Reforming Social Care

TIME FOR RADICAL CHANGE

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Published by the **Centre for Welfare Reform**

Publishing Information

First published March 2018
Reforming Social Care is published by the Centre for Welfare Reform

www.centreforwelfarereform.org
Designed by Henry Iles: www.henryiles.com
50 pp
ISBN download: 978-1-907790-99-7

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Summary

Ten years ago Dame Denise Platt, the outgoing chair of the Commission for Social Care Inspection, indicated that the values of social care might be similar to health but the underpinning policy assumptions were different.

The argument that a merger of health and social care will be mutually advantageous is based on a mistaken belief that synergy inevitably confers advantages.

In order to prevent a collapse of health and social care, this report advocates a number of major reforms:

- Department of Social Care
- Introduction of new funding streams
- Social Care Research Council
- Social Care Training Council
- Social Care Inspectorate
- Social Care Enterprise Agency
- One-year compulsory national community service

In the coming years, there is likely to be a declining role for centralised government; increasing pressure to equalise wealth distribution; and a diminution in the role of the large urban conurbation.

The impact of artificial intelligence and robotics in the next two decades will be profound and lead to significant changes in the employment market affecting industrial, commercial, clerical and service occupations.

Because of these changes people will be forced to explore alternative patterns of living including, for example, the development of ecovillages in urban and rural settings which emphasise community and social cohesion, economic sustainability and ecological sensitivity.

The speed with which fundamental changes are taking place in our economy and society makes necessary the introduction of major reforms.

The author of this report is not confident that any of the main political parties understand the seriousness of the situation facing social care or have the strategies to respond effectively to any of the changes identified in this report.

1. The social care crisis

"The UK is one of the most centralised states in the developed world and one of the most disaffected and politically passive populations in Europe. We hold our leaders in contempt, but despair of doing anything for ourselves or our community. The dysfunction at the highest level of society stems from the collapse of our social and personal foundation. There is little doubt that we are becoming an increasingly fragmented and individualist society and this has deep and damaging consequences for our families, our communities and our nation state."

Crawford and Read (2015)

If radical measures are not put in place in the near future, the social care sector in England will collapse (Plimmer, 2017). 'Reforms' introduced by successive governments since 2000 have led to a seriously under-funded and under-performing sector, heavily dependent on the profit-oriented private sector and outsourced provision to powerful global companies. Most for-profit companies have shown scant interest in maintaining adequately staffed facilities and an appropriately trained workforce (Bow, 2015). On the contrary, in order to keep costs down there has been a strong incentive on the part of such companies to engage poorly qualified staff and maintain less than full staff establishments (Jackson, 2010).

It is well documented that some of the larger companies currently providing social care in the UK are financially over-stretched, with some that are not far from financial insolvency (Ruddick, 2017). At the time of writing one of the largest care home operators in the UK – Four Seasons – is at serious risk of having to close its 343 homes which provide care for 17,000 people (Davies, 2017). There is little appetite for companies to invest in this sector because spending on social care by austerity-hit local authorities has fallen, while costs have arisen. In the event that companies providing care fail, what is there to attract new companies to come in and invest? Concern about the extreme fragility of the private care sector should prompt urgent questions as to the wisdom of permitting so much of this sector to be in the hands of private companies – many from overseas whose only interest is in generating a profit for their investors. The only 'quality of life' that is enhanced through this arrangement is that of the well-heeled investors!

The situation has been made worse by the recent government decision that companies and charities providing care homes have to provide back pay to 'sleep-in' care workers (McAleese, 2017). The Chairman of Mencap indicated that the bill for six years of back pay would be 'unaffordable'. He further commented that despite the government's stated commitment to creating an economy that works for everyone – it appeared nevertheless to sacrifice the wellbeing of some of the most vulnerable members and place at risk the jobs of people who are amongst the lowest paid. It has been estimated that the total back pay bill could cost the social care sector £400 million and bankrupt many providers, including the learning disability charity Mencap, which would owe £20 million. As a result of the government's decision, Mencap faces the possibility of closing 200 residential care homes and services and making 4,000 staff redundant.

The community wellbeing body of the Local Government Association has pointed out that it was Government guidance that caused the confusion over whether the National Minimum (Living) Wage should apply for sleep-in shifts. It was further noted that the

councils were already facing a £2.3 billion annual social care funding gap by 2020. If the Government does not fund this historic liability then there will be more care providers going under, more contracts being handed back to councils and more care workers being made unemployed.

A further consequence of the cut backs has been a return in certain local authorities to old forms of residential care including the creation of large-group settings. Greig (2016) has been strongly critical of this move away from the policy of making placements in small supported settings in the community. He highlights what he believes to be wrong in the current process of social care commissioning by local authorities:

- a failure to understand the concept of 'cost-effectiveness' in housing and care given that the Audit Commission made clear that good value for money is not about achieving the cheapest possible price, it is about getting the best outcomes for your money
- a worse staff-to-person ratio inevitably means people will receive less individual attention and support leading to more large group activities and less personalised support important for the development of life skills and independence
- it ignores the purpose of the personal budget which is for the individual client to determine not the council
- the rights-based approach promoted by the 2001 Valuing People policy appears to have been abandoned (Department of Health, 2001).

Current problems have been further exacerbated by the effect of Brexit and the drying up of social care staff recruitment from East European countries (McKenna, 2016). In the past eight years the number of non-British EU nationals in the health and social care workforce has grown exponentially (Mulholland, 2017). In 2016, 209,000 people working in this sector in the UK were EU nationals, up from 121,000 in 2009 – a rise of 72% (Office for National Statistics, 2017). However between January and March 2017 the number of non-British EU nationals working in the public sector fell by 27,000. This loss is particularly felt by public services already adversely affected by staff shortages. British workers are reluctant to fill vacant care jobs because of the 'zero hours' culture operating in that sector. Difficulties in recruiting staff, when combined with the exodus of substantial numbers of care staff is encouraging some local authorities with limited social care budgets to return to larger more institutionalised types of care settings (Jackson, 2015).

The responsibility for the current crisis in social care lies in part with those who have pushed for the merger of health and social care in the belief that the benefits accruing from combining these two sectors into one are greater than those resulting from leaving them as two separate entities (Ham, 2014; Barker, 2014). In other words, there is a belief that synergy inevitably confers advantages. But this mistakenly presupposes that there are strong similarities between health and social care. The word synergy derives from the Greek word synergos meaning working together. In corporate business terms, synergy refers to the ability of two or more units to generate greater value working together than they could by working apart (Goold and Campbell, 1998). It is contended that synergy can provide a big boost to the bottom line of most large companies.

However the challenge is to separate real opportunities from illusions. There are four forms of bias that should be highlighted. The first is synergy bias, which leads to an overestimation of the benefits and an underestimation of the costs of synergy. Then comes the parenting bias, a belief that synergy will only be captured by persuading or

compelling the separate units to cooperate. The parenting bias is usually accompanied by the skills bias – the assumption that whatever know-how is required to achieve synergy will be available within the organisation. Finally, executives often fall victim to the upside bias, which causes them to concentrate so hard on the potential benefits of synergy that they overlook the downsides. In combination, these four biases make synergy seem more attractive and more easily achievable than it truly is.

Synergy often fails because those seeking the synergy are focused too much on the financial and strategic aspects and frequently underestimate the cultural aspects of the organisations being merged. Indeed in the one sector that one might reasonably have expected synergy to have a successful track record – mergers and acquisitions – Leon Coopman, a senior executive at Goldman Sachs, has confessed to being unable to identify one example of success (The Economist, 2009).

1.1 Ways in which health and social care differ

The National Health Service employs 1.4 million people and social care 1.6 million people, (Imison & Bohmer, 2013). Together the health and social care sectors employ one in ten of the working population! The health care workforce differs from the wider workforce in a number of significant ways:

- It is highly educated – 48% of staff are professionally qualified.
- It has a high proportion of women workers – almost 80% of non-medical health service staff are women compared to 46% of the wider workforce. In England, 43% of doctors are women as are the majority of medical trainees.
- There is a strong demarcation of roles and responsibilities, such as prescribing powers, between different staff groups which are often reinforced by legislation or regulation.
- The length of time it takes to train doctors, nurses and other professional staff means that it is difficult to balance supply and demand.

The social care workforce is different:

- As in health care, about 80% of all jobs in adult social care are done by women; the proportion in direct care and support-providing jobs is higher at 85-95%.
- Most adult social care jobs (1.3 million, 74% of the total) involve providing care. The rest comprise: 147,000 managerial and supervisory jobs, 100,000 professional jobs (including social workers, nurses and occupational therapists) and 204,000 administrative, ancillary and other jobs.
- More than 20,000 social workers are employed, mainly by local authorities, and their role is changing in response to different models of service delivery
- The rest of the social care workforce is relatively unskilled. In 2008 two-third (67%) of people working as 'care assistant and home carers' claimed to be qualified to National Vocational Qualification Level 2 or above, and 7% had no qualifications at all. It should be noted that a NVQ is a formally recognised work-related, competence-based qualification, which reflects the skills and knowledge needed to do a job effectively and shows that a candidate is competent in an area of work, or individual segments of work, within an area at a certain level of achievement. However it is not a professional qualification.

The National Framework for NHS Continuing Healthcare has sought to clarify the difference between healthcare need and social care need (Department of Health, 2012a). Whilst there is not a legal definition of a healthcare need (in the context of NHS continuing healthcare), in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).

In general terms (not a legal definition) a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation.

Social care needs are directly related to the type of welfare services that local authorities have a duty or power to provide. These include, but are not limited to: social work services; advice; support; practical assistance in the home; assistance with equipment and home adaptations; visiting and sitting services; provision of meals; facilities for occupational, social, cultural and recreational activities outside the home; assistance to take advantage of educational facilities; and assistance in finding accommodation (e.g. a care home).

