The King's Fund

Ideas that change health and care

Stories from social care leadership

Progress amid pestilence and penury

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Foreword

Supporting leaders in the NHS has been a longstanding priority for The King's Fund. Yet as the importance of greater integration between health and social care has grown it has become just as important to understand, and support, leadership practice beyond the NHS. This is why we are publishing this report now and will later in the year also report on work with Directors of Public Health.

We believe that the evidence is clear that compassionate and inclusive leadership provides benefits to staff working in health and care and the people that use their services. This report highlights some of the strengths of social care leaders with their more inclusive approaches to sharing power and decision-making with the people that use their services, as well as the communities they come from. It underlines the power of local leadership when given the freedom to act and there is much here that the wider system can learn from.

There are, of course, also real challenges for leadership in the sector. This includes the relative lack of data and research and the absence of a national vision and strategy for the sector as a whole that builds on and supports these strengths while tackling the obstacles.

If we are to integrate health and care to improve population health and wellbeing, we need to build on, and support, the leadership strengths of each part of the system, whether NHS, social care, local government or the voluntary sector. This will include tackling longstanding issues that have got in the way of more compassionate and inclusive leadership wherever they may have come from. This leadership journey is one that The King's Fund is committed to supporting.

Richard Murray
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Key messages

Adult social care is the too often forgotten, too often invisible, arm of the British welfare state. It has, for a decade now, been under acute financial pressure. As part of The King's Fund's work on leadership in health and social care, Richard Humphries and Nicholas Timmins interviewed some 40 people about the nature of leadership in the sector. Where does it lie? How effective it is? What might be done to improve it?

From those interviews, we have drawn some conclusions, and raised some issues for discussion.

- Local authority support for user groups, and for local care home associations and their equivalents for domiciliary care, appears to pay dividends. The best local authorities appear to value that feedback, the worst hide from it.
- Leadership matters at every level in social care, and there is a powerful case for investing more in training and development – at every level.
- Longstanding promises to improve the quality of data need to be honoured.
- There is a case for finding a mechanism to take the heat out of the annual battle between commissioners and providers over fees.
- The sector might well benefit from a more unified voice than that provided by the current myriad of representative bodies, and the work of the Association of Directors of Adult Social Services in particular could be strengthened.
- There is also a case for an annual assessment, probably by the Care Quality Commission, of the quality of both local authority and NHS commissioning in this sector – assessments that should strengthen the hand of those seeking to improve services locally.
- Leadership from the top is judged to have been missing for some time, and while the Department is taking steps to address that, those steps need to be pursued with vigour.

The most depressing quote we heard in the course of this work was not from one of our interviewees but from Lord Bethell, the social care minister in the House of Lords. He told peers that 'There simply is not the management or political capacity to take on a major generational reform of the entire industry in the midst of this massive epidemic.' That may well be true in the short term. But a minimum requirement is that the Department is put into a position where it has the management and policy-making capacity to undertake that once the pandemic is contained.

1 Introduction

> *The ordinary man in Great Britain has been spending his life for the last couple of generations in this will-o'-the wisp pursuit of power, trying to get his hands on the levers of big policy and trying to find out where it is, and how it was that his life was shaped for him by somebody else.*
> (Aneurin Bevan 1943)

Social care is the often forgotten, too often invisible, arm of the British welfare state. It lacks the landmark buildings that keep schools, hospitals and universities in the public eye. It doesn't even have the shop fronts of the jobcentres. Much of it happens, very quietly, very invisibly, in people's own homes.

Yet today, publicly funded adult social care in England supports almost a million people at any one time, and its mixed economy sees hundreds of thousands more pay for elements of social care themselves. Social care employs more people than the National Health Service (NHS). It is estimated to contribute more than £40 billion to the economy and, at its best, enables people with a wide range of needs to lead independent lives. It provides essential care and support to others, and it protects people from harm. At its worst, however, it can cause anguish and even lead to abuse.

In the words of the Association of Directors of Adult Social Services (ADASS):

> *Social care at its best enables and transforms lives. It enables millions of us to live the lives we want to lead, where we want to live them. Whether we need support with our mental health, because of physical disabilities, learning disabilities, or because we are older and need additional support. It supports us to work; to socialise; to care and support family members; and to play an active role in our communities.*
> (**ADASS 2020**, p 4)

The coronavirus pandemic has for once, though in unwelcome ways, thrown social care into the spotlight. To paraphrase the recent words of one social care leader, 'the penny has dropped' that social care matters, even if there is still no full public

grasp that its reach goes way beyond the issue of discharges from hospital and that it needs to be seen as a sector in its own right. Adult social care is not a junior partner of, or handmaid to, the National Health Service.

Social care is, nonetheless, inevitably conjoined to the NHS, and there is a widely recognised need to better integrate the two services. But unlike the NHS, which is still recognisable as one system, adult social care is anything but. As already mentioned, it embraces not just the care of older people – the bit that gets media attention on the relatively rare occasions that social care does in fact get media attention – but services for those of working age, on which around half the publicly funded budget goes, though one would not know it from most of the public analysis.

Adult social care is mind-blowingly complex (*see* box). It is almost as hard to explain as the structure of health care in the United States. It has a hugely tangled mix of public and private funding, of fees and of top-up charges, and of what is known as 'self-funding' in the jargon – that is, money spent privately by individuals and families for care in their own homes or in care homes. That funding can involve tensions between the NHS and local authorities over who pays for what, with much heartache and trauma for the recipients and relatives involved in those decisions. It is an equally tangled mix of mainly private but also some public provision. And social care works across many other boundaries, both public and private. It has a workforce larger than that of the NHS, though again most people would not know that. Its labyrinthine nature makes it extremely challenging for those charged with leading it.

The labyrinthine world of social care: simple it is not

Expenditure
Public spending in England on adult social care is around £22 billion, funded through a mix of central government grant and council tax. There is no reliable estimate of private expenditure but it is thought to be around £11 billion. And an army of unpaid friends and family carers contribute an estimated £100 billion to £132 billion worth of care. Just over half of the public spending goes on adults of working age, as opposed to older people. The data on social care is so thin that many of the numbers are estimates.

Who commissions it?
One hundred and fifty-two local authorities in England commission the bulk of publicly funded care. The NHS funds around 10 per cent of nursing home beds through NHS continuing healthcare. It also pays for the nursing for a relatively small number of people through NHS-funded nursing care.

Who is it provided by?
Some 18,000 organisations, who have around 34,000 establishments. There are a small number of local authority and NHS-owned beds. Around 95 per cent of residential and nursing beds are in the independent sector. The four or five biggest corporates own between them around 12 per cent of that market. The 30 largest providers have only 30 per cent of the beds. Owners of just one home supply around 29 per cent, and owners of fewer than five have 45 per cent of the market. Agencies and the voluntary sector provide care-at-home services, alongside NHS community provision that includes district nurses and occupational therapists.

There are also various forms of sheltered housing and extra care housing in both the public and private sectors, sometimes supported by increasingly sophisticated technology.

Who pays?
Forty per cent of those in care homes pay their own fees. Local authorities pay for the bulk of the remainder. But in a quarter of cases, individuals and families have to top up the fees. Adults of working age can receive both free care and charges. Some people also pay for entirely private care.

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The labyrinthine world of social care: simple it is not *continued*

Who works in social care, and where?
Around 1.5 million people work in social care, slightly more than the NHS employs. Just over a third work in domiciliary care – providing care in people's own homes. Add in those who pay privately for care in their own homes and the figure is thought to be over 40 per cent.

Roughly 280,000 of the workforce are not British citizens, coming from the European Union (EU) or the rest of the world. The impact of Brexit on that workforce is still unknown.

Some 145,000 carers are employed directly as personal assistants, either through direct payments and personal budgets supplied by local authorities, or employed privately by those who do not qualify for public funding.

What is central government's role?
Two government departments are involved. One is the Department of Health and Social Care, which has been responsible for policy and legislation since 1974. For the most part, it negotiates the central government grant with the Treasury. But those monies flow through the second department – the Ministry of Housing, Communities and Local Government – although the money is not ring-fenced, and there are debates between both departments and the Treasury as to how much should fall on council tax.

Sources: Bottery and Babalola 2020; Skills for Care 2020; Laing 2019; Competition & Markets Authority 2017.

This picture of an essential public service in a mixed economy that is highly diverse, fragmented and fractured led The King's Fund (which has done much work on leadership in the NHS and some on leadership in social care) to ask Richard Humphries and Nicholas Timmins, two of its Senior Fellows, to take a further look at social care leadership. Where does it lie? How effective is it? What might be done to improve it?

