyone who has a future need for care or support can get their wishes and needs fulfilled.

Jo Cleary, Chair,
Independent Age

Care needs to be done differently — now

At Independent Age, it is our mission to make the UK the best country in which to grow old. This starts with each of us individually challenging our preconceptions of older age and if we are not old yet, we need to think ahead (and plan ahead) to our own old age.

Changing our misconceptions of older age is certainly one side of the coin. The other is changing the system to make it work, but not just for today's older people, for all of us. We all have a vested interest in designing our own futures.

Not all older people need care services and not all people who need care services are older, but there are nearly half a million care home residents in the UK while 1.2 million older people currently have an unmet care need. So when we consider how to make older age a more fulfilling experience, social care is a good place to start.

Throughout the blogs, I have seen a recurring theme where a multi-agency approach is proposed to deliver better care. When has it ever not been such? Yet it's still the single thing that doesn't happen from the perspective of people who are trying to navigate the complexities of our outdated care system.

It's not about family and friends providing all the support, nor is it about the local authority or the NHS or the government doing it all. There is not one solution that will save the social care system in one go (as much as we might wish there was).

We began our *Doing Care Differently* series in the absence of government action on the promised social care Green Paper. We wanted to keep the debate, that had finally begun to get the attention it deserved, alive and make sure the topic was fully explored. In the course of over 30 blogs on the topic, what has become apparent is that care is already being done differently. Small scale and pioneering approaches to care are out there already; they're just far too few and far between and in no way meet the level of demand.

However big or small, we all have a role to play. Those within the system need to look to the examples of best practice and ask themselves – is there any reason we can't do this in our local area? Those already doing best practice need to shout even louder.

We don't have time to wait for politicians to carve out time away from the dominant Brexit agenda to focus on sorting out the social care system. We need to get on with it now.

Acknowledgements

You can read our blog series in full at
www.independentage.org/policy-and-research/doing-care-differently

advice and support for older age

Independent Age

Whatever happens as we get older, we all want to remain independent and live life on our own terms. That's why, as well as offering regular friendly contact and a strong campaigning voice, Independent Age can provide you and your family with clear, free and impartial advice on the issues that matter: care and support, money and benefits, health and mobility. A charity founded over 150 years ago, we're independent so you can be.

For more information, visit our website at **www.independentage.org**