Williams (2003) has outlined what he sees as the essential characteristics of social care. Firstly, it is recognised that care of both the self and care of others are meaningful activities in their own right; they involve us all, men and women, old and young, able bodied and disabled. Care is an activity that binds all. Secondly, in receiving and giving care we can, in the right conditions of mutual respect and material support, learn the civic virtues of responsibility, trust, tolerance for human limitations and frailties, acceptance of diversity. Thirdly, an ethic of care demands that interdependence be seen as the basis of human interaction; in these terms, autonomy and independence are about the capacity for self-determination rather than the expectation of individual self-sufficiency. Fourthly, it attributes moral worth to key positive dimensions of caring relationships such as dignity and the quality of human interaction, whether based upon blood, kinship, sexual intimacy, friendship, collegiality, contract or service. And it recognises and respects diversity and plurality in the social process of care. Finally, it argues against inequalities in care giving and care receiving; it recognises that these inequalities may be constituted through different relations, including gender, disability, age, ethnicity, race, nationality, class and occupational status, sexuality, religion and marital status. Care requires time, financial and practical support and the recognition of choices. These extend beyond income maintenance benefits and social services to public space, transport, anti-discriminatory and anti poverty policies.

It is not difficult to provide illustrations of the way in which successive governments have failed to understand the meaning of social care. Nowhere is this more evident than in the various attempts which have been made to regulate social care.

1.2 Regulation of social care

In April 2004 the Labour Government set up the Commission for Social Care Inspection (CSCI) with the aim of modernising the system of regulating care services. In November 2004 the CSCI published its first performance ratings of all councils with social services responsibilities. The rapid privatisation of the care sector coincided with the decision by

the CSCI to transfer greater responsibility for the assessment of care standards to care providers. Thus, within a short time of the CSCI having been established, self-regulation was accorded a high priority. In November 2004 the CSCI published a consultation document *Inspecting for Better Lives - Modernising the regulation of social care* in which it proposed that self-assessment be introduced for care providers (CSCI, 2004). The Commission expected care providers to be honest about the strengths of their service and explain what they were doing to improve it. It went on to state that it would take a tough line on misleading self-assessments and view them as a sign that the service was not being well managed (Jackson, 2017).

In a follow-up document, published in July 2005 entitled *Inspecting for Better Lives - Delivering Change*, it was belatedly acknowledged that there were some who believed that the adoption of a self- assessment system could be open to abuse (CSCI, 2005). Notwithstanding these reservations the CSCI made clear its determination to introduce what it described as 'provider self-assessment' which it viewed as an essential part of its new ideas. Given the scale of the problem facing the CSCI, in terms of seeking to raise care standards, it was all the more surprising that it proposed to cut its own workforce by 25%! These changes, which were a direct result of the Government's policy of devolving powers in the public sector and its commitment to reducing public sector expenditure, appear to be built upon the naïve assumption that if care providers take part-ownership of the regulatory process that they will do so in a responsible manner. Unison, the principal trade union representing social care staff in the UK, campaigned to highlight the effects of these changes on the safety and quality of care provision. Union members were reporting that the new regulatory system, with its reduced staffing, was failing because of a lack of time:

- to target its resources on those providers giving a poor service
- to follow up on concerns and complaints or detect problems in the early stages
- to impose and follow up on enforcement measures
- to spend time in the field talking to service users.

Unison pointed out that inspectors were 'too thin on the ground' and that the situation would be further exacerbated by planned redundancies (Samuel, 2009a). However, in 2009, only five years later, responsibility for regulating and inspecting adult social care and healthcare had passed to the Care Quality Commission which represented a merger of the CSCI, Healthcare Commission and the Mental Health Act Commission. This merger was born of yet another synergistic impulse. In its final report in 2009 the CSCI noted that services for those with complex needs were being adversely affected by poor strategic commissioning, lack of person-centred care and 'marginalisation' of human rights (CSCI, 2009; Latchem, 2009). It also drew attention to the fact that some service users had little if any choice about their services and councils had to rely on inappropriate out-of-area residential care (Ahmed, 2009). In the opinion of Nigel Hawkes, health editor of *The Times*:

"…the latest reform of health care regulation risks adding nothing and seems no more than politics driven by whim… Ministers who constantly uproot the trees they themselves have planted are doing serious mischief."

Hawkes (2008)

The outgoing chair of the Commission for Social Care Inspection, Dame Denise Platt, went out of her way to warn about the ability of the CQC to be an effective social regulator. She stated that it would struggle to balance its health and social care responsibilities because the focus of public attention would be on health care which meant that failings in adult social care were unlikely to attract much attention. She highlighted the fact that the CQC lacked people with social care expertise at senior level, as many CSCI managers had not transferred to the CQC. She also questioned the ability of the CQC to shape social care policy in the way that the CSCI had done through the publication of its annual *State of Social Care* reports. She further observed that the focus on social care policy was likely to be diluted in a body which had been set up to look at both social and health care (Samuel, 2009b).

Dame Denise could not conceal her exasperation that the decision to abandon the CSCI appeared to have been made out of ignorance: "there was really a big misunderstanding in central government about the nature of our role. People think social care is the mirror image of health. It isn't" (Davies, 2005, p.1). She pointed out that their values might be similar but the underpinning policy assumptions were different, not least because users have to pay for social care and stressed that:

> *"...many of the things the Chancellor wanted to achieve around burdensome regulation can be achieved by changing the regulations, not necessarily by changing the institutions."*
>
> Davies (2005)

1.3 Performance of the Care Quality Commission

Not only had the Government succeeded in creating one of Europe's biggest regulators but also there was an increased fear that the move heralded the long anticipated 'takeover' of social care by the health service. When asked if Chancellor Gordon Brown had been badly advised, Dame Platt pointedly and crisply replied: "The level of ignorance in the Department of Health about how social care as a sector operates should not be underestimated" (Davies, 2005). For its part the former Labour Government made clear that the Care Quality Commission would continue to focus on reducing its operating budget. Early indications suggested that this meant a reduction of 40% on the budgets of the three predecessor organisations. Clearly the assumption here was that the synergistic impulse would realise very considerable savings but because the focus was solely directed to the financial and strategic aspects, the cultural aspects of the organisations in the process of being merged were ignored, a risk that Dame Denise had been at pains to highlight (Jackson, 2017).

Closely linked to the budget reduction was the decision to continue the deregulated inspection methodology practised in the CSCI which was termed 'proportionate risk-based inspection'. What that meant was fewer inspections. The previous statutory requirement to inspect care homes twice a year was abandoned. Now the minimum requirement was for care homes and home care providers to be inspected once every three years and inspections were to be replaced by 'Annual Service Reviews' which were paper exercises based on provider 'self-assessment' and any other intelligence received (Jackson, 2017).

In 2014 the Care Quality Commission published a review which focused on services that provided social care for people with a learning disability and challenging behaviours. CQC inspectors carried out 150 unannounced inspections that looked at two national standards: (1) care and welfare; and (2) safeguarding (protecting people's health and wellbeing and enabling them to live free from harm). The inspections took place at 71 NHS Trusts, 47 private services and 32 care homes. Five of the 150 inspections were pilots and were not included in the overall analysis. Of 145 inspections:

- 35 met both standards (24%)
- 41 met both standards with minor concerns (28%)
- 69 failed to meet one or both standards (48%)

It was noted that many of the failings were a direct result of care not being centred on the individual or tailored to their needs. Almost 50% of hospitals and care homes that were inspected did not meet national standards, (CQC, 2014). However, the King's Fund Centre warned against expecting the CQC to guarantee high quality in the social care sector. It argued that the CQC can only ever be the third line of defence against poor care (Foot, 2014). It argued that the first line of defence must be frontline staff who deliver the care and who when properly empowered and supported can improve quality and address problems. The second line of defence is the leaders in the relevant professions and the managing boards of organisations. And the third line of defence is the national bodies, of which the CQC is one. In the opinion of the King's Fund Centre the expectation that the CQC can guarantee high quality care at all times is not only unrealistic but it runs the risk of distracting our attention away from the fact that the quality of care offered is a local responsibility.

According to Philpot (2011) the CQC was an unhappy creation, for the merger of the Commission for Social Care Inspection, the Health Commission and the Mental Health Act Commission led to a budget that was a third less than the total budget of its predecessors and with a third less staff. The new body had to reconcile three different management systems and three very different managerial cultures. To complicate matters further, dentists and GPs were brought under its oversight.

In 2012 The Department of Health published a Performance and Capability Review of the CQC which noted that since its establishment, it had faced:

- operational and strategic difficulties
- delays in registering providers
- shortcomings in compliance activity
- a negative public profile. (Department of Health, 2012)

All of these deficiencies seriously challenged public confidence in its role. The Review further acknowledged that the Department of Health and CQC had seriously underestimated the scale of the task, as Dame Denise had warned. Whilst the CQC was charged with the responsibility of encouraging the improvement of health and social care services, it was noted that there was a lack of clarity as to how the CQC fulfilled this role given its emphasis on compliance against essential standards rather than seeking ways to improve the quality of services above essential standards, as the previous organisations had sought to do.

The prediction made by Dame Denise that the CQC would prove an ineffective social care regulator was clearly demonstrated not least by the growing number of cases of

abuse and maltreatment in a variety of health and care settings and by the highly scathing judgements on the operation of the CQC made by a succession of Parliamentary Select Committees.

In 2011 the Health Select Committee identified the following factors which it believed had contributed to a serious distortion of priorities:

"the CQC was originally established without a sufficiently clear and realistic definition of its priorities and objectives

"the timescale and resource implications of the functions of the CQC, in particular the legal requirement to introduce universal registration of primary and social care providers, were not properly analysed

"the registration process itself was not properly tested and proven before it was rolled out

"the CQC failed to draw the implications of these failures adequately to the attention of ministers, Parliament and the public."

Commons Health Select Committee (2011)

In 2013 Stephen Dorrell, Chair of the Health Select Committee, stated:

"The CQC's primary focus should be to ensure that the public has confidence that its inspections provide an assurance of acceptable standards in care and patient safety. We do not believe that the CQC has yet succeeded in this objective."