This research was only possible because almost 40 people in more than 30 interviews (a few of them were collective) somehow found the time, generously, in the midst of the Covid-19 pandemic, to talk to us about these issues. To encourage people to be honest, all the interviews were non-attributable.

We chose seven reasonably diverse parts of the country: three counties with a wide geographical spread, one London borough, two cities, and one town that is a unitary authority and thus responsible for social care. We sought in each to speak to the Director of Adult Social Services along with at least one provider and/or user group in each area, plus local authority Cabinet members for social care. We also spoke to a limited number of more national figures. This cannot claim to be a fully representative sample; given the time available and the prevailing circumstances, we did not succeed in talking to all the players we sought. Nonetheless, a clear picture emerged. Not everyone held the same views, but there was a strong consensus on many of the issues.

What follows is what we found. In a nutshell: huge variation, some real highlights, but a set of leaders at various levels struggling to get things to work well in a system that is so fragmented that it is scarcely worthy of the name.

A little background, and a little history

Social care is, of course, a product of its history. Its modern origins lie in the National Assistance Act of 1948 – passed in the same year as the National Health Service was launched. The Act boldly claimed to 'abolish the poor law', although it didn't, quite. Social care remains first needs-tested – individuals need a certain level of care to qualify for taxpayer assistance – and then means-tested. Those with assets of more than £23,500 (a figure that has not been uprated since 2010) do not qualify. Those that do, need to run their savings down to £14,250 before receiving entirely free care. As a result, individuals and families who need long-term care can, at the furthest extremes, find £250,000 and more of their savings consumed. And indeed, for those who go into a residential or nursing home, the value of their house can also be eaten up. As Sir Andrew Dilnot pointed out in his 2011 report (**Commission on Funding of Care and Support 2011**), social care is the one big risk in life that is, in practice, uninsurable. Aside from the other difficulties with the way social care operates, this causes huge resentment when – often only at the point at which it is needed – individuals and families discover that that is how the system works. A far cry from the NHS, which aims to cover almost all kinds of needs, large and small, and is mostly free at the point of use.

In addition, it pretty much goes without saying – but needs to be said – that social care in England has been under immense pressure for at least a decade. In the wake

of the 2008 global financial crisis, many local authorities did their best to protect the social care budget (though with mixed results) in the face of cuts to local government spending, which, at their peak, reduced their expenditure by 40 per cent. Even now, spending on social care in real terms is not back to where it was ahead of the financial crisis, and demand has been rising as the population ages (Bottery and Babalola 2020).

Finally, by way of background, governments of different political persuasions have made promises to reform adult social care for at least 25 years. Those include the repeated but so far unfulfilled promise by the current Prime Minister, Boris Johnson – to 'fix' social care. We return to this issue below.

2 What we found

There is another, more famous, Aneurin Bevan quote, describing how, when he was a miner, he got himself elected to the town council, because that is where he was told the power lay. When he got there, it appeared to have slipped up to the county council. So he got onto the county council, only to discover that power seemed to have disappeared upwards to parliament. So he became a Member of Parliament (MP), only to discover that the power had been there, but that all he saw of it was its coat tails – 'slipping away around the corner' (Bevan 1943). Bevan, of course, became a cabinet minister and proved, in the words of the historian Kenneth Morgan, to be 'an artist in the uses of power' (Morgan 1992, p 205).

Bevan's quote resonated hugely as we sought to find out where the true leadership in social care lies. Its coat tails too often seemed to be disappearing around the corner, and certainly we did not always find it where one might have thought that it would necessarily lie. Where we did find it – by and large – was almost the opposite of Bevan's quote. He was chasing power up to the centre. We found, by contrast, that much of the most inspiring leadership we heard about was local. Indeed, at times, the more local, the more powerful.

The more local, the more powerful

Thus we spoke to a group of adults of working age in one county where the self-support systems they had built were inspirational. Individuals – thanks in part to personal budgets – were taking control of their own situation, supporting not just themselves but each other, although operating in an environment where the local politicians and social services director had deliberately shared power with them. Not every suggestion they made for ways to improve services had been adopted – and they recognised budget and other limitations – but they were clear that their voice was heard and made a difference.

Equally, we heard examples where care workers had changed services for the better. For example, during the first wave of Covid-19, when confused older people found the sudden arrival in their home of carers hidden behind a mask daunting, even frightening, one came up with the idea (adopted by others) of printing their

picture to pin to their uniform – at least making it clear who they were, and that there was a friendly, recognisable face behind the mask. We heard about a former postman with dementia who used to disappear from his home and go wandering. The carer worked out that all he was doing was following his old round. So she came up with the idea of a simple GPS tracker so that when he did disappear, his wife could check that was all that he was doing… and be able to find him if he deviated from the route. The carer also put a mirror on the exit door, to encourage him to ask himself why he was going out. These are small but potentially crucial changes that demonstrate leadership at, so to speak, the coal face.

In another example, the director of one home care agency persuaded the local council to fund a rapid response team, linked to NHS 111. If someone calls and it is judged that an ambulance may not be necessary, the response team of carers goes in, equipped with blood pressure monitors and other equipment. They can lift people off the floor, undertake an assessment, call the ambulance if necessary, and provide relief, assurance and comfort. The project has saved resources – ambulance time, accident and emergency (A&E) attendances and precautionary hospital admissions – and has equally saved the recipients from the stress of all of that, not least when it is clear that no older person wants to go to hospital unless that is strictly necessary. (Unfortunately, as we explain below, this project has not had an entirely happy ending.)

Equally the owner of one domiciliary care service who started out running one, then sold to a larger corporate, has since become an owner again. Her motivation for returning to running her own business in a relatively, but not entirely, rural area was:

> *…that they had about 120 businesses dotted around the country, and their big mistake in my eyes was that they tried to standardise everything. So everywhere ran as it would in Birmingham or Manchester or London. They just did not understand that the communities in more rural towns and villages need different things to those people who are living in a city. You have to understand your community.*

And indeed, on the theme of how powerful local leadership can be, more than one of the directors of adult social care that we talked to, when asked the opening, framing question of 'Where do you think leadership in social care lies?', started with the recipients and their experience and worked their way up. One local government cabinet member for social care says: 'I see leadership in the amazing voluntary

sector leaders we have locally, who are saying "Come on you, sort out the quality of care locally". That's where I take my leadership from.'

Another political lead for social care in a county says: 'Co-production is important – creating services together. I think it is about the leaders understanding the community and the people within the community, and about that social purpose. The further away leaders get from understanding the people that live within the community, the weaker the leadership is.'

One national figure says:

> *It comes from the fantastic care home manager, the amazing community support worker, or the great outreach worker and, of course, from the experts by experience. And you can see that in the public sector, the voluntary sector and the private sector. It comes from hugely dedicated personal motivation, which is rarely accompanied by great pay and conditions.*

And when it comes to the question of whether very local leadership – indeed, user leadership – matters, it is worth recalling that the arrival of personal budgets, and with that other parts of the personalisation agenda, happened because a group of disabled people in Hampshire launched the campaign to get them.

Co-production

Co-production is a horrible piece of jargon. But in one hyphenated word it does sum up one of the most positive trends in social care – giving people who use these services a say in how they are designed, commissioned and delivered. A model of leadership that is about doing things 'with' people, rather than 'for' them, or worse 'to' them.

And while providing some minimal office support for associations of local care home providers and care agencies does not fit quite into the same category, we heard about gains from that as well – an ability to do things 'with them' rather than 'to them', not least because it can help get both the conversation and the action beyond the annual battle over fees between local authorities and providers.

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Co-production *continued*

Co-production is there in personal budgets and direct payments to users. Currently around 240,000 people receive a direct payment, with 75,000 of these employing their own staff. This is one component of 'self-directed support' that affords the opportunity of enhancing people's choice and control over their lives. Although it is notable that the take-up of personal budgets and direct payments, which rose sharply after implementation of the Care Act 2014, has stalled at around 4 out of 10 working age adults and 2 out of 10 among older clients.

Examples of co-production cited to us include the partnership board that one council has set up that gives people with learning disabilities a seat at the table, and a website that provides information relating to events, activities and groups being run for people with learning disabilities. One council has a gathering on the lines of a people's parliament, a wider forum that enables people with learning disabilities to engage directly with councillors.

Another puts money into enabling services users and their carers to work with the council in shaping decisions about services. During the pandemic this proved valuable in bringing together council and health staff with people living in care homes, their relatives and care home staff to devise safe ways of retaining social contact with residents.

Elsewhere, relatively small-scale local authority support for a local care home association has both helped it serve its members better and was said by its chair – as a result – to have significantly improved relations with the council, moving both sides on from just an annual battle over fees.

