ADULT SOCIAL CARE: Hope I die before I get old?

Introduction and Background

The NHS and Community Care Act 1990 was based on the Griffiths Report, compiled by Sir Roy Griffiths, whose business background included Sainsbury supermarkets: currently finding itself in financial difficulties: as does the NHS and social care system. One result of this government's successful drive to cut hospital beds means the health and welfare of older people is now more at risk than in 2007, from increased waiting times for NHS treatment and cuts in care at home and the failing private care market, including nearly 30% residential and nursing home care providers now having closing down or handed back contracts.

The government inexcusably blames older people for a 'bedblocking' crisis for which it is responsible.

The 1990 Act required Local Authorities to seek tenders from providers for a specified percentage of domiciliary or home care services, previously their responsibility. As Bob Hudson has written, a percentage now approaching 100%.

My view of the dangers facing social care comes from 40 years' social work practice mostly with adults, in hospital- and community-based teams, in Local Authorities (LAs) and the voluntary sector, liaising with residential, nursing home, day and home care services. I trained social workers in various locations around England and visited families in England, Wales and Scotland. In 1994 I wrote a dissertation on the implementation of the NHS and Community Care Act in Cambridgeshire.

When the 1990 Act took effect, social workers had to attend training in a 'new' approach to assessments - implying we lacked knowledge about the process. Under the Act: "any adult aged 18 or over who is eligible for and requires services from the Local Authority has the right to a full assessment of their needs and the services provided should be individually tailored to meet those assessed needs."

This procedure involved an increased amount of somewhat repetitive report writing (later, hours at computers). Administrative support was reduced: so we had to type up these long reports, reducing time available to visit and make assessments.

Also required was reviewing 'wider' aspects of the lives of those we assessed, including, I particularly remember, their sexual needs.

After explaining this as sensitively as I could to the partner of a patient lying in a ventillator, a machine totally enclosing patients apart from their heads, assisting their breathing (in a specialist thoracic unit), I was asked sarcastically if that meant I would arrange for the services of a prostitute. That experience made me decide to spend a year studying what lay behind the Act.

My studies included Conservative, neo-liberal politics - and marketing, areas new to me. Researching in the council library, I was shocked to read Tory plans to reduce public services, leaving state funding for social care only available at a 'safety net' level, for those proven unable to support themselves otherwise: a situation we are near to now. The plan would attack, then cut all areas of

public service; the NHS left to last, due to its status as a ‘sacred cow’. This utilised Friedrich Hayek's ideology: taxation is immoral, taking money from the wealthy that is rightfully theirs.

I believe those who have reduced social care funding so viciously hope the much larger debate about the NHS’s future means few will notice the death throes of most of state-funded social care.

‘Integrated Care’

My objection to so-called Integrated Care: most likely a deliberate disguise behind which Accountable Care Organisations are introduced, is that while NHS services are free, social care assessments include the individual’s financial situation. If income is above a certain level, those assessed have to contribute toward the cost of care provided.

I therefore foresee this goverment’s adherence to the US health service model, ‘nudging’ us into marrying the NHS and social care systems, resulting in healthcare needs being included in assessments and, eventually, subject to charges.

The 11.6.2018 Health and Social Care Committee report on Intergrating Care recommends caution and careful evaluation of the integration process, criticising the lack of involvement of local service users and staff and the use of “acronym spaghetti”: a clear sign of management techniques totally inappropriate to public services, and incapable of convincing the general public to ‘buy’ what is being ‘sold’ to us.

Liverpool KONP is currently demanding of its Health and Wellbeng Board Committee: “Before planning to reorganise health and social care [into an IC system], the...Board disclose...hard evidence...this would improve services, allowing the public, healthworkers and their unions to evaluate and debate the plans.”

Katie, quoted in Leonard Cheshire Organisation’s current social care campaign states: “The people making these decisions about care, and the cost of care, have no idea about how disability and mental illness affects a person's day to day life”.

‘Integration’ involves deliberate de-professionalisation of roles, blurring competencies, risking serious problems. An example: a recent safeguarding case arose in England when nurses were expected to undertake discharge planning and arrangements - normally done by social workers. This led to a frail older person being discharged home from hospital without sufficient home care hours, or the adaptations and equipment needed to live at home safely.

What is ‘social care’?