Commons Health Select Committee (2013)

In 2015 Meg Hillier, Chair of the Public Accounts Committee, observed that:

"…six years after being set up the Care Quality Commission is still not fully effective. There's too often a long gap between inspections and reports being published - and sometimes an alarming lack of attention to detail when reports are being prepared."

Commons Public Accounts Select Committee (2015)

If we continue as we are, there are a number of probable consequences:

- recruitment of poorly qualified staff
- negative consequences of understaffing
- high staff turnover
- poor supervision
- a poor quality of life in receipt of care
- the continuing inadequacy of CQC inspection regime
- a rise in involvement by global organisations – Atos, Capita, G4S and Serco
- a remorseless drift back to different forms of institutionalised provision.

A compelling case can be made for the reversal of the merger of health and social services so that social care can retain its distinctive professional identity and voice.

2. The integration smokescreen

In 2013 ministers were told that they must go further with their overhaul of social care in England by merging its budget with the NHS (Triggle, 2013a). It was proposed that the government pilots would commence in September 2013 with the aim of fostering greater integration between the NHS and social care on issues such as assessments and hospital discharge. According to Ham (2014) the momentum behind integrated care, generated by the work of the NHS Future Forum and Norman Lamb's appointment as care and support minister, increased in 2013. Ham singles out a number of areas that were intended to take forward integrated care; the establishment of the "better care fund" which would require all areas to develop plans to integrate health and social care; and changes to the GP contract which were designed to reinforce the role of GPs in coordinating care for older patients.

Whilst Ham welcomed these developments, he noted that there were many barriers still standing in the way of translating policy aspirations into practice. While some of these could only be tackled at a local level, others required changes in government policy if integrated care was to move forward at the scale and pace demanded by current financial and service pressures. The most important changes identified by Ham were:

- ensuring that provider regulation did not get in the way of partnership working
- ensuring that quality regulation was not overly focused on organisational performance
- developing payment systems that create incentives to integrate care
- supporting commissioners to promote greater integration.

Monitor and the NHS Trust Development Authority would play an essential role in ensuring that providers were well led and financially sustainable. The challenge in carrying out this role was to ensure that the regulators did not make partnership working harder to achieve by requiring providers to strengthen their balance sheets at the expense of the other NHS organisations they worked with.

The King's Fund's work with NHS organisations at a local level indicated that this was already happening in some places. If it became more widespread there was a risk that providers would, quite rationally, concentrate on their own survival to keep the regulators at bay. This would make it difficult for providers to collaborate with commissioners and other providers to achieve closer integration of care in what could descend into a zero-sum game (Ham, 2014).

Developments in quality regulation present another set of challenges. Under its new leadership, the Care Quality Commission had been moving to strengthen inspection with an initial focus on hospitals, general practice and social care. In so doing, the CQC was putting the emphasis on assessing organisational performance rather than system

performance, partly in response to well publicised concerns about quality failures in hospitals, care homes and general practices. Whilst this was understandable it risked downplaying the need to regulate how organisations worked together to meet the needs of people whose care depended on different parts of the system being joined up. The actions of the CQC could, according to Ham, unintentionally force organisations to focus on their own performance, thereby giving less attention to how they could work in partnership to deliver high quality and well coordinated care.

In Ham's opinion, commissioners have a key role in promoting greater integration but this has become much more difficult since the population based budgets which are controlled by primary care trusts have been fragmented between clinical commissioning groups, NHS England and local authorities. If integrated service provision is to become a reality then ways have to be found to reintegrate commissioning responsibilities and budgets. Health and Wellbeing Boards have a part to play here but they remain in an early stage of development and much remains to be done to strengthen their role (Ham, 2014).

All of these issues are being played out when financial and service pressures are growing by the day. Alongside action by ministers to remove barriers to progress, priority should be given to the development of collaborative, system-wide leadership without which there is a clear and present danger that organisations will adopt a fortress mentality to cope with these pressures. Ham (2014) concludes by observing that a coherent and consistent policy framework is needed to support the undoubted commitment in the NHS, local government and the third sector to build on the foundations that have been established. In the absence of such a framework, Ham believes that policy aspirations would remain unfulfilled and patients and users would be the losers.

But it can be argued that the kind of arguments advanced by the King's Fund Centre ignore a key fact, which is that the NHS no longer exists, for NHS contracts are now open to unlimited privatisation (El-Gingihy, 2015). In 2014, out of £9.63 billion worth of NHS deals signed, £3.54 billion (nearly 40% of them) went to private firms. In other words, private providers are cherry-picking lucrative services to boost their profits leaving the NHS with less money to provide comprehensive care which neatly ties in with the next aspect of the legislation.

Clinical commissioning groups (CCGs) are now only legally obliged to provide emergency care and ambulances. Beyond this, the CCGs can provide services as they deem to be appropriate. This translates into unlimited rationing. According to El-Gingihy we already have had £15 billion to £20 billion of what have been termed 'efficiency savings'. Whilst Simon Stevens' *Five Year Forward View* asked the government for an extra £8 billion each year a further £22 billion in efficiency savings was expected. The NHS has never undergone such a funding squeeze since its inception and yet we spend significantly less on the NHS than the EU average and well below France, Germany and the Netherlands. Out of the G7, only Italy has the same level of spending.

The Health Act also severs the government's responsibility for the NHS devolving it to a series of bodies. In the opinion of El-Gingihy, devolving health and social care spending to regional control is tantamount to dismantling the NHS under the guise of localism. There is now nothing to stop the CCGs breaking away completely whilst commissioning support units (CSU) are to be spun off and privatised. This means that global conglomerates like UnitedHealth and Serco will be in the running to take over these crucially important bodies.

The merging of health and social care also raises the prospect of healthcare becoming more like social care – means-tested. The rolling out of personal health budgets will be extended to 5 million complex patients by 2018 and is likely to lead to top-up payments (i.e. co-payments and therefore private health insurance). Integrated care, transferring

specialist hospital care into the community, will mean a massive programme of hospital closures. There are 66 hospitals up and down the country facing closures of some kind. Tens of hospitals are running into deficits with Private Finance Initiative (PFI) debts as a major factor combined with cuts to hospital tariffs.

Meanwhile, it has been argued that general practice is imploding – 656 surgeries have been merged, taken over or closed completely since 2010 largely due to chronic under-funding and under-investment. Smaller GP practices will close or be forced to merge into federated organisations – a corporate model. This will be the likely precursor to privatisation of general practice with buy-outs and take-overs of these federated organisations. Whole swathes of out-of-hours care have already been outsourced and GP surgeries are being run by private companies. Virgin Assura claims to look after some 3 million patients in their network of 30 surgeries.

So how, ask El-Gingihy (2015) will this brave, new world look? The 21st-century health service in England will have CCGs (supported by privatised CSUs) acting as insurance pools. They will commission care increasingly from private providers with the NHS budget translating into a funding stream. In effect, the NHS will become a state insurer along the lines of Medicare in the US. Meanwhile, more patients will have personal health budgets, supplemented by insurance in the future, thus making them self-paying consumers in a market-based system. It has been concluded that the Health Act is a one-way road leading to charging and universal private health insurance.

Should we be surprised? Back in the 1980s, Conservative MPs Oliver Letwin and John Redwood set out their vision in a think-tank paper with the ultimate aim of introducing universal private health insurance. The policies of the past 30 years have adhered to this vision with remarkable fidelity. The revolving door spins smoothly between the lucrative pastures of private healthcare and the Department of Health and top tiers of NHS management – to give one salient example, NHS chief executive Simon Stevens' last job was as a UnitedHealth executive. Jeremy Hunt is officially on record as saying that the NHS should be privatised. Back in 2005, Hunt co-authored a book called Direct Democracy, which called for the NHS to be dismantled. David Cameron's health adviser Nick Seddon, formerly of private healthcare company Circle, suggests that CCGs should be merged with private insurance companies and those who can afford to should contribute to their healthcare. David Cameron states that he wants to turn the NHS into a fantastic business. Whilst he vowed that he would never privatise the NHS because it had looked after his family, his government set about doing exactly that.

Outsourcing in the NHS in England has increased substantially over the past 15 years as both Labour and Tory led governments pursued policies of divesting frontline care and non-medical support services to external suppliers. Department of Health figures show that the proportion of the overall NHS budget spent on private healthcare providers increased from 2.8% in 2006-07 to 6.1% in 2013-14 (Giacobucci, 2015).

As this report is written it has been announced that Britain's second largest construction company and state contractor – Carillion – has gone into liquidation (Jenkins, 2018). As a consequence accountants now have to reallocate to other firms the billions of pounds in contracts for prisons, schools, hospitals, railways and military bases. In the opinion of Jenkins this company's demise is attributable to favouritism, cost escalation, excessive risk, obscene remuneration and reckless indebtedness. Carillion's failure also demonstrates the rampant indiscipline in the contracts themselves. There is clearly a need to undertake an urgent review of how privatisation is working. However it should be noted that companies like Carillion are not true private entities as they depend on the state, and the state depends on them. Over recent years Carillion has swallowed up nearly all its main competitors. No attempt has been by governments of different political

persuasion to intervene even though it was obvious that the choice of contractors was becoming increasingly restricted. Or put another way, past governments and the present government have been complicit in this process.

A further problem is that the lobbyists for these businesses develop an 'unholy' relationship with ministers and officials. Two years ago the Parliamentary Advisory Committee on Business Appointments drew attention to the record number of former ministers seeking permission to take jobs in sectors that they used to regulate. The government of David Cameron was singled out for failing to give this Committee powers to stop exploitation of the "revolving door" between Whitehall and big business. More than 25 former government ministers were being paid thousands of pounds a day working as directors, advisers and chairs since leaving their posts in government. The Committee called for new powers that would allow the criminal pursuit of those who deliberately ignored the committee's instructions (Syal, 2016).

The integration of health and social care is a smokescreen. While it has been a long-term policy since the 1960s there seems to be no prospect it will be realised, because these are fundamentally different kinds of service. Focusing on integration is merely a way of avoiding the more important challenges that confront health and social care - from inadequate funding and poor governance through to deeper misunderstandings of purpose and community capacity. The first step in reforming social care must be to stop trying to integrate it with healthcare.