When we heard from people who are engaged in similar initiatives it is clear both that they were highly valued and that those involved felt they had a genuine voice over the way services were provided. It meant they were active participants in shaping the decisions that affected their lives instead of passive recipients of care. It seems clear that the best councils value the feedback that these mechanisms provide and use that feedback either to improve services as far as they can within the financial constraints or enable individuals to do that for themselves – although again within the financial constraints that will always be there but have been particularly acute in recent years.

Where did our interviewees think that leadership more broadly lies?

All over the place, is the answer. From ministers, the Department of Health and Social Care, council leaders and chief executives, to cabinet members for health and social care, directors of adult social services, providers, the regulator, recipients, trade bodies and pressure groups. Along with perceptions of increased influence from NHS England and NHS Improvement, which is far from always seen as constructive. In other words it is hugely fragmented, widely dispersed, too often unco-ordinated – with many having withering criticisms of the leadership from higher up this hierarchy, to which we will come.

One highly experienced owner of care homes says:

> *I struggle to find out who is actually leading us. Because I don't see it as the Secretary of State, I don't see it as the minister, I don't see it as the CQC [Care Quality Commission], I don't see it as ADASS, I don't see it as the local authority cabinet members in that sheet you put to me of outline questions, and I don't see it anywhere. It's all fragmented. I struggle to come up with anybody in charge, to be honest. Ours comes from our care home managers, many of whom have been with us for years. But finding new ones is a challenge.*

A service user puts it this way: 'It is between county council level and national government that it all breaks down massively. I don't feel that I have any sort of influence at that type of level, whereas I feel I have some influence at the county level.'

One or two argue that having highly dispersed leadership is a strength as well as a weakness – 'the vibrancy, the choice and colourfulness'. Directors of adult social services were widely seen as key, but their quality – a judgement made by directors themselves, not just by their critics – was seen as very variable, through a mixture of experience and personalities. This is another issue to which we will return.

The view of many was summed up by one director who says:

> *Any leadership that does exist does so in the vacuum of a nationally defined vision and plan – meaning it's a diffuse mess. Most things are reactive. What we are all trying to do is the best job that we can with the deck of cards that have been dealt, which this year includes pestilence on top of penury.*

There is some leadership in the provider sector. And there has been an increased role for people who use care and support. But I think that austerity has hampered co-production and has hampered the progress that was being made on personalisation.

The head of a national pressure group in this area says: 'The notion of leadership within something that is not a system is quite a hard one to think about.'

The Local Government Association (LGA) was recognised as having a role to play, but some felt it had become less effective in recent years. And there were highly mixed views about the Care Quality Commission (CQC), the independent body that licenses, regulates and inspects health and social care providers.

It should, of course, be said that nobody is going to love their regulator, and there was recognition that in its annual 'state of the nation' report, the CQC tells it like it is. But to many, in the words of two of the care home providers we spoke to, it is, these days, 'just a policeman'– and one that several felt was there to catch people out, rather than acting as a force for improvement. There is, again of course, a tension here in that the CQC is there to assess quality, which includes spotting and rooting out bad practice – even closing homes and services if necessary. It cannot be too friendly, and legally it is not an improvement agency. But within that many felt it could do appreciably more to help, by pointing individual care homes and other services to resources and good practice during the inspection process, rather than just damning the absence of standards. And again, to be fair, in one of the areas we spoke to, both providers and the local director of adult social care said that relations were good and the CQC was a positive force. So again, there appears to be at least some variation within the CQC's approach. Its annual State of Care report was cited as an example of the regulator speaking truth to power and giving a leadership voice to the evidence from its regulatory work.

ADASS also attracted mixed views. Those who were aware of its activities praised its current President, James Bullion. Its annual budget survey is widely regarded as an authoritative and accurate picture of the financial state of the commissioning side of adult social care. But there was, including from directors, a feeling that it is under-powered. One director started to list the organisations ADASS has to liaise with if it is to have influence, and pretty much gave up after the number passed 10 – another indication of the fragmented nature of social care leadership.

'It struggles with capacity,' one director said. Directors pointed out that it has a tiny, albeit industrious, staff. Its president, who is the public face of ADASS, serves just a one-year term before changing, which means the new individual has to build new relationships with the many other individuals and organisations with which ADASS has to interact. 'We got to the point where people weren't coming forward even to be vice president. We were having to rustle people up.'

Another says:

> *It is tricky. A lot of councils, particularly in recent years when money has been so tight, are very iffy about giving up their director for a year for them to do this on top of their day job. I think there is a big question for ADASS. It does have some successes. But to make it more effective we'd need to pay more in and change its nature somewhat.*

So if leadership is fragmented and dispersed and of differing quality, what does this lead to?

Variation, is the one-word answer. That, of course, should not come as a surprise to anyone. It is there in the results of CQC inspections and its annual 'state of the nation' report. But it absolutely is the experience on the ground. One service user who has chaired various support groups that cross local authority boundaries, says the one he lives in 'does a great job. They engage. They listen. We have influence.' But the two neighbouring authorities are, he says, 'dreadful' – a view almost entirely mirrored by a care home provider in the same area. One authority, he says, 'is really good. We know where we stand. Not just the social services director but the chief executive comes to visit us – comes to our homes.'

> *When Covid-19 came, the first thing they did was to ring all the home owners and say 'we are going to have a Zoom meeting with all our team, director of social services, deputy, all the commissioning team, and some social workers'. What a fantastic thing. We knew where we stood, right from the word go. So they are leaders. The neighbouring authority is not too bad. But the third is, in my opinion, the worst in the country. The lack of communication, the lack of empathy with the private sector – and they are the lowest payers. They are just awful.*

Another provider, who deals with both a county and a city, says 'the relationship with the county is much better than it is with the city. The county consults. It listens. It adapts where it can. The city much less so.'

One national figure says:

> *There is a lot of variation. It can depend on the financial situation of the local authority, some have been worse hit than others. But culture, attitudes, the quality of the formal leadership and its ethos all make the difference. Even within an area that has got some really good innovative stuff that is enabling people to live the life they want to lead, as much as they possibly can, with whatever support they need, it is a bit like in a hospital where you can have fantastic wards and services and right next door something dreadful is going on.*

Social care inevitably interacts, for at least some of the time, with the National Health Service. Does it provide support for social care leadership?

There was widespread recognition of the fact that Simon Stevens, the Chief Executive of NHS England, has repeatedly spoken out on the need for a proper funding settlement for social care – as indeed have Chris Hopson, the Chief Executive of NHS Providers, and Niall Dickson, until recently Chief Executive of the NHS Confederation. Such support from the health service was welcome for at least keeping the issue in the public eye. But there were differing perceptions of how far the NHS's drive for integrated care systems (ICSs)[1] is improving matters, when ICSs – the clue is in their name – are meant to include integration with social care. It is a mixture of good and not so good news.

The good news is that the majority of our interviewees – where they had an opinion – said that relations with the NHS have improved, particularly with general practice. But, that word 'variation' creeps in again, with differing opinions on how far this was due to ICSs.

[1] For a description of integrated care systems, *see* NHS England (2020). 'Integrated care'. NHS England website. Available at: **www.england.nhs.uk/integratedcare** (accessed on 3 December 2020).

We heard of fine examples of joint working. One director says:

> *We've got some cracking integrated services here that provide a whole raft of support for people in the community with dementia. We've got a falls prevention service that's targeted and reduced secondary falls hugely, again with multidisciplinary input. We've got 33 multidisciplinary teams linked to GP practices that have got GPs, district nurses, social workers, mental health experts, the voluntary sector all involved to look at connecting people into local communities and a kind of holistic view. So when you've got the right people with the right skill sets and the right mindset, which is 'let's just try and simplify this and focus and wrap around the individual', it works great. It's when the start point [in discussions with the NHS] is, well, let's focus on the logo on the door, that's when it all goes west.*

Indeed, one local government political leader who had been in the role for eight years, says that relations with the NHS were '100 times better' than when she started:

> *We have multidisciplinary teams working across health and social care. It has been a long time coming, and it is relatively recent, but yes. Far better. Though I chair a group of political leads of councils in the region and some of the reports I get are not so favourable.*

In another example, one political lead says: 'We have excellent relations with our clinical commissioning group' and indeed with the hospital and mental health trust, with another describing how not just general practice but the hospital are working with the council to get health facilities into a leisure centre the council is planning. And all of that is clearly built on relationships, shared objectives, system leadership and personalities – another point to which we will return.

As for ICSs themselves, some interviewees say they were moving on from talking to implementation – 'Very much so, yes. We're scoping plans that we intend to put into place for April.' Another figure with a more national view says:

> *Certainly some of the ICS chairs are absolutely seeing the need for local government and NHS locally to work hand in glove and many of them are starting to do that at a system and place level, wherever place is – recognising that places are bigger in some places than others. So you see that. And there are people in NHS England and NHS Improvement who get this, and they can influence the Department. It is*

actually probably more likely that NHS England will be in a cross-government discussion about social care than anyone from local government will be, which is sad but true.