I’m sure if asked, many people would not know. In 2003 the (late) National Institute for Social Work definition was: “Social Care concerns itself with helping people live their lives comfortably …who require a certain degree of extra practical and physical help. Social care workers endeavour to provide…practical support...helping individuals maintain their independence...increase their quality of life and...lead fuller more enjoyable lives [and].. help..with...tasks that seem small..., but can make a massive difference to someone else's life as well as being a rewarding experience for the carer involved. Those involved in social care choose their job because they help… people live their lives to the highest possible quality. Whether... requiring a lot of intense help or.. a small amount of

practical help. Social care careers are often available as...part-time and full-time vacancies with a variety of...working hours...outside the typical 9-5 drudgery."

Note important changes

It is vitally important to recognise that NISW's definition is out-of-date, in many very important respects. Firstly the 'social care' above occurred in people's homes. It describes workers, the majority of whom still are women, with those from BME backgrounds, also refugee backgrounds often well represented.

They then worked with people with medical needs and/or disabilities, many of whose medical personal care needs, eg catheter care, giving or supervising medication was undertaken by District Nurses and/or Health Visitors. Community Psychiatric Nurses would visit people at home to assess and provide support too: people with professional training, well supervised, receiving ongoing training, working to professional ethical codes.

These days, people with depression and anxiety are not automatically seen by a CPN, eg in 2014, I knew an 88 year old being very inappropriately in my view, recommended to follow a CBT course at home, online.

Social care workers' tasks have progressively altered, and now include catheter care. There are fewer medically trained staff now available for several reasons, sadly including disillusionment and burnout from overwork: the theory clearly is to save money having work done by non-professional staff who are paid less.

The name change or 'rebranding' of social care, from home to domiciliary then social care is a classic marketing ploy, to convince recipients the 'product' has been altered/improved. However, care is not a product: it involves a relationship and interaction between two (or more) people, one more vulnerable than the other(s). The 'new managerialism' rhetoric depersonalised the interaction: promise of greater satisfaction and fulfilment for both recipient and giver of care was marketing 'spin'.

The original Home Helps' visits lasted an hour as minimum, included dusting, cleaning, shopping and helping people to dress. If time allowed, sitting with and chatting over a cuppa, provided company and social stimulation many older isolated people lack, causing much of the depression they suffer.

Most who needed what is now called 'personal' social care either lived in nursing homes or in hospitals, on long-stay wards.

Have care needs increased?

I am actually not sure that adults' care needs have intensified or become more complex. In the 1980's I worked with 'Young Disabled Unit' residents. One was paralysed from the neck down after a road accident; two others had advanced MS. The staff were NHS nurses, overseen by a Consultant in Rheumatology and Rehabilitation. Some residents requested me, as it happened, to obtain advice from a specialist organisation for people with severe disabilities wishing to pursue active sex lives.

The point is that today, domiciliary care staff are not only expected to undertake work formerly done by NHS professionally trained staff, but the setting was usually in a hospital unit.

A Social Services manager and I exchanged looks of incredulity at an NHSE-organised meeting (in Tameside, Greater Manchester in 2014) when PwC and Kaiser Permanente employees running it told NHS and other local services representatives present that the aim to cut 30% of hospital beds by caring for people at home, would produce the savings the goverment expected the NHS to make.

Why? Because we knew quality community care does not come cheap. LA social workers did the assessments and planned 'packages of care': the supermarket-style name given to the weekly programme of social care visits. After the 1990 Act, LA's found themselves paying for multiple hours of care: far more than when Young Disabled Units, for example, existed to provide extensive care.

As budgets became stretched, LAs had to find ways to live within them. This has been addressed, by tightening 'eligibility criteria' for funded care: leaving many now self-funding - or going without, who formerly would have qualified for state funding.

Today the BBC and Guardian reported on the ADASS (Association of Directors of Social Services) recent survey of all 152 councils in England: 75% will cut the care they provide, and nearly 50% will increase charges: so more people will be pushed into the private market.

The 1990 Act rhetoric about 'needs-led assessment' had sounded so exciting: if you were unable to walk your dog, the carer would do it. If you preferred to go to bed at 11pm, the carer would visit then - services would be 'flexible'. Remember, "services" here means staff, who are people.