3. Real reform of social care

Instead of repeating the same failed integration strategy this report supports Crawford and Read's contention that power should be devolved to the lowest appropriate level and that public services and neighbourhoods should be governed and shaped from the 'bottom up' by families and the communities. It also strongly supports the case, not only for moving away from a top-down approach to service delivery, but that such activity should be driven by a holistic vision.

To realise this new vision of an organic and shared society, it will be necessary to counter head on what this writer sees as powerful processes working against the realisation of that vision:

1. **Depersonalisation** - the action of divesting individuals of their human characteristics or individuality (e.g. through the misapplication of assistive technology)
2. **Marketisation** - the exposure of an industry or service to market forces where precedence is accorded to financial and not human benefits (e.g. the prevalent notion of the 'care industry')
3. **Centralisation** - the concentration of control of an activity or organisation within a single authority (e.g. Department of Health)
4. **Commodification** - the action or process which treats an individual as a mere commodity (e.g. the development of care 'packages')
5. **Deprofessionalisation** - the reduction in workers' professional discretion and autonomy so that they are limited in their capacity to act in the best interests of their client (e.g. the current culture of management and regulation for social workers and social care workers)
6. **Academicisation** - where an undue emphasis is placed on the acquisition of formal academic qualifications at the expense of developing an individual's personal, social and cultural aptitudes and skills; the corollary being the attachment of low status to the development of vocational and social skills
7. **Politicisation** - where a policy, procedure or practice has become politicised (e.g. the uncritical adoption of an ideology)
8. **Bureaucratisation** - where systems are governed by unnecessarily complicated administrative procedures (e.g. where protocols and procedures take precedence over human-to-human exchange)

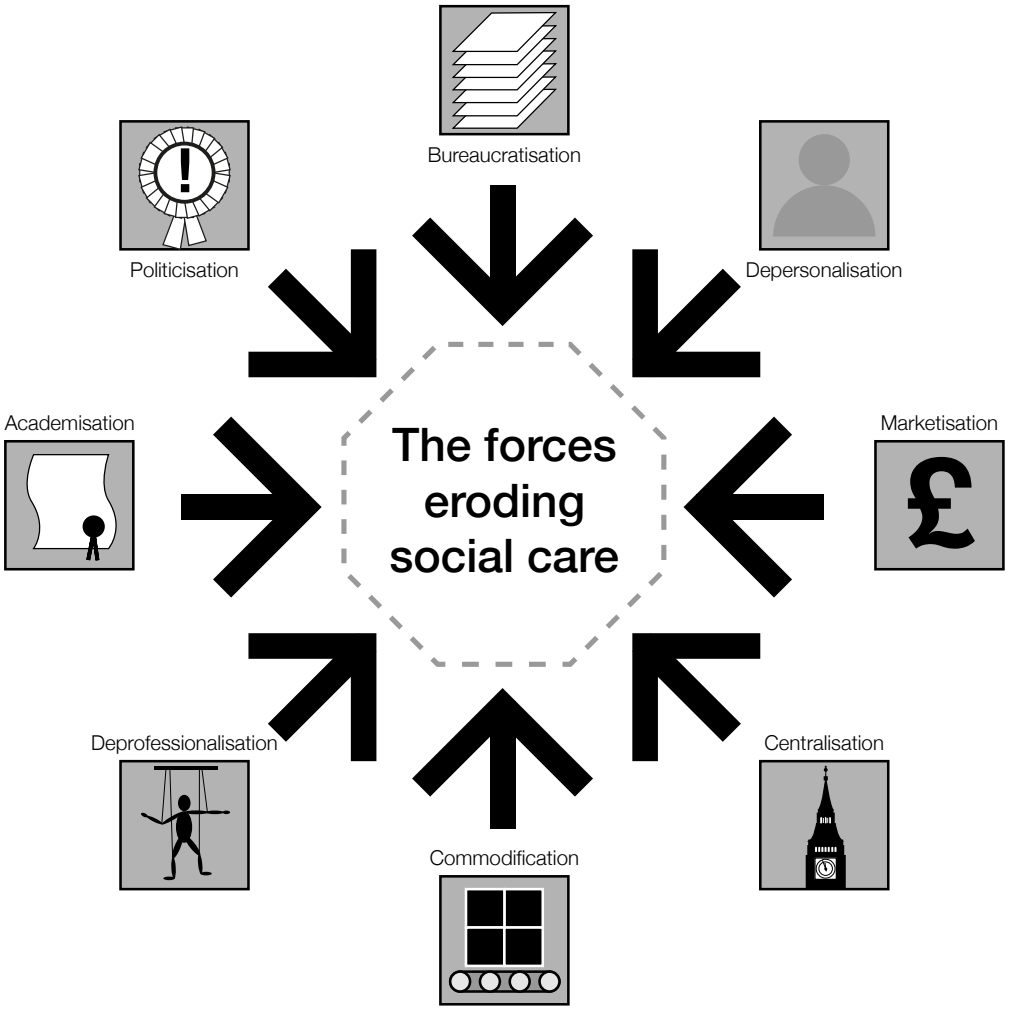

FIGURE 1. **The forces eroding social care**

These processes have not only to be challenged but be replaced by different policy priorities and organisational structures. It is time that the dominant mantra driving the Brexit bandwagon – 'taking back control' – was applied to the delivery of social care services so that they are more localised and meet more closely the needs of local communities:

1. **Personalise** - emphasis is given to the importance of meeting the needs of the individual
2. **Nationalise** - the allocation of essential social services precludes the inclusion of private companies operating on a for-profit basis
3. **Localise** - the determination of social care policy is undertaken at a regional or local level
4. **Humanise** - those receiving social care are treated as individuals worthy of respect and not as objects to be processed
5. **Teach** - more training time is spent working alongside skilled and experienced professionals and less time as passive recipients of knowledge much of it of tangential value and relevance

6. **Learn** - where a greater emphasis is placed on the personal, social, creative and holistic aspects of education with less emphasis on the acquisition of qualifications of limited vocational value and relevance
7. **Reflect** - where the formulation of social care policy is based on reliable evidence and not on the uncritical acceptance of a particular ideological position
8. **Balance** - where effective checks are put in place to restrict or prevent over-regulation, procedures and excessive documentation.

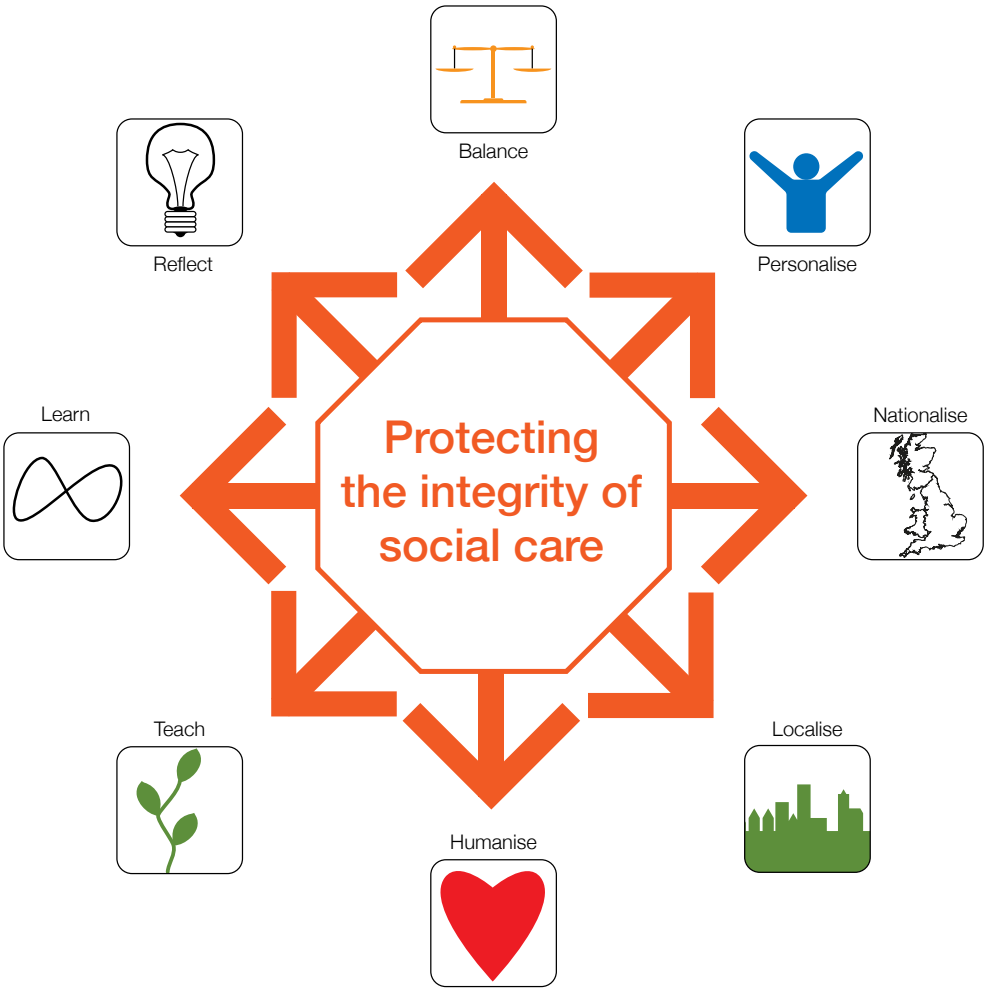

FIGURE 2. **Protecting the integrity of social care**

In the following suggestions I build from these principles and make some practical policy suggestions which I think offer us a way forward. At the heart of these proposals is the central proposition that social care is an essential pillar of the welfare state. Clearly it has links to all the others (healthcare, housing, income security and education) but it is not helpful to treat it as if it were merely an add-on to any of those systems. Social care has its own meaning and integrity. Getting social care right depends on understanding and supporting the integrity of social care, not making it subservient to other priorities.