Another director says: 'ICSs are not just talk. There is a lot of talk, but it is also translating into better services.'

Others have a less rosy view, feeling that the NHS – or more particularly the hospital sector, which tends to dominate in these discussions – still does not really 'get' social care, seeing it largely through the lens of seeking to discharge, as swiftly as possible, patients who no longer have a medical need to be in hospital. Some also worry that as ICSs become, not yet legally responsible, but more responsible for performance, the focus will move up the line and away from the very local arrangements, and the very close personal relationships, that make integrated care work in practice.

Against that, some believe that Covid-19 has opened the eyes of some in the NHS to social care's role. 'I think there's some pennies dropping around the system more widely that social care is important,' one council lead says. There appears to be more of an understanding that it is not just care homes but domiciliary services that support people of working age, and support older people, in their own homes, helping keep both groups as healthy and active and engaged as possible – and out of hospital.

Indeed, some of those we talked to said that the Covid emergency had broken down barriers and led to people making instant decisions to work better together. Most of these interviews were conducted after the peak of the first wave and before the second, but already there were worries among some that the older, slower, more formal and bureaucratic ways of working will reassert themselves. One domiciliary care provider says:

Covid-19 brought about an amazing change for a very small period of time, which worked really well. What I saw was that peeling back of the layers around decision-making. People needed to just take action – really, really quickly. Just find a solution to the problem. There was that need for speed, and it worked really, really well.

I find that people are now, within the local authority, drifting back into a situation where they're sort of saying 'oh, we need to review that'. And the review will

need three or four months to work through, and 'we'll need a proper proposal put forward'. It was really refreshing that people were able to break down those barriers, just do what needed to be done. But it's all coming back in now and it's a shame.

Another also took the view that a small silver lining to the pandemic was better understanding and closer working. 'Our relationship with our CCG [clinical commissioning group] partners had evolved massively [ahead of the pandemic],' one director says, but during it 'we saw NHS colleagues piling in behind us rather than seeking to determine or control'.

For all the progress that is being made, and was being made ahead of Covid, barriers remain. A few stories. The first about the home care agency's rapid response team, mentioned earlier.

It started out as a two-year trial, funded by the local authority. All the gains, however, were accruing to the health service in terms of less pressure on the ambulance service, and reduced A&E attendances and short-term admissions. According to the agency owner whose project this was, some six months ago the local authority said that because all the gains were going to the health service, it no longer wanted to fund it. So they passed it over to the local CCG, saying: 'We're not going to fund this any more. But it's a valuable service. Will you fund it?' The NHS took it on for six months while it ran a review. It decided the service was not being used intensively enough. It then came up with some less than helpful proposals – such as the emergency response teams only being paid when they were called out, which, as the owner said, would not be applied to any other health emergency service, and would not be viable. It would be impossible to retain the staff who are 'just two members on duty at any one time – 12-hour day shifts and 12-hour night shifts'. To avoid the service being overwhelmed, limits had, from the start, been placed on who could call on its services. Spreading the net wider – a little wider in terms of geography, somewhat wider in terms of who could ask for its assistance – would, the owner argues, have increased uptake. But the CCG would not agree to that. 'They wanted to keep the pathway small and narrow.' So, at the time of writing, the service is to close. 'Money has won over outcomes,' the agency owner says.[2]

[2] This account has not been checked back with the local authority or the CCG involved. It is the provider's perception.

Then there is the story of an elderly client who received a 30-minute evening visit to help her to bed and provide a hot drink. She was prescribed surgical stockings and creams for her legs, which need cleaning and creaming before retiring. The council refused to pay for a slightly longer visit from the carer to cover that, saying it was a health need. But health declined to pay, saying they did not have a district nurse to do it. The agency said they did not need a district nurse for a simple, if cumbersome, task.

> *We said, as we had said before, we'd do the work. So we went back to social services who said again they would not pay for it, and health again said they would not pay. Which is a shame because, without this, her legs will break down, she'll get ulcers and end up in hospital when the NHS will be paying more.*

The solution? The carer now does the client's late night hot drink as part of teatime, not bedtime, providing the 5 or 10 minutes to do the legs and the stockings. 'But it is not ideal. It is not what the customer wants. It shouldn't happen like that.'

A care home owner we interviewed said they had just been told by the GP who looked after residents in one of their homes that his service was going to cease. The CCG in which the doctor was based had decided on geographical limits, and the home was situated outside of those. The GP said, according to this interviewee:

> *'I know we've looked after you for the last 30 years, but we can't look after you as from 1 October. I'm ever so sorry, but it's not my decision.' Well, it would have been nice to have had a letter from the CCG, a phone call, or somebody from health to say, 'I'm sorry, you're losing your GP and you've got to register all of your residents now with a new GP, 50 of them – and we will help you find one'. Not good practice. That's not leadership. It gives a bad reputation to the health authority in my opinion.*

And then again from another part of the country, a political lead says:

> *I was talking to a GP the other day who has a post-Covid patient with terrible lasting diarrhoea, and needs a shower, ideally a walk-in shower. But the GP can't order a shower and the patient does not have the sort of sharp elbows to be able to sort it for himself. So the GP writes to the council, which replies saying 'you can't*

tell us to put a shower in, only an occupational therapist can tell us to do that'. So I'm trying to sort that out while the person affected is living in really miserable circumstances and probably acquiring more care needs.

Some parts of the country, including the one referred to here, have appointed 'care navigators' to help the less able clients navigate the system. But both of those who told us about that see them almost as an admission of defeat. As one put it: 'We talk about this as an innovation. But I have really mixed feelings about it. It is awful that we've got such a complicated system that individuals need so much advocacy to get the services that they need.' Another said that when the primary care network suggested appointing some:

...my response was that the minute you employ somebody with the words 'care navigator' in it you're basically admitting that your system is too complex for your citizens to sensibly be able to use, and therefore we have failed. And they're going, 'that's a bit harsh'. So we are looking at other ways of getting the mainstream services to work better together.

So how does social care feel about itself?

In three words, far too invisible – at least to the public eye, with degrees of invisibility within that. In most public debate, it is care of older people that gets whatever limited attention is going, and within that, care homes. Adults of working age, whose needs are often very different to those of older people, feel excluded from that conversation, even though, as already noted, around half the public budget is spent on them. And some worry about the transition from being classed as working age. For example, those supported by personal budgets worry if their relative freedoms will be lost as they become defined as needing older people's care. One speaks for many when she says: 'Don't lump us all in together. We all have different needs, whatever our age.'

The same sense of invisibility applies even within care homes. The head of one local care home association comprised mainly of small- and medium-sized providers, says:

I do feel sometimes that we are a lost voice. The bigger corporates have their association and their access to DHSC [the Department of Health and Social

> *Care]. But probably 75 or 80 per cent of the market is made up of smaller providers. We have created the Care Association Alliance for the smaller- and medium-sized homes to create some sort of voice and make a noise about the challenges that we face.*

And despite the United Kingdom Homecare Association (UKHCA) – the representative body for domiciliary services, which some see as having made a good public case around fearsomely time-limited visits, low pay and zero hours contracts – some providers of care in people's own homes feel even more invisible. The proprietor of one such agency says:

> *You have seen it on the media during Covid. 'We must look after the NHS. We must look after care homes, and making them priorities for PPE [personal protective equipment].' And I am screaming at the telly, 'What about domiciliary care?' We need PPE, we need testing, and we are still not [at the time of writing] a priority for that, and our workers are going out there, taking the same risks, picking up people coming home from hospital and equally worried about infecting those we care for.*

Adding to the sense of invisibility is the public's awesome ignorance about social care; about its components – working age social care, older people's care, domiciliary services and the NHS contribution. But also about how it works – the way it is both needs-tested and means-tested.

To be fair to governments of all persuasions over the past 25 years, they have sought to address that. A longer-term reform of social care is still missing. But there have been more than a dozen Green Papers and White Papers since 1996, each of which has sought to explain how things work. Several involved significant consultation exercises. There has been a Royal Commission and the Dilnot Commission, aside from the efforts of assorted think tanks which, in the case of The King's Fund alone, included a review of social care by Derek Wanless (**Wanless 2006**) and the Barker Commission on Health and Social Care in England (**Commission on the Future of Health and Social Care in England 2014**). In the past two years, three cross-party parliamentary committees have achieved political consensus in calling for major reform. Still, as recent work by the Health Foundation and The King's Fund shows, 'The public has little understanding of how social care operates, and even less understanding of how it is funded' (**Bottery *et al* 2018**).