The 'packages of care', that social workers, renamed 'Care Managers' would design to suit individuals' preferences, sounded like a shopping list for Sainsbury's, one tin of this on Mondays and two packets of that on Wednesdays.

However, carers aren't inanimate objects. They have their own lives, get sick, need holidays - may prefer not to work at 11pm. Also working regular hours and proper, not zero hours contracts, getting paid for their travel, and not being expected to provide a 'satisfactory' level of care during 15 minute visits, partly taken up by phoning the HQ to 'clock in' and 'out'. And vulnerable people can change. The carer allocated 15 minutes to arrive, serve a microwaved meal and leave, may find the person distressed, and/or having soiled themselves, thus requiring far more than 15 minutes care.

How independent does it feel when living alone: your carer gets sick, doesn't arrive, their office can't find a replacement carer able to arrive at 11pm, leaving you unable to reach the toilet or go to bed - or take your medication? Or, your usual carer is unwell, a newcomer arrives, an hour late - or early as s/he is covering other people's sick leave too. The lack of continuity of care is now a major problem.

These are the dangers of living alone: being overlooked - unless you have a live-in carer. Good reliable services cost money.

Many care workers are inappropriately paid for the level of care they provide, and certainly lack the status or recognition that nurses do - or did, until overwork due to falling staff levels has left many demoralised and burnt out. Richard Vize wrote in the Guardian on 2 June 2018: 'the NHS is now

locked in a cycle of overworked staff making avoidable mistakes, in turn creating more demand." We need to look at the examples of privatisation going wrong.

Could Social Care be 'renationalised'?

Certain rail services have been. Now - linked inextricably to social care, assessment procedures allocating Personal Independence Payments and Employment Support Allowances may be too.

On 5 June 2018 the DWP announced the extending of ATOS's and Capita's contracts for PIP and ESA functional assessments for two years: allowing for "a stable transition to any new provision", over which period it would develop in-house IT capacity.

The Work and Pensions Committee has reported that 4,000 disabled people sent them evidence of inadequate performance by ATOS and Capita, an "unprecedented public response to a departmental committee". They reported "a pervasive culture of mistrust" around assessment processes."

Those claimants are likely to be receiving care, whose funded care hours may well have been reduced due to LA cuts as described above.

The Committee concluded: "The decision to contract out assessments...was driven by a perceived need to introduce efficient, consistent and objective tests for benefit eligibility ... None of the providers has ever hit the quality performance targets...many claimants experience … great ... anxiety over assessments.

The Department … need to consider whether the market is capable of delivering assessments at the required level and...rebuilding claimant trust. If it cannot—as already floundering market interest may suggest [also in the case of some social and residential/nursing care services] —the Department may well conclude assessments are better delivered in-house." "Successive evidence-based reviews … identified a ... fear of...face-to-face assessments ... [with] implications far beyond the minority of claimants ... directly experienc[ing] poor decision making … [adding] to claimant anxiety even ...[if]... the process works fairly. While that culture prevails, assessors risk being viewed as ... lacking in competence and ... actively deceitful. Addressing this is ... vital ... in restoring confidence in PIP and ESA."

We cannot expect social care workers - or benefit assessors - particularly, those not professionally trained and supervised, working above their pay grade, to provide consistently efficient and reliable services: we do them a great injustice if so - and those receiving their service.

Conclusion

New managerialism and the market have proved incapable of either saving money plus the ability to provide trustworthy, safe social care to adults - or indeed children, - with, of course, some exceptions. Neither is state-provided social care - or the NHS - immune from failings. However, the drive for profits involved in privatised services cannot in my view 'integrate' with a care system that truly cares for both its recipients and its workers. Private companies also leech money from CCGs and LAs when contracts end early, due to poor performance, or corporate collapse.

Public service requires - and rewards - the worker's motivation: with all involved knowing the activity is not concerned with financial profit.

Since most voters so clearly wish to preserve the NHS, governments must do so, ensuring that inappropriate transfer of medical and nursing work to social care staff (or machines) is halted and/or reversed.

Social care workers' status needs review, with their contribution to society's health and wellbeing recognised. Appropriate funding of both social care and the NHS will benefit ill, disabled and frail citizens, their families and other unpaid carers. It can only improve general prosperity, by bringing down avoidable stress and stress-related conditions amongst a significant proportion of our society.

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12.6.18