3.1 Department of Social Care (DSC)

In order to prevent a collapse of the health and social care system, this report advocates the creation of a single government department responsible for:

- creating national policies and legislation relating to social care
- providing the long-term vision and ambition to meet current and future challenges
- putting social care at the heart of government
- being a global leader in social care policy and practice
- supporting the integrity of the system by providing funding, assuring the delivery and continuity of services
- accounting to Parliament in a way that represents the best interests of the individual, public and taxpayer
- encouraging innovation and improvement by supporting research and technology
- instilling a culture that values compassion, dignity and the highest quality of social care
- introducing and monitoring a one-year compulsory national community service
- encouraging staff in social care settings to understand and learn from people's experience of social care.

Whilst the Department would establish the principles and guidelines for social care, the operation of the system would be devolved to regional councils in a system comparable to that in present-day Sweden and which existed in the UK before 1974. The intention of the organisational reform in 1974 was to reduce the amount of money spent on public services and to ensure increased efficiency, neither of which aims was achieved.

3.2 Funding of social care

The Health Foundation has indicated that pressures on publicly funded adult social care are projected to rise by an average of 4.3% a year, using modelling by the London School of Economics (Hancock, Wittenberg, Hu et al, 2013). It is assumed that between 2015/16 and 2019/20, social care funding may rise by an average of 1.6% a year, based on projections for England including funding from the new council tax precept and additional investment through the *Better Care Fund*. Between 2019/20 and 2030/31 it is assumed that funding will rise in line with projected growth in GDP. Under these assumptions, there would be a funding gap of £9.2 billion for adult social care in the UK in 2030/31, worth 40% of the projected budget.

The establishment of such a department can only happen if sufficient financial resources are made available. There are a number of options:

1. Increase income tax
2. Create a tiered levy on high executive pay
3. Create a separate category for social care in the National Lottery

For instance, there is no reason why we could not increase income tax in some discriminating manner (as they have in Scandinavia) or introduce a new health and social care tax. It is evident that the United Kingdom is some way behind the overwhelming majority of Western European countries in the amount allocated to social expenditure. Further, according to Eurostat the UK is the only rich EU country to cut welfare spending as a proportion of GDP between 2011 and 2014 (Eurostat, 2016).

In order to meet the continuing and growing shortfall in funding for health and social care Dr Dan Poulter, a former Minister in the Department of Health, has strongly argued for introducing a new health and care tax in order to save the NHS and the social care system from collapse. In his opinion one of the simplest ways of raising such a tax would be by raising national insurance (Helm 2016).

However an alternative approach could be to dedicate the revenue from a specific tax for a particular purpose. We are talking here of a hypothecated tax where the revenues from the tax go only to financing the particular service and that service being financed only through the revenues from this tax.

Four main arguments in support of hypothecation have been advanced by Keable-Elliott:

1. **transparency** – hypothecated taxation makes the link between revenues from taxes and government spending more visible
2. **accountability and trust** – hypothecated taxes may help when the government is not trusted. With hypothecation, it will have to follow a plan made in advance and will have no flexibility
3. **public support** – the knowledge that the money paid on taxes will go directly to some needed service (social care) can help to reduce the dissatisfaction of the population with an increase in taxes
4. **protecting resources** – earmarking can protect resources for financing the services such as social care from being spent on something else (Keable-Elliott, 2014).

If taxpayers are aware that a dedicated amount is set aside for the funding of a particular service then there is a high probability that they would be supportive of such a measure. It would also be incumbent upon the government to demonstrate that the hypothecated tax was being used for the purposes agreed.

It is relevant here to make reference to the National Disability Insurance Scheme (NDIS) which has been recently introduced in Australia: a scheme not uninfluenced by the personalised support movement in the UK (Fitzpatrick, 2010). In Cummins' opinion the NDIS is possibly the most important social reform in recent Australian history. It is based on the principle of rights to personal choice and control, as opposed to the traditional Australian paternalistic welfare model that has dominated the delivery of disability services. It is particularly remarkable for the fact that all political parties agreed to fund it (Cummins, 2016).

The NDIS was legislated for in 2014 (National Disability Insurance Scheme Act 2013, 2014) and requires the National Disability Insurance Agency (NDIA) to provide support and assistance to eligible participants. It creates a uniform system of disability services across Australia "based on individual aspiration and choice". The Act has the twin objectives of:

1. supporting the independence and social and economic participation of people with disability; and
2. enabling people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports. Crucially, NDIS payments are not made to organisations but directly to either the participant, or to a person who is managing their funding.

The most outstanding feature of NDIS, according to Cummins, is that it has normalised disability (Cummins, 2016). Because funding is linked to a universal tax, all Australians directly contribute to this form of insurance. Thus, the NDIS has created a shared conceptual space, where drawing on the NDIS resource is as socially acceptable as claiming on any other form of personal insurance. Funding for disability does not diminish public moneys for other purposes. Neither can the need to fund for other purposes diminish funding for the NDIS.

Cummins makes the further point that the NDIS cleverly avoided the pitfall created by the philosophy that demands complete societal integration to meet the standard of normalisation. Instead of 'integration', the NDIS legislation and documentation aims for 'inclusion'. This may be defined as 'the belief that all people should feel that they are included in society, even if they lack some advantages'.

It is important to highlight here the influence of Dr Simon Duffy, pioneer of personalised support in the UK, on the final shape of the NDIS. In a report that he wrote with Robbi Williams, the authors stated that the purpose of the NDIS is to advance people's life chances in line with their human rights and with the goal in mind of citizenhood (Duffy and Williams, 2012). This is not simply a matter of transferring the necessary resources to the control of the individual but it is also about treating people living with disability and their families as citizens at every stage of the process. In their opinion the NDIS needs to establish two things: firstly, have a clear notion of what it means to be a citizen; and, secondly work closely with people living with disability and their families to ensure that the process feels respectful, effective and enabling at every stage. It would seem, according to Cummins' most recent assessment, that these goals have been achieved.

Another option is to impose a tiered levy on high executive pay. It has been estimated that executive pay has climbed by a third alongside the stock market since 2010 and that in a period in which average wages have essentially stagnated. Consideration should be given to charging companies a levy of 2.5% on employees who are paid above £300,000 annually. This could be a tiered levy which rises to 5% for those who are paid £500,000 or over. This proposal has to be set in the context of findings from the think-tank The Resolution Foundation that around 1% of adults, some 488,000 people, own 14% of the nation's assets - worth about £11 trillion. At the other end of the financial scale, 15% (7.3 million people) either own no assets at all, or are in debt.

A third option would be to create a separate category for social care in the National Lottery. Given the crucial importance of social care in our national life, it does not seem unreasonable to suggest that social care be made a separate and distinct beneficiary.

NATIONAL LOTTERY BENEFICIARIES: 2017	
In the year ending 31 March 2017, the funds were shared as follows:	
Health, education, environment & charitable causes	40%
Sport	20%
Arts	20%
Heritage	20%
Recommended new allocation:	
Health, education, environment & charitable causes	35%
Social care	20%
Sport	15%
Arts	15%
Heritage	15%

TABLE 1. **National Lottery beneficiaries**

3.3 Social Care Research Council

A case can be made for establishing a Social Care Research Council analogous to the Medical Research Council which would be a publicly funded government agency responsible for coordinating and funding social care research in England. It would be answerable to, although politically independent from, the Department of Social Care. [The Medical Research Council is answerable to the Department for Business, Innovation and Skills.] The SCRC would have a small number of research units based in those universities possessing a proven record of innovative work in the field of social care; particularly in pioneering experimental and demonstration projects.

3.4 Social Care Training Council

The last two decades have witnessed a succession of major crises in social care which has produced a seemingly endless series of enquiries and reports indicating profound concern about the working of this sector (Wagner, 1988; Utting, 1991; Waterhouse, 2000). One area of concern identified in all these reports has been the quality and appropriateness of the training for those working in the child care sector. For example, the Warner Report recommended that urgent consideration be given to looking at the European experience of training social pedagogues and social educators (Warner, 1992). In Denmark, Germany and the Netherlands, the main requirement for people working in residential child care is a qualification in social pedagogy.

Social pedagogy is not narrowly concerned with just schooling but relates to the whole child and young person: body, mind, feelings, spirit, creativity and, crucially, the relationship of the individual to others. It has more in common with parenting than with social work or social care, as social pedagogues working in residential settings share all aspects of the children's everyday lives. Petrie et al. (2002) have argued that framing work in terms of pedagogy has the potential for creating a more inclusive and normalising

approach, while recognising that some children and young people have special and additional needs. According to Petrie et al. (2002), this emphasis on relationships and living alongside children and young people, expanding their world through creative activities and providing positive role models, has much to commend it.

What is noteworthy here is the contention that services for children and young people which adopt a social pedagogic model provide a more inclusive and normal setting – one in which the individual needs of the children and young people are likely to be better met. Particularly important here is the transformation in the nature of the relationship between the social care worker and child and young person from client-ship to friendship.

The Social Education Trust (2001) acknowledged that while the adoption of social pedagogy would not offer a panacea, it has the potential of offering a number of significant strengths:

- services would be provided which better fitted the needs of individual children and young people rather than the current situation where too often children and young people had to fit the needs of services.
- by taking a holistic view of the child and young person and the way in which all parts of the their lives come together, there would not be the narrow negative focus on client pathology.
- those working directly with children and young people as social pedagogues would be provided with a professional image and identity which would give them a sense of pride, self-worth and confidence.
- the debate associated with the establishment of a new profession could have an impact on the wider community's thinking about parenting and work with children and young people.

However an acceptance of a social pedagogic approach would necessitate not only a radical transformation in the character of social care but also fundamental changes in the nature and purpose of professional training for those working in social care services. Whilst a strong case has been made for the adoption of the social pedagogic model for children and young people, there is no reason why that model cannot be applied to care professionals working in the adult sector. Workers in countries such as France, Holland and Germany are relatively well prepared vocationally for the care sector because these countries generally operate better training systems. There is a strong case for designing curricula, training courses and assessment methods in the light of the needs of particular occupations like social care. But where there is a centralised system, too much power and influence is given to the government responsible for the training.