On one level, the public's by and large 'ostrich' view is not so surprising. As one social services director puts it:

> *We are asking government to prioritise something that the vast majority of voters don't understand and/or don't want to think about. And it is not that surprising. Nobody wants to think about diminishing powers as you grow old, and for working age social care you assume it won't happen to you: until it does.*

But these views do raise the question of whether social care's visibility, and with that public understanding, might be helped by a stronger voice?

A stronger voice for social care?

One of the many contrasts between the NHS and social care is that, quite aside from NHS England and NHS Improvement being responsible for the service, the NHS has a strong provider side voice. To be fair, there are two voices – that of NHS Providers, which essentially represents NHS trusts; and the NHS Confederation, which includes not just trusts but also CCGs, the emerging ICSs, and the Independent Healthcare Providers Network, which represents private and independent providers of NHS care. It is also fair to say that both the public and private influence of these two groupings has waxed and waned over the years. But separately, and at times together, they provide a clear voice for NHS organisations.

By contrast, and reflecting the highly fragmented nature of social care, its landscape is littered with representative trade bodies. Aside from the UKHCA (already mentioned), which represents domiciliary care providers, and the National Care Association, which chiefly represents small- and medium-sized home owners but also some domiciliary providers, there is the grandly named – and much better resourced – Care England, although it is chiefly the bailiwick of the bigger corporates. Then there is the National Care Forum, which represents the not-for-profits; the Registered Nursing Home Association, whose membership chiefly includes nursing homes as opposed to care homes; the Association of Mental Health Providers; and the Association of Retirement Community Operators. Another body, the Voluntary Organisations Disability Group, speaks for not-for-profit service providers for people with disabilities. These groups and others are brought together in the Care Provider Alliance, which describes itself as an informal body.

To the outside observer, their collective voice appears to add up to less than the sum of the parts. And tensions can ripple across them. Locally we heard from one care association for small- and medium-sized homes which argued that bringing in domiciliary care members – and, indeed, homes that are provided by the council – had brought much better relationships with the local authority. Its chair says: 'We have to appreciate that it's not "them and us" with home care and care homes. We have to work together to represent care.' One of its ambitions is to bring supported living and day care centres into membership, 'even if it means we sometimes have to switch off our personal interests to get to one voice'. By contrast, a care home association in another part of the country refuses to let local authority-provided homes into membership, arguing that the council favours them over privately provided ones.

There have in the past been attempts at mergers, and some felt that the interests of the different parts of social care can be so diverse that a single voice is impossible. Most of our interviewees, however, believed that having a more unified voice for the provider side would be a strength, providing a clearer narrative for the public and a clearer message to government.

This section discusses, so far, only the provider side. There is, of course, a somewhat bewildering array of other players – including not just care staff but family and friends who care for those in need, and who are, perhaps, the most invisible of all in this somewhat invisible sector. Attempts to bring some of them together include the Care and Support Alliance, whose members include individual providers, Care England, and charities and advocacy groups such as Age UK, the Alzheimer's Society, the British Heart Foundation, Carers UK and Disability Rights UK. Formed to argue the case for funding reform, it remains, in the words of one of its instigators, 'more an opinion place than a leadership place'.

At another level, an informal forum – the 'social care leaders group' – has recently been formed, bringing together the Local Government Association, the CQC, ADASS, Skills for Care, the Social Care Institute for Excellence and others to share information and seek to align messages. More a matter of internal liaison, it has not, at least to date, sought a public profile.

Aside from leaving the public somewhat confused, this must, from ministers' points of view, feel like a cacophony of too often competing interests rather than the more unified, bullet-like message that NHS Providers (for health) or the National Housing Federation and the Chartered Institute of Housing (for housing), or Universities UK (universities) can often deliver to government.

3 What else did we hear?

It is not just local leadership, it is relationships that matter

There can hardly ever have been a piece written about leadership that does not say that relationships matter. But the fact that it has become a cliché does not make it any less true. The relationships between directors and the 'experts by experience' user groups that some local authorities support matter. As do relationships with strong local organisations for care homes and home care agencies that take the conversation beyond the annual battle over fees. As one user said of one director, 'He's a great leader, a good colleague as well, with a clear aim, and he definitely has the human touch and the human element in his leadership style'.

Personalities, style and relationships matter, not just within social care but in its relationship with the NHS. One director says:

> *We've got some very good NHS chief execs. We've reached the point where we can be really honest with each other but very respectful. We get things done. So there is a very happy coalescence of some great individuals. But it can be very different on a different patch. One talks to colleagues, and I know of one area where there are at times real battles with NHS colleagues. Some of it is scary, but it is down to personalities.*

And it almost goes without saying that good relationships take time to build, and churn on either side – in social care and in the NHS – can easily set that back.

Lack of data, lack of infrastructure, lack of research

According to one hugely experienced director of services, 'There is a real shortage of data about what's actually going on in social care. Certainly compared to the NHS but even compared to the police, we just don't really know what's going on.' Indeed, that was briefly illustrated in the early days of the Covid-19 pandemic when, amid critical shortages of PPE, the Department of Health and Social Care appeared not to know how many care homes there were, let alone domiciliary care agencies, or how to get PPE to them.

Local authorities do, of course, know what they spend – with and without user charges – and those figures are available nationally. But quite what the private market is for care homes, home care services, sheltered accommodation and extra care housing is the subject of estimates. The Competition & Markets Authority (CMA), which is not short of number crunchers, had to estimate the size of the care home market in 2017 (CMA 2017), and in 2020 the Office for Statistics Regulation (OSR) reported that:

> *…this important sector of public policy is very poorly served by data… a scarcity of funding has led to under investment in data and analysis, making it harder for individuals and organisations to make informed decisions. This needs to be addressed… Improved data matters in solving problems, supporting efficiency and maximising outcomes. It is also important to inform decisions made by individuals about the care they receive or provide for themselves and their families.*
> (OSR 2020)

Local authorities have a legal 'market shaping' duty that includes forecasting demand for social care. But in this highly mixed economy – some care homes take a large proportion of local authority-funded residents, some take more of a balance, others are largely or entirely filled by self-funders – the inability to fully understand that mix and how it is evolving hampers forecasting and planning, for both physical provision and workforce. And that is just for the care home sector. There is even less knowledge of the private domiciliary care market and indeed of new trends in both the public and private sectors. For example extra care housing and other, often technology-driven innovations. Indeed, the CMA in 2017 recommended that a new independent body be set up to gather data in order to help councils plan (CMA 2017).

One social services director says: 'No one has the overview of workforce, of market stability, of other sorts of data. It's all dispersed all over the place.' To take just one example, there is no requirement for private providers to disclose workforce numbers, and only half of providers fill in a survey run by Skills for Care.

Another director says that Helen Whately, the current Minister of State for Care, and who previously worked in the health care division of the management consultancy McKinsey:

> *…cannot understand why you can't aggregate social care up nationally, as you can in the NHS, and understand how many people are being served and how*

> *many people are waiting and not getting services. It is a fair question. But we don't do it that way because it's distributed out in local government. So we lack a national infrastructure.*

The OSR pointed out in early 2020 that no one knows the value of unpaid care, other than through hugely varied estimates of between £100 billion (OSR 2020) and £132 billion (Carers UK 2015) – far exceeding the £25 billion of public money spent on all forms of personal social services. The CQC, it said, is seeking to drive up the quality of care but 'without cross-government working to improve the data collections, it will be unable to comprehensively monitor and measure improvements to care'.

The Office for Statistics Regulation also said that, in contrast to health care:

> *… where the effectiveness of interventions is a priority research area, in social care there is very little understanding of the most cost-effective interventions and what the impact of each intervention is. In order to ensure people are getting appropriate care, comparable linked data on spending on care packages, the needs being met and the individual outcomes is needed.*
> (OSR 2020)

It noted that the Department of Health and Social Care had plans back in 2014 for a significant improvement in data collection, but that remains 'work still in progress'.

Most recently, and well after we started our interviews, the Social Care Sector COVID-19 Support Taskforce itself underlined the need for much better data (Social Care Sector COVID-19 Support Taskforce 2020, *see* recommendations 35 and 36).

Lack of data means lack of research. The head of one of the larger providers says that the Social Care Institute for Excellence is providing some 'concrete and practical tools' but the broader picture, outside of a few academic centres such as the London School of Economics and Political Science (LSE) and the efforts of think tanks, is 'the absolute paucity of research into social care'. The National Institute for Health Research does now have a School for Social Care Research, and the Economic and Social Research Council and the Health Foundation are to fund a new evidence centre for innovation in adult social care. But the fact remains that not enough data means not enough for the researchers to get their teeth into. It is more than likely that quality, effectiveness and cost-effectiveness suffer as a result.

Lack of training and development

There is a serious underinvestment in training and development in social care – for leadership, but not just for leadership.

Health Education England, the body for education and training in the NHS, has a budget of around £4 billion (Health Education England 2020). The equivalent for social care – though to call it an equivalent is a misnomer – is Skills for Care. Health Education England is a non-departmental body of the Department of Health and Social Care, often in the room with ministers; Skills for Care is an arms length charity based in Leeds, the Department's 'delivery partner on leadership and workforce development'. It has a budget of some £30 million, most of which is a grant from DHSC.[3]

As already noted, the social care workforce and the NHS workforce are of similar sizes, and the disparity between £4 billion and £30 million is striking – a 133-fold differential. There is nothing like 'parity of esteem' here.

To be fair, the figures are far from directly comparable. Health Education England funding includes support for the training of doctors (typically a seven-year course including obligatory post-graduation qualification), nurses (a three-year course), and professions allied to medicine, where course length varies but is never short.

And again, to be fair, the social care sector does not need the same level of training investment as the NHS. Care workers are skilled, but clearly do not require the highly technical and specialised training of medics or nurses. Nonetheless, like NHS staff, those working in social care need continuing professional development. And the skills needed to be a director of adult social services, which include being a systems leader, are on a par with those of a chief executive in the NHS – with the requirement growing, within the NHS, to be a systems leader, not just a leader of an individual organisation. (*see* **www.kingsfund.org.uk/topics/system-leadership** for more on system leadership).

All that said, the Skills for Care budget equates to just £14 per head for the adult social care sector. What can you buy for that?

[3] Equivalent bodies to Skills for Care in Scotland, Wales and Northern Ireland are non-departmental bodies. Their responsibilities go wider, including registering and regulating the social care workforce, which does not happen in England.

An independent audit of the organisation's work – admittedly commissioned by Skills for Care itself (Skills for Care 2019) – concluded that those who have received its training programmes 'experienced a range of positive outcomes. This includes an improvement in the skills, knowledge and confidence of the workforce, from entry-level to senior leadership.' But the organisation's limited budget leaves holes everywhere, even at the most basic level.

The National Audit Office (NAO) in 2018 reported that 65 per cent of newly recruited care workers since 2015 had taken or were taking the 'care certificate' – the minimum standards for a care worker, which are meant to be part of basic induction. This means that 35 per cent were not. The NAO reported that most of Skills for Care's work 'is small-scale and constrained by the amount of funding' (NAO 2018, p 30).

It also underlined, as did our interviewees, that there is no national workforce strategy for social care. The NHS has been criticised for being slow to draw up its own workforce strategy. But for social care, it is quite simply absent. Health Education England's draft workforce strategy for both the NHS and social care, published in 2017, devotes just 4 of its 130 pages to social care, chiefly describing the problem and the limited support available while indicating that there will be more to come in the (still promised) social care Green Paper (Health Education England 2017). The NAO in 2018 noted that the Department 'has not followed through on commitments to training made in the 2012 White Paper *Caring for our future: reforming care and support*' (NAO 2018, p 29).

In the past, training has been seen as primarily a responsibility for care providers and for local authorities. But the NAO reported that while local authorities have a duty to encourage training and development under the 2014 Care Act:

> *…providers are not formally required to offer development opportunities to staff. Local authorities lack the strategic ability to require providers to support training programmes, so development opportunities for staff vary depending on the provider. Both providers and commissioners from local authorities told us that current funding constraints necessitate them prioritising the provision of care in the short-term, over offering extensive long-term support for learning and career development to their staff. They told us that providing better training would be a priority if extra funding was available.*
>
> (NAO 2018, p 29)

Nothing has changed since then. And if that is the picture for training generally, our interviewees also worried about leadership training for directors of adult social care in particular. One made the point that as funding constraints have stripped out posts, individuals have been promoted within local government to assistant director posts and above more rapidly than in the past, and thus with less experience. Although there is a short development programme for new and aspiring directors, run by Skills for Care and ADASS, this may not go far enough. Another interviewee says:

> *We need a package of support for newly appointed directors. You need a range of skills and not everybody is the rounded creature. So there are very practical skills. But then there is managing the political landscape skills and being a systems thinker – not everybody's a systems thinker. There is a real breadth of skills you need and not everyone will have picked them up on the way up.*

Another interviewee felt there needed to be much more attention paid to equality and diversity in leadership development.

Lack of leadership from the top

Here, it has to be said, painful though it will be to read for those involved, that the vast majority of our interviewees were scathing about the Department – the one place where one might have thought leadership at the top would lie. The only other issue about which they were more distressed – indeed somewhat close to despair – was over the endless unfulfilled ministerial promises about a comprehensive reform to 'fix' social care.

One should always guard against 'a better yesterday'. Memory plays tricks, with many people tending to recall the more golden of the ages in preference to the more painful ones. But our interviewees were clear that there was indeed a better yesterday. The older hands recalled Bill Utting and Herbert Laming; younger ones Denise Platt, David Behan and Jon Rouse. While their titles varied, each was the chief adviser, or director general, for social care within the Department of Health and built strong teams around them. All were of and from the sector, with the exception of Jon Rouse who, as a former local authority chief executive, had a strong grasp of social care.

Although they had differing styles, they were regarded (by those of our interviewees who had been close enough to observe them or know them) as not just individual leaders, but as leaders of strong teams they had helped to build. These were seen as people who would speak truth back to the sector, as well as to ministers. As one director of adult social services says:

> *I do remember David Behan coming to an ADASS conference, where he gave us an absolute bollocking because we had all said fairly disparaging things about the NHS in a session the day before. He told us that the NHS 'has got more clout than you governmentally, it has more clout than you with the public, it has more budget than you, and it has more power than you'. And that if we went to war with it, we would do nothing but lose. We had to work with it, and constructively.*

Should the charge be that, although these people were seen as leaders, there has still been a quarter-century long failure to 'fix' social care, the answer is that there have been real and significant improvements over that time – personal budgets, for example, along with shared lives schemes, asset-based approaches, reablement, innovative models of housing with care, and 'home first' hospital discharge programmes with the NHS. Indeed, their cumulative efforts in later years eventually led to the Care Act of 2014. Most of the directors of adult social services we spoke to regard this as a good piece of legislation that was genuinely put together with the sector – 'co-produced', in the jargon. Its two drawbacks have been first that austerity has limited its application, and second that the government postponed – indeed, may well have cancelled for good – the clauses that implemented the funding recommendations from the Dilnot Commission: namely, those that set a cap on individual liability for social care costs and significantly raised the means test so that even the least well-off will retain appreciably more of their assets than under the current system.[4]

These days, however, leadership from the top feels very different to our interviewees. 'A vacuum,' says one. 'Diminished,' says a second. 'The days when we had very clear leadership at the top are somewhat distant,' says a third. A fourth adds: 'There hasn't been any evidence, for a long time, of what you might describe

[4] As enacted, the Dilnot Commission led to the threshold for the means test being raised from £23,500 to £100,000, allowing the less well-off to keep more of their assets. In addition, after the first £75,000 of approved care costs, the taxpayer would pick up the bill, in effect providing the tail end insurance for the most costly cases.

as leadership coming from there [the Department]'. A fifth says: 'It's been dire for a long time. There hasn't been visible leadership for a long time.' And a sixth added: 'There's a really quite astounding lack of understanding of social care at the centre.' The list of quotes could go on.

If that is the view of what has happened in the longer term, there is a shorter-term version over the response to Covid-19. One says:

> *All you get from the centre is eleventh-hour short-term requests for reams and reams of data to provide assurance to the minister. That's not leadership, it is form filling. All of the things that worked about the response to Covid were about the local services and the local communities and what they did to keep the show on the road, and everything that has been a monumental fuck-up has come directly from Whitehall.*

The core issue here is that since the days of Jon Rouse, who left to run Manchester's combined health and care system in 2016, there has not been, for any length of time, a director general for social care whose background is from the sector. Several cited David Behan's time as the last time when they felt there was someone in the Department 'who understood what it was like to lead these services, understood the finances, the rights-based agenda, personalisation and all the rest,' and who was seen as having real influence with ministers and NHS colleagues. The number of civil servants covering the issue within the Department has since then diminished and, according to our interviewees, those moved in to cover it do not have a social care background.