3.5 Social Care Inspectorate

With the introduction of a Department of Social Care, a new regulatory and inspection body would be needed - Social Care Inspectorate - to replace the malfunctioning Care Quality Commission:

- to register social care providers
- to monitor, inspect and rate services
- to take action to protect people who use services

- to speak with an independent voice
- to publish its views on major quality issues in social care
- to point to areas that merit research.

Burton (2017), a former CQC inspector, has argued that the regulation and inspection of social care in England at the present time has been doing more harm than good. In his judgment the CQC is not effective or responsive; it does not understand how social care works; it rarely uncovers neglect and abuse, and it responds too slowly when problems are brought to its attention; its judgments are flawed and its ratings inaccurate and unhelpful; its inspections reports are poorly written and constructed, it costs much more than it should and imposes vast unnecessary costs on social care providers; it dominates and distorts the whole social care sector; and the organisation is itself blinkered, risk averse, top-heavy and hopelessly bureaucratic.

Burton contends that since social care is a local service, with care homes and care at home provided and organised for neighbourhoods, inspection should also be organised locally and inspectors should be responsive, responsible and accountable to local communities. He believes that this would be more effective; it would give the public direct access to and relationship with the inspector of their care; it would free users, teams and manager to collaborate in creating their sort of care together, and it would cost less.

3.6 Social Care Enterprise Agency

The purpose of this agency would be to:

- evaluate new patterns of day and residential care provision
- examine patterns of day and residential care provision in other countries
- work in conjunction with the Social Care Research Council and, where appropriate, part or wholly fund experimental projects (e.g. centres for inclusive living)

It could derive its funding from the levy on high executive pay and an allocation from the National Lottery.

3.7 Compulsory National Community Service

An idea that perhaps merits attention is the introduction of a one-year compulsory national community service for 17 to 20 year-olds which can be served either as one complete calendar year or two 6-month periods: the service to be undertaken in either the UK or overseas. This is not a new idea. David Cameron, when Prime Minister, called for every teenager in the country to undertake national service in the community, pledging an all-out effort to mend Britain's "broken society" (Brown, 2005). Gordon Brown, too, called for a million young people to get involved in voluntary work, when he launched the "Year of the Volunteer" in 2005. He hinted that the government was giving consideration to the establishment of a model not dissimilar to that of the American *Peace Corps* (Brown, 2005).

What is not being argued for here is the establishment of a volunteer force, for volunteering is about free choice. A national community service would be quite different although it might involve some choice, over timing and the type of work and training

undertaken. There should be very few exemptions. Within such a scheme, there should be an element of choice within the compulsory framework, a recognition that people have different skills, interests and abilities, and also may have existing obligations – looking after family members, for example (Williams, 2011).

Williams has pointed out that compulsion should not be viewed negatively. As a member of society we have to pay our taxes, and children must be in full time education to the age of 16. Supporters of such a scheme argue that young people not only need boundaries but often desire some sort of order and structure to their lives. One of the troubles of a certain type of liberal thinking current in recent years is that setting limits is somehow wrong, that we interfere with the "rights" of the individual, and that we must be "non-judgmental". This path has led us to a position where young people have set their own boundaries, often far away from what is 'acceptable behaviour', and the notion of respect.

It has been argued that too many on the political Left have failed to understand what civil society actually means and requires (Williams, 2011). Learning that with rights go responsibilities is a fundamental reason to introduce a compulsory national community service. This is part of the positive basis for the introduction of such a scheme. Increasing political concern with citizenship and community involvement should be good enough reasons for introducing a scheme in its own right. The notion of 'rights and responsibilities' is a more positive concept than that of simple 'duty.' Opportunities for training, gaining practical qualifications and chances to travel either in the UK or abroad more than justify an obligation to 'serve' the community, which is, or should be, a good thing.

There is also an equally urgent, though more 'negative' rationale for this discussion which is the increasing divisions in society between the included and the excluded and between different ethnic groups. There are no longer any common reference points between more privileged young people and those who are more disadvantaged. National community service should be seen as a common rite of passage which is shared by all young people. But such rites of passage no longer exist. As President Kennedy might have said but didn't:

> *"Think not what your community can do for you, but what you can do for your community."*
>
> Williams (2011)

A bill to reinstate compulsory national service for 18 to 26 year olds was proposed in 2013 by Philip Hollobone MP, who was convinced that some form of service for youngsters, be it in charitable work, care for the elderly, work linked to the NHS or participation in the armed forces, would help instil a greater sense of "self-respect, personal reliance, discipline and behaviour" into society (Denham, 2013). The scope of such a scheme would include "instruction in personal financial budgeting, household bills, nutrition, cooking, time-keeping, life skills, tolerance towards others, treating elderly and disabled people with dignity and respect." However the Bill failed to complete its passage through Parliament.

Whilst this writer would not put the introduction of compulsory national service near to the top of a list of priorities, it perhaps merits consideration. However one must wonder at the motivation of some of those – like Philip Hollobone – who proposed the Bill in 2013. The rather negative view of young people and their role in society that appears to have been held by Hollobone is not one this writer shares.

4. Creating community

So far we've considered the fate of social care within the context of our current social structures and norms. However there are good reasons to think more deeply about the kind of society we want to develop in the future.

If we are to explore new patterns of social care, it is important to understand the implications of some of the profound changes that are taking place in our society. Robert Peston, for example, has challenged the conventional view that technology always makes us better off. During the first 300 years of industrialisation, in what are normally regarded as the three industrial revolutions – the steam age at the turn of the late 18th and early 19th centuries, mass industrialisation of a century later and the information technology era of the late 20th century – were all technological shifts that altered the nature of work and eventually ended up making most of us richer (Peston, 2017). But for how much longer can that continue? Are we now in a fourth industrial revolution that is somehow fundamentally different from the previous ones? Is this the one in which the machines – in the form of robots and artificial intelligence really do get the upper hand forever? Peston cites Stephen Hawking's observation that the automation of factories has already decimated jobs in traditional manufacturing and that the rise of artificial intelligence is likely to extend this job destruction deep into the middle classes, with only the most caring, creative or supervisory roles remaining (Hawking, 2016).

According to a Bank of England forecast, 15 million British jobs are at risk of automation. To put that in context – that would mean 47% of all those currently in work in the UK could see themselves made redundant (Haldane, 2015). Peston makes the point that we need to go into this fourth industrial revolution aware of the risks it brings of social strife and also that it presents us with urgent choices. For example, our schools are teaching the wrong things, they are creating a generation of young workers vulnerable to being made irrelevant and unnecessary by the machines. Mathematics, reading and writing are vital for living but not so much for earning a decent living, because machines can already do all basic information management and processing much faster and more accurately than us.

Peston highlights what machines cannot do – and quite possibly never will be able to do – is to negotiate, build relationships, instil confidence, win trust, create great art, write moral philosophy, dream, or any of the other emotional and intuitive activities that are central both to highly paid careers and the sheer joy of being alive. With schools ordered by government to become 'sausage factories' churning out students with the best exam grades, little time is given to helping young people become more creative, better communicators or adept empathisers. Recent reforms which return to emphasising exam prowess and away from project work makes no sense because it disproportionately rewards ability to memorise and meet deadlines and inadequately promotes initiative and team working.

Up to this point this report has focused on changes that the government of the day could introduce that have the potential to improve the quality of social care. However, if the predictions made by Peston and Hawking are realised then in the not too distant future profound changes are likely to occur:

- a declining role for centralised government
- a growing decentralisation of the processes of policy making and service delivery
- increasing irrelevance of much of the content of secondary and tertiary education demanding profound changes in curricula
- eventual disappearance of most clerical and service occupations
- a decline in the role and influence of the major political parties
- the emergence of new political movements promoting radical social change
- growing pressures to equalise wealth distribution
- a diminution in the role of the large conurbations leading to a process of accelerating deurbanisation
- the development of ecovillages in urban and rural settings emphasising economic sustainability and ecological sensitivity
- the growth of self-help enterprises and co-operatives.

Richard and David Susskind (2015) have pointed to the fact that knowledge and expertise is no longer the privileged and exclusive domain of any one profession. They are not arguing that the professions will disappear but rather that their character and function will undergo a profound transformation. One implication flowing from this analysis is the future character and shape of professional training. It could be argued that the current lengthy and highly expensive training offered for different professional groups could be significantly reduced given that much of what was previously privileged knowledge and know-how is now accessible and in the public domain. There is then a sense in which the growing accessibility and affordability of knowledge and expertise can be represented as a form of democratisation which hopefully may lead to the creation of a fairer and more open society. One potential benefit of the creation of such a society is the opportunity it affords to challenge ill-conceived policies and practices based on ideological beliefs lacking empirical support.

The Susskinds concede that they cannot predict with any certainty the impact of technology in the decades ahead given the exponential growth of different forms of artificial intelligence. Already there are machines that not only can think like human beings but, crucially, can outthink them! If one is not vigilant a society may be created which is no longer open and fair and where crucial decisions concerning the health, welfare and security of citizens are determined by algorithms - complex problem-solving formulae - and not human beings. At that point - what opportunities will citizens have to challenge such decisions?

In the opinion of Ford we are headed toward a transition that will put enormous stress on both economies and societies throughout the world (Ford, 2015). Beyond the potentially devastating impact of long-term unemployment and underemployment on individual lives and on the fabric of society, there will be a significant economic price. He predicts that the virtuous feedback loop between productivity, rising wages and increasing consumer spending will collapse. Indeed, that positive feedback effect is already seriously diminished: we now face soaring inequality not just in income but also in consumption.

Any discussion about creating a fairer society in which the needs of the disadvantaged are met has to be set against the impact of the kind of technological developments described by Ford. It is important to re-emphasise here that he is not just describing what may happen in a distant future but what is happening now. As we move into these uncharted waters, we have to face the fact that we do not possess the maps to help us

navigate a safe course. Pleading for greater investment by the government in health, social and education services at this time is not the answer. We need to think far more radically.