There is some sympathy for the officials involved. 'The nature of social care being so confused, contested, fragmented, it actually probably is a pretty difficult intellectual challenge to suddenly come in as an official to understand all of that, unless you had some sort of background in it.' A second, more conspiratorially, says: 'You do end up wondering whether it is like this because ministers don't want someone there who can make them sit up and listen.' A third, more kindly, says: 'some of the senior civil servants have been very good. But they move on all the time. So it is really difficult. The key missing person is the director general role.' A director general was appointed in April 2020, only to be replaced by a temporary appointment in September 2020.

It should be said that this was not just a case of people in the field wanting one of their own in the Department as a sort of comfort blanket. As already noted, previous chief advisers could be as tough with the sector as they were clear with ministers and their NHS colleagues in the Department. It is the expertise and the advocacy that is missing.

There was sympathy also from some for Helen Whately, the current Minister for Care. One interviewee says:

> *…watching the realisation on her face over the last six months that 'I've got no bloody levers. I can't make the CQC do anything, not very easily. I certainly cannot make local government do anything. The providers spend their life whinging at me and I can't make it better for them, even though I have found them some money.' I think it is a really horrible role.*

Sympathy aside, however, there was a widely held view that, for all the constraints around it, leadership at the top has gone missing – and that the one thing that social care desperately needs right now is the long-promised but undelivered reform to its funding and operation.

There is one notable exception to this trend: the creation of the post of chief social worker in the Department of Health in 2013 is widely viewed as having boosted the professional leadership of social work by providing an expert voice for social work within government. In the words of the first post-holder:

> *One of the key messages I have heard from social workers over the last year, is that they really value having a chief social worker to give the profession a voice within government and particularly within the Department, and the recognition that social workers have a key contribution to make to improving outcomes in adult services.*
> (**Department of Health 2014**, p 22)

The chief social worker works closely with the national network of principal social workers in each local authority, creating a stronger link between frontline practitioners, senior management, and nationally to the Department of Health and Social Care. 'It's been very limited in resources, certainly up to now,' one outsider says. 'But it has been a positive. It has got social work closer to ministers and it has supported the network of principal social workers in local authorities.'

4 What did we conclude?

Given our small sample size, we do not have the temerity to make recommendations. But from what we have heard this is what we would conclude:

Leadership matters at every level in social care, but local is critical

Some of the most inspirational and effective examples of change that we heard came from users and providers and care staff who had taken leadership upon themselves – in many cases because they had been liberated so to do by relatively recent changes in the way social care operates – changes supported by the Care Act of 2014.

In the jargon, this is known as 'co-production': the product of personal budgets, direct payments, and how leading local authorities and directors of adult social services have encouraged – and, in the best examples, supported – 'experts by experience' and care providers to help shape the way services are delivered. These groupings do not always get what they want. Even in better times than these, resources will be limited. But in the last analysis social care is about enabling those who need support to live as independently as they wish, and as independently as possible. Individual decisions about that cannot be directed from Whitehall. It seems clear that the very best organisations cherish user feedback whereas the poor ones tend to hide from it. In social care, to be effective, power has to follow the mantra that it needs to be devolved to where the best expertise and motivation sits. That offers the prospect for using limited resources to best effect, and is entirely consistent with previous work by The King's Fund on system leadership (The King's Fund 2020; Bailey 2018; Timmins 2015).

The NHS should not 'take over' social care, nor local government the NHS

This is something of an on-and-off perennial debate, and it came up with our interviewees. Given that they came essentially from local government, or from services heavily influenced by local government, it is scarcely surprising that most objected vehemently to any suggestion that it should be the health service that commissions social care.

They pointed to the accountability that local government has, but which the NHS lacks, through the ballot box – and to the fact that social care stretches way beyond the issue of delayed discharges from hospital. One interviewee says: 'The fact that people still think this is only about delayed discharges, "so let's let the health service fund them", shows we still haven't got across our understanding of this.'

Some of the directors to whom we spoke argued lucidly that social care at its best is tied into a wide range of other council services, including housing, leisure, wider community facilities and, indeed, economic regeneration – services well beyond the reach of the NHS. And as one councillor put it: 'People do exit social care and we want them to. But there is a huge number of people who are effectively coming under our wing to live the rest of their lives.'

One or two – while acknowledging that it was probably a bit of a fantasy – speculated about local government commissioning the more community-based bits of the NHS. But most recognised that what that was likely to do was simply move an existing barrier elsewhere. And, either way, there would be a huge opportunity cost. In social care, as in the NHS, the memory of the disruption caused by Andrew Lansley's Health and Social Care Act 2012 lingers on, as does (for those with longer memories) the repeated restructuring of primary care trusts in the 2000s.

One of our most experienced interviewees says: 'Any idiot can put two organisations together and it doesn't change a single thing on the ground. If you speak to NHS chief executives about what they can get sacked for, none of it includes integration.' It would be better, he argues, to look for 'an incentive framework, legal, financial, regulatory and performance that is consistent in rewarding collaborative behaviour. People [in the NHS] are not rewarded to be collaborative at the minute. That is where I would go rather than some great upheaval which would just soak everybody's energy away and it wouldn't be a lot different.'

Or, as one director puts it succinctly: 'Integration "yes". Structural change "no".' And – at least on the basis of these interviews – there is progress, if not yet universal, on integration.

Data is missing and needs to be assembled

That was the view of a number of our interviewees – quite apart from it being the view of the competition and statistics authorities. Assembling it will include requiring more information from purely private providers as well as those who are commissioned by local authorities. Better information on workforce, market stability, and on the outcomes of care and its cost-effectiveness would result. Leadership would be assisted.

Training for skills, training for leadership

We set out earlier the limited nature of training at all levels in social care, and its impacts. We would conclude that while providers and local authorities do indeed need to themselves invest in training and development – and that central government should not take over the entire responsibility – a significant injection of funds is required to help them do that. Skills for Care needs not just a larger budget but more clout, perhaps becoming a non-departmental body. We also note, for others to consider, that England is the only part of the United Kingdom where social care staff are not registered and regulated.

Supporting user groups and associations of providers pays dividends

As already related, some of the most encouraging accounts we heard were from user groups – some operating through the Think Local Act Personal partnership – and from associations of care homes and/or home care agencies closely engaged with their local authorities.

In most of the examples we heard, councils had supported these with infrastructure costs, though we also heard of examples where local authorities had ceased to do that as money for social care has tightened. One care home owner who runs their county-wide association says:

> *They pay us to disagree with them, which is quite a brave thing. But it does produce better understanding. Both parties are going to be open and willing to accept the other side's point of view. We challenge each other. And ultimately both parties want the same thing, which is to improve the quality of care.*

Or as one director puts it: 'It is a bit of a crunchy relationship. But at least you get the advocacy coming to you telling you what is working and what is not, and stopping you from making the obvious mistakes that you might make.'

There is a case for a more unified provider voice for social care

There were mixed views on this. But many did feel that social care lacked the clout that NHS Providers or the NHS Confederation brings to the health scene (or in another sector, that of Universities UK). Some felt that the interests in social care are so diverse that a single voice will not be possible. However, a model on the lines that the Confederation has used might help – a federated one with, for example, sections for care homes, home care agencies, etc, which can then produce a single voice on the issues where there is common ground.

And for beefing up the voice of the Association of Directors of Adult Social Services

As our interviewees noted, ADASS is under-powered, relies on volunteers for its leadership, and arguably suffers from rapid turnover. It should be one of the most influential voices for social care because it has a professional rather than political stance, its members are the commissioners for almost all publicly funded services, and the directors have a wider system leadership role, including with public health and relationships with the NHS. In the past, it has been more influential. Perhaps because, when social care departments were better staffed, local authorities were more willing to give up their director for a year to be more of a full-time president for the organisation. It is a charity, which for some restricts its willingness to intervene in ways that might be seen as 'political' (with a small 'p'). It is not for us to make detailed recommendations. But there is a case for its members to rethink how ADASS can strengthen its capacity and leadership – for example, by moving to an organisational model like NHS Providers with a paid full-time chief executive. And it needs to become, in the words of one interviewee, 'much more savvy in political influencing'.

Is there a case for a national approach to setting fees?

The annual battle over fees – for care homes and for home care agencies – bedevils the sector and can poison relationships. Some of our interviewees favoured a more nationally determined approach, arguing that this would provide clarity and make clear where the ultimate responsibility for the public funding of social care lies. This could take the form, for example, of a mandatory methodology for establishing and agreeing the local cost of care; or open-book accounting; or a nationally set price with adjustments for different parts of the country to reflect differing costs. The CMA raised the latter as a fallback option in its 2017 report (Competition & Markets Authority). Such approaches should not absolve the government of its responsibility for ensuring that councils are able adequately to fund the actual cost of care. Not everyone favoured such changes. But it is worth examining the case for one or more of them to reduce the heat of the annual battle over fees, allowing both councils and providers to concentrate more on outcomes and quality.

There is also a strong case for assessing how well local authorities are discharging their duties

Not many of our interviewees raised this, but those that did felt it would strengthen leadership, providing more power to the elbows of both the lead councillors for social care and directors. The CQC would be the obvious body to do this, and indeed, in the earlier part of the previous decade, it had begun to do annual reviews of councils' performance. That, however, fell victim to a government decision and the budget cuts that the CQC, like other parts of the public sector, underwent. There are signs that the CQC itself is considering this again, but would need departmental permission. One director says: 'There's a desire now for the CQC to be much better joined up with local authorities to have a shared quality improvement agenda but also an ambition to inspect the commissioning of councils. I think councils might welcome that now.' Its absence, they continue, 'has almost enabled government to avoid looking at the consequences of the impact of funding reductions since 2010 onwards'.

Another says:

> *Inspection is no substitute for leadership. But the fact that the CQC only inspects providers is a bit of an anomaly. Local authorities have been losing funding, and they have been in a position – not because they have wanted to – to keep cutting*

their cloth [to what is available] without any really strong oversight of the impact of that. And that puts local authority leaders – directors, chief executives, political leaders, social workers – in quite an invidious position. There is no inspection to say that this authority has cut things to the bone, and this group of people who would have got social care are no longer getting it. There is no national lens on that at all. Good scrutiny with benign accountability can help leaders deliver, because it gives them something to make their case with when things are not working well.

Any assessment of how local authorities are performing would also need to take into account the NHS's role in commissioning social care.

The social care function in the Department of Health and Social Care needs restoring

As already noted, by far the most withering criticism we heard was aimed at the Department.

The creation of the chief social worker role (referred to earlier in the report) has created a welcome focus within the Department on the professional leadership of social work. However, this forms a very small fraction of the wider 1.5 million strong social care workforce, and the chief social worker is not on its own a substitute for the director general post. The Department has also recently appointed a chief nurse for social work. But the fact that this is only a six-month secondment, not a permanent position, in the eyes of many, says it all, unless the secondment is a prelude to a permanent post.

As we were completing these interviews, the Social Care Sector COVID-19 Support Taskforce also recommended in August 2020 that 'DHSC significantly boosts its own expertise and capacity, in relation to social care, for the duration of the pandemic and beyond' (Social Care Sector COVID-19 Support Taskforce, *see* recommendation 34). It recommended bringing in figures with current or recent experience at senior levels, both within social care and public health.

The Director General post needs to be re-created and filled by someone with real experience of the field, and with sufficient staff to make an impact – both upwards to ministers and out into the field. An interim director general has been appointed, in September 2020, though not someone with experience of the field,

and the Department is planning to recruit a revamped social care group, which will apparently have a staff of more than 300.

This restoration – or re-creation – of the director general role, with sufficient staff to have a real impact, would clearly be welcomed by our interviewees – providing this reinforcement of the Department's expertise is there, as the taskforce recommended, for the long term, and not just for the course of the pandemic, and providing it has the skills within it to cover the full spectrum of the issues in social care. To say that is not to deny the huge effort of those civil servants brought in to address the pandemic and, indeed, the wider social care reform agenda, pending these changes.

We have repeatedly stressed here that much of the best of the leadership in social care is local. But it needs to be able to function with high-quality leadership from the top around those things that only central government can do. And that has clearly been absent.

5 And finally...

We believe that the changes outlined here would – from what we have heard – strengthen leadership in social care. But we would forcefully make the point that more effective leadership is not in itself a solution to the longstanding problems in the sector. Not just the government, but all the political parties, have for a long time now acknowledged that a much broader reform of social care in England is needed. But it has not happened.

The failure to fix social care

2021 sees the 25th anniversary of Stephen Dorrell, the Conservative Secretary of State for Health launching a consultation on a 'partnership' approach to reforming the funding of social care. Since then there have been Green Papers, White Papers, plenty of independent recommendations for reform, plus two government-commissioned inquiries, but still a failure to 'fix the crisis in social care once and for all'.

In the past 25 years there have been...

Eight green papers and consultation exercises

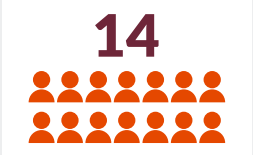
Four white papers

Many independent recommendations for reform[5]

Two government-commissioned inquiries[6]

Overseen by...

Nine Secretaries of State for Health



Fourteen Ministers for Care Services

For more on the development of social care funding, see 'A short history of social care funding reform in England: 1997 to 2019' (www.kingsfund.org.uk/audio-video/short-history-social-care-funding)

5 Including recently from three cross-party select committees in the House of Commons and the House of Lords.
6 The 1999 Royal Commission on Long Term Care, and the 2011 Dilnot Commission on the Funding of Care and Support.

The most depressing statement we heard in the course of this work was that from Lord Bethell, the social care minister in the House of Lords, who told peers: 'There simply is not the management or political capacity to take on a major generational reform of the entire industry in the midst of this massive epidemic' (Hansard 2020).

That may well be true in the short term. But a minimum requirement is that the Department is put into a position where it has the management and policy-making capacity to undertake this reform once the pandemic is contained, and that the political capacity – the political will – is there to do it.

Annex

We sent all interviewees the following very broad outline set of questions, while being clear, as in point 3, that they could – as some did – raise issues not covered here.

LEADING ADULT SOCIAL CARE

ISSUES FOR DISCUSSION

1. **Where do you think leadership in social care lies?**

- And how is it shared across directors of social services, local authority chief executive officers (CEOs), cabinet/elected members? (What role do principal social workers play in offering leadership to social work teams?) Does the local NHS play a role?
- And on the provider side – CEOs/owners versus local managers of care homes, home care services, etc? How does it differ between big national chains versus small local organisations?
- The voluntary sector and the voice of users and carers?

2. **The national context of social care leadership – Department of Health and Social Care (DHSC)/Ministry of Housing, Communities and Local Government (MHCLG)/the Care Quality Commission (CQC), etc**

- The role of national bodies in leadership versus setting the framework – eg the CQC is both regulator/standard setter and inspector. Does that amount to leadership?
- How far does NHS England influence or contribute to social care leadership?
- Does the NHS's shift towards integrated care systems (ICSs) change any of your views?

  How far do you think your perception is typical, or is there just huge variation?

3. **What aspects of leadership are we missing – in your personal experience/ locally, and nationally?**

4. **What changes would help make things better? In terms of changes within the current system, or changes to the system itself?**

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A graduate of LSE, his professional background is social work, and over the past 35 years he has worked in a variety of roles, including as a director of social services and health authority chief executive (the first combined post in England) and in senior roles in the Department of Health. Richard is a non-executive director of Wye Valley NHS Trust and also a Visiting Professor at the University of Worcester.

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For The King's Fund, his work on the nature of leadership includes *No more heroes* (2011), *The practice of system leadership* (2015) and *The chief executive's tale* (2016). His other work includes *Never again?*, an account of how the 2012 Health and Social Care Act happened, and *The world's biggest quango*, the tale of the first five years of those reforms. He has co-authored *A short history of NICE* (the National Institute for Health and Care Excellence), and has recently updated *Glaziers & window breakers: former health secretaries in their own words*. He was rapporteur to the Barker Commission and is an Honorary Fellow of the Royal College of Physicians.

Declarations of interest

In October 2020 Richard Humphries became a trustee of the Association of Directors of Adult Social Services (ADASS). He is also a senior associate of the Social Care Institute for Excellence. Nicholas Timmins is a trustee of Think Ahead, the fast-track scheme for mental health social workers.

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The King's Fund Ideas that change health and care

Adult social care provides essential support to people with a range of needs and provides more jobs than the NHS, yet its invaluable role is often not properly understood. The King's Fund conducted interviews with a range of people who commission, provide and use social care to find out where leadership lies, how effective it is and what might be done to improve it.

Stories from social care leadership: progress amid pestilence and penury shares insights on the role of leadership in the sector at all levels, from local authorities, local providers and people who use social care, to national bodies and central government.

Key findings emerged.

- There is huge variation in the quality of both services and leadership, with some of the most inspirational leadership coming from places where directors of adult social services actively engage with providers and people using social care.
- Leadership from the very top has been missing for some time and the Department of Health and Social Care's plans to strengthen capacity and expertise should be pursued with vigour.
- Social care could benefit from a more unified national voice for providers and a strengthened role for the Association of Directors of Adult Social Services.
- There needs be more investment in workforce training and development and better data and research to support effective leadership.
- Local co-production and partnerships, not structural integration with the NHS, should be the way forward.

The report concludes that better leadership alone will not resolve the longstanding problems of the social care sector without fundamental reform of how it is organised, delivered and funded.

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