Because the political and social landscape is and will continue to undergo accelerating change, we need to come up with radical ideas for the creation of new structures and ways to redistribute scarce resources. If we wait – events will overtake us and we will end up with mass unemployment. Given the speed of technological advances that time may not be so far away. We need to act now.

It is worth recalling that over 40 years ago Alvin Toffler coined the term 'future shock'. He pointed to the fact that at the time of his writing society was undergoing enormous structural changes which were overwhelming people (Toffler, 1970). He attributed this to the accelerated rate of technological and social change which was leaving people disconnected and suffering from "shattering stress and disorientation". In short, they were suffering from future shock. He identified a number of features of this 'new' society:

- the increasing disposability of many goods as mass production has made them so cheap
- the design of goods quickly becoming outdated
- whole branches of industry dying off and new branches of industry arising
- people frequently changing their profession and workplace
- people becoming increasingly nomadic in order to follow transient jobs, and
- as a result of this transience relationships with most people tending to be superficial.

Toffler distinguished three important stages in the development of society and production: agrarian, industrial and post-industrial (or information era). What is interesting here is Toffler's description of the third stage where homes become the dominant institutions. Most people carry on their own production and consumption in their own homes or 'electronic cottages' where they produce more of their own products. Services and markets become less important for them. What Toffler is describing here is what is now happening at an accelerating pace in a growing number of countries.

What are some of the implications for the Western world in general and for the UK in particular of the forecasts made by the Susskinds and Ford? What is striking about their respective analyses is their conviction that profound changes are now in train that will directly and negatively affect our economy and society and for which we are wholly unprepared because of a refusal by successive governments to address such issues.

In the coming years there is likely to be a significant reduction in the amount that the state can spend on health, social care and education given the rapid contraction in the industrial and commercial sectors and the consequent loss in tax revenues. Declining personal income is likely to lead to increased pressure on individuals and families to seek ways either to supplement reduced incomes or to replace salaries or wages which are no longer available. In turn this may lead to the establishment of new enterprises which are locally based thus reducing commuting costs and thereby lowering atmospheric pollution caused through using private or public transport. There is already an increasing trend for people to work from their home and be directly linked via the internet to a central hub somewhere in the UK or abroad. Also significant increases in the cost of food and drink at out-of-town shopping malls may encourage the creation of local community horticultural projects supplying the immediate neighbourhood with affordable and fresh produce.

One consequence of these various trends may be a growing sense of identity with the locality in which the residents live and a greater willingness to engage in local community

activities whether of a recreational, social, commercial or political nature. At some point this growing sense of identification with the local community may encourage residents to conclude that it is their responsibility either to provide or to support different patterns of local and accessible social care – whether for young children, the elderly or people with a disability.

What is important here is that social care is not seen merely as a service or a commodity but rather as an effort to strengthen the fabric of community life. For the kind of changes identified by the Susskinds and Ford will put pressure on social networks to become less locality bound and less close knit. In the face of these changes, community recedes in its meaning to the individual and it declines as a significant means for the organisation of social life. A range of 19th century philosophers – including Comte, Marx and Durkheim – saw the demise of the community not simply as a matter of regret but a cause for concern, as community for them was the binding force that sustained the fabric of society without which it was destined to fragment, disintegrate and collapse. What is needed now is acceptance of the fact that when we talk about social care we are, in effect, talking about community care or care of and by the community.

One option that has the potential to offer key features of a supportive community is the ecovillage. No claim is being made that it is the answer to all the many challenges that are coming our way but it is an option that does merit our serious attention.

5. The ecovillage

One of the most significant developments in the next two decades is likely to be a growing interest in and development of ecovillages. Ecovillages are traditional or intentional communities whose goal is to become more socially, culturally, economically and ecologically sustainable. Populations can range from 50 to 150 individuals. Although some are smaller, traditional ecovillages are often much larger. The larger ecovillages often exist as networks of smaller subcommunities. Certain ecovillages have grown by the addition of individuals, families, or other small groups who are not necessarily members who settle on the periphery of the ecovillage and effectively participate in the ecovillage community.

PILOT ECOVILLAGE PROJECT. **Architectural drawing of Almere, Amsterdam © EFFEKT Architects**

Ecovillagers are usually united by shared ecological, social-economic and cultural-spiritual values. They are opposed to what they see as ecologically destructive electrical, water, transportation and waste-treatment systems and to the larger social systems that mirror and support them. Many see the breakdown of traditional forms of community, wasteful consumerist lifestyles, the destruction of natural habitat, urbanisation and over

reliance on fossil fuels as trends that must be changed in order to avert ecological disaster and create richer and more fulfilling ways of life.

In an earlier report – *Back to Bedlam* – attention was drawn to one type of ecovillage – the Camphill village community – which provides residential provision for people with a learning disability (Jackson, 2017). However, this is just one example of the wide range of ecovillages that are currently in existence. And to put the Camphill village community example in context, there are no more than half a dozen such communities in the whole of the UK. However, there are six qualities that can be found in Camphill village communities that are mirrored in many different types of ecovillage (Jackson, 2013):

- mutuality
- rhythmicity
- well-being
- tranquillity
- ecological sensitivity
- economic sustainability

In 1991, Robert Gilman set out a definition of an ecovillage that became standard for many years. An ecovillage is:

> *"…a human-scale full-featured settlement in which human activities are harmlessly integrated into the natural world in a way that is supportive of healthy human development, and can be successfully continued into the indefinite future."*

More recently Kosha Joubert, Executive Director of the Global Ecovillage Network, has defined an ecovillage as an:

> *"…intentional, traditional; rural or urban community that is consciously designed through locally owned, participatory processes in all four dimensions of sustainability (social, culture, ecology and economy) to regenerate their social and natural environments."*

Joubert and Dregger (2015)

In this view, ecovillages are seen as an ongoing process, rather than a particular outcome. They often start off with a focus on one of the four dimensions of sustainability, e.g. ecology, but evolve into holistic models for restoration. In this view, aiming for sustainability is not enough; it is vital to restore and regenerate the fabric of life and across all four dimensions of sustainability: social, environmental, economic and cultural. Dawson (2005), former president of the Global Ecovillage Network, describes what he sees as the five core ecovillage principles:

1. They are not government-sponsored projects but grassroots initiatives.
2. Their residents value and practice community living.
3. Their residents are not overly dependent on government, corporate or other centralised sources for water, food, shelter, power and other basic necessities; rather, they attempt to provide these resources themselves.

4. Their residents have a strong sense of shared values often characterised in spiritual terms.
5. They often serve as research and demonstration sites, offering educational experiences for others.

However, according to the Global Ecovillage Network it is also important to understand what ecovillages are not:

- An ecovillage is not a particular outcome, but an ongoing process. Each ecovillage is a living and learning centre for a regenerative future, a place of continuous exploration.
- Ecovillages are not designed by outside developers, architects or experts, but by communities themselves.
- Ecovillages do not focus solely on ecology, even though many ecovillages start with a strong focus on the ecological dimension. Preservation and restoration of nature can only succeed when the social fabric is strong, cultural heritage is celebrated and people find ways to marry their love for the planet with their need to make a living. Experience has shown that, given enough time, ecovillages will naturally develop to encompass all four dimensions of sustainability.

Creating ecovillages is not easy. Gilman (1991) has invited us to look at the six major challenges that are entailed by the ecovillage vision.

5.1 The bio-system challenge

To fulfil the ideal that the activities of the ecovillage be harmlessly integrated into the natural world requires that the ecovillage find ecologically friendly ways to:

- preserve natural habitats on the village land
- produce food, wood, and other bio-resources on site
- process the organic waste produced on site
- render harmless any initially toxic waste from the village
- recycle all solid waste from the village
- process liquid waste from the village
- avoid adverse environmental impacts off site from the production and delivery of any products brought in from off site
- avoid adverse environmental impacts off site from the use and disposal of any products.

5.2 The built-environment challenge

To fulfil the ideal that the activities of the ecovillage be harmlessly integrated into the natural world also requires that the ecovillage:

- build with ecologically friendly materials
- use renewable energy sources
- handle solid, liquid, and gaseous wastes from buildings in an ecologically friendly manner

- have a minimal need for motorised transport
- build in ways that have a minimal impact on the land and the local ecology

To fulfil the ideal that the ecovillage support healthy human development requires that the buildings in the community:

- have a good balance of public space and private space
- encourage community interaction
- support a full diversity of activities

5.3 The economic system challenge

To fulfil the ideal that the ecovillage support healthy human development and be full-featured requires that there be significant economic activity in the ecovillage. To fulfil the ideal of fairness and non-exploitation that is part of the sustainability principle requires that the economic activities of the members of an ecovillage do not depend on exploitation of other people and places, nor on exploitation of the future by the present. The implications of these goals are not as clear as, for example, the implication for the built-environment that energy sources should be renewable. Instead, we can identify some of the likely questions that an ecovillage will face concerning its economic system:

- what are sustainable economic activities, both in terms of what will sustain the members of the community and what is sustainable in ecological terms?
- what parts of the community should be held in common and what parts owned privately?
- more specifically, how should the ownership of land and buildings be handled?
- how can we be simultaneously economically and ecologically efficient, so as to reduce both expenses and environmental impact?
- what are the most appropriate forms of business organisation for ecovillage associated businesses?
- are there useful alternatives and/or supplements to the money economy for facilitating economic exchange within and between ecovillages?

5.4 The governance challenge

As with economics, the ideals of fairness and non-exploitation point ecovillages in a general direction, but do not provide clear guidance as to how these ideals are to be put into practice. Here again, however, we can identify some of the likely questions that an ecovillage will face concerning its governance:

- how will decisions be made, and which methods will be used for what types of decisions?
- how will conflicts be resolved?
- how will decisions by the community be enforced?
- what will be the roles for, and expectations of, leader-ship?
- how will the ecovillage relate to the government(s) in the surrounding community?

5.5 The 'glue' challenge

To deal with all these challenges the members of the ecovillage need something that holds them together, some basis of shared values and vision that can provide a 'glue'. Developing and maintaining this 'glue' is yet another level of challenge which will raise questions such as:

- What is the appropriate interplay of unity and diversity?
- What common values, behaviours, or practices will be expected in the group?
- What, if anything, is the group's shared vision?
- How shall the group discover, develop, and evolve that vision?
- How close shall the group be interpersonally?
- How is this closeness best developed?
- How will the group relate to others outside the group?

5.6 The whole-system challenge

There is an even deeper, and often unperceived, 'whole-system' challenge. Perhaps the biggest challenge faced by anyone attempting to create an ecovillage is that it requires change in so many different areas of life. All too often a community foundered if it attempted to, or felt forced to, work on all aspects of these changes simultaneously. Almost all of these changes take longer than expected and are often more costly than expected. In addition, each area of change interacts with the other areas in unpredictable ways. In the process, financial resources, emotional resources, and interpersonal relationships can be put under great stress. When attempts to create communities have failed, one of the reasons has almost always been that the group simply tried to do too much too fast relative to the resources they had available.

The whole-system challenge is to get an honest sense of the scope of the undertaking and then develop an approach that allows the community to develop at a sustainable pace. In other words, sustainability is not just a characteristic of the 'completed' community; it needs to be part of the thinking and the habits of the group from the very beginning.

Building a successful ecovillage requires a balance of activities among three major phases:

1. research and design
2. creation and implementation
3. maintenance – for each of the challenge areas.

Given these challenges, it should be no surprise that as far as the Global Ecovillage Network has been able to discover, there are as yet no communities that fully express the ecovillage ideal. The good news is that there are many communities and other groups that have made considerable progress on every one of these challenges. There are even some communities that could, within a few years, be considered full ecovillages (Global Ecovillage Network, 2018).

The illustration on the front cover of this report is of an ecovillage in Amsterdam built by ReGen Villages, a Californian-based development company. It is an off-grid development of 100 homes which seek to be almost completely self-sufficient. Each 25-home cluster encircles several food production facilities for growing organic produce

and raising chicken and fish, using advanced agricultural technologies that require less land, like aquaponics and vertical farms.

Vertical farming is where plants and produce are grown in a vertical orientation, maximizing the use of a location's square footage. Most often this is achieved through the use of growing shelves suspended on a wall or fence. Because vertical farming uses so little space, it is a popular and preferred method for roof-top and other urban forms of agriculture. The settlement in Amsterdam generates its own wind, solar and biogas power and manages its wastewater in a closed-loop system that also captures waste to be recycled as energy and fertilisers (Spanne, 2016).

5.7 The future

Attention has been drawn to the fact that ecovillages have been existence for over 40 years (von Lüpke, (2012). And in those four decades they have multiplied, changed and organised themselves internationally. But as von Lüpke points out, in the eyes of the public, they are still sometimes seen in the light of the old cliché: places for old, long-haired hippies who never really became adults and who lived a backward life – an outside society. This cliché may explain why mainstream social science has never taken the initiative to research the subculture because it seemed there was nothing new and relevant to find.

Von Lüpke, however, argues that ecovillages are "islands of the future" at a time of growing insecurity, crisis and collapse. To understand this argument it is necessary to take on board the fact the current process of disintegration does not represent a catastrophe but is a phase of cultural and societal change. However it is becoming more and more obvious that if no transition takes place in the coming years, there may soon be a grim future for some, if not all societies

Ecovillages have led the way in a number of critical areas. Firstly, ecovillages have adopted practical actions that reduce the size of the community's ecological footprint. Secondly, they have proven to be a low-tech developer for the rest of society with many technological innovations coming out of experimentation in ecovillages. Thirdly, through their high levels of internal communication, discussion, idea-sharing and consciousness-raising work, ecovillages have often proved to be in the avant-garde in leading value-based ecological life styles, demonstrating to the rest of society that a reduced use of resources and energy can be combined with an actual growth in quality of life. Most ecovillages focus on enhancing an individual's personal potential and see this as a precondition for collective transformation.

Von Lüpke concludes by observing that a different world cannot be built without new cultural, ethical and spiritual values. Further, these values have to be practised. As long as new experiments are conducted in the realm of old paradigms, they cannot go beyond the threshold of conventional thinking. If they do not go beyond this threshold, all experiments will, sooner or later, be consumed by the old system. Only when the values and worldviews of an old, failing system are understood and also transformed can a new world, community, and society be built.

6. Conclusion

Unless major reforms of the kind touched on in this report are implemented, then there is a high probability that systems providing social care in England will collapse. The consequences of that for the social fabric of the country will be devastating. For a society already characterised by increasingly sharp social divisions and the loss of an effective social care system to support the disadvantaged could prompt civil unrest and disorder.

The problem has been that successive governments of all political persuasions have misguidedly placed their faith in solving problems by attempting macro-solutions – none of which have worked. If a genuinely caring society is to be created then we need to seek micro-solutions which foster localism and community endeavour and enable people truly 'take back control' of their lives. If no appropriate action is taken then there is a strong probability that an Americanised health and social care system will emerge which fails the overwhelming majority of the population but has minimal impact on the moneyed few.

A recent example of a macro-solution is the proposal by Jeremy Hunt – the Minister for Health and Social Care (sic) to introduce Accountable Care Organisations (ACO) which would allow commercial companies to run health and social services across a whole region. However this proposal is now subject to a full judicial review. A particular concern here is that the ACOs could choose to either subcontract the service or provide it themselves. Critics claim that this would allow ACOs to control the allocation of NHS money but that their accountability for spending it and their obligations to the public would be under commercial contracts, not parliamentary statutes (Khan and Matthews-King, 2018). Such a development would possess many of the negative features of a macro-solution to which reference has already been made: marketisation, centralisation, commodification, politicisation, bureaucratisation.

It is accepted that the kind of ideas put forward in this report are very unlikely to be brought about by any of the major political parties. However, it is just possible that as a result of the continuing and conflicting pressures within the different political parties over Brexit, we may see the emergence of a new progressive alliance with a radical and strong community-oriented agenda!

Regardless of whether or not the government intervenes, economic, social, environmental and political pressures are going to force individuals and organisations to explore ways of adjusting to the rapid changes with which they are confronted. The changing character of work, the growing obligation to be more closely involved with one's immediate community, the need to develop more harmonious relations with one's immediate physical environment, the assumption by the individual of greater personal responsibility for one's actions; all these will require considerable readjustments.

One particular area where the individual will have to make the swiftest adjustment is the exponential acceleration in the development of artificial intelligence and robotics to a wide range of everyday personal, commercial and professional activities. The present

government and previous governments have shown little awareness of the consequences of ignoring these profound changes.

Two seemingly unrelated but nevertheless significant events occurred whilst this report was written. Firstly, Carillion – Britain's second biggest construction company and state contractor – has gone into liquidation. It is to be hoped that this will lead the government to think again about the consequences of its growing reliance on such organisations and the monopolistic powers they come to assume. The Labour Party should be cautious about making this a party political issue given that some of the most enthusiastic advocacy for privatising health and social care services occurred during their last period in power.

Secondly, Laurence Fink, founder and chief executive of the investment firm BlackRock, one of the world's largest investors, has sent a letter to companies across the USA urging them to contribute to society because social responsibility is one way for a corporation to generate goodwill. He observes:

> *"Society is demanding that companies, both public and private, serve a social purpose. To prosper over time, every company must not only deliver financial performance, but also show how it makes a positive contribution to society."*

He goes on to make the point that many governments are failing to prepare for the future, on issues ranging from retirement and infrastructure to automation and worker retraining (Sorkin, 2018).

Whilst this present report has focused on the kind of structural changes that the government could introduce in the next decade which have the potential to improve the quality of social care for the individual, it needs to be emphasised that these changes can have only a limited and transitory relevance. And that is because our society will be experiencing a series of profound social, political and economic shocks that will demand the introduction of radically different and untried strategies if relevant and genuine forms of social care are to be provided.

As Dr Simon Duffy, Director of the Centre for Welfare Reform has rightly observed, whilst the welfare state is intrinsically a very good idea, the problem is that we have yet to find the right design! And it is essential that in on-going debate the voices of independent think-tanks like the Centre for Welfare Reform are heard.

Forty years ago Meyer, Petersen and Sorensen (1978), the authors of Revolt from the Center, made the following observation which this writer believes is more relevant today than when it was written:

> *"Democracy requires a radical break with prevailing development trends; but the goals of democracy are not so utopian as to make their demands on the present generation inhuman: on the contrary the demands are for humanity and solidarity, for solidarity, too, with the future generations whose conditions of life depend on what we do and fail to do. When we consider what the alternative is, we cannot accept that the democratic, ecologically sustainable society should be only a utopia."*

This report has sought to make the case that politicians and administrators are, whether through ignorance or design, subverting both the policy and practice of social care. It is essential that we reverse the overall direction of travel and focus clearly on what social care really means to the individual, the local community and society in general. Amongst

other things – policies need to be introduced that encourage the promotion of new and radically different forms of mutually caring communities (e.g. ecovillages). But as this report has sought to demonstrate, time is fast running out.

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About the Author

Robin Jackson is currently a Visiting Research Fellow at the University of Hertfordshire. He has a PhD in Education from the University of Exeter. The subject of his doctorate was an assessment of the post school adjustment of leavers from day special schools for pupils with an intellectual disability in Edinburgh and Midlothian. On completing his doctorate he spent 10 years at Aberdeen College of Education where he lectured in the Sociology of Education. He then moved to King Alfred's College (now the University of Winchester) where he was responsible for setting up the first Master's Degree in Special Education in the UK.

After 10 years in Winchester he returned to Scotland and took up a post as Principal of a residential special school and farm training centre in Aberdeen. This experience convinced him of the critically important role residential special schools play in the range of provision for pupils with special needs. He rejects the frequent portrayal of such schools as institutionalized forms of provision which are out of touch with best professional practice. One of the most rewarding aspects of his role was the opportunity to work in close partnership with the parents. A lack of appreciation by some professionals of the experience and expertise of parents with children with special needs prompted the publication of *Bound to Care* (1996) which he edited: this anthology chronicles the often heart-breaking experiences of parents trying to seek an appropriate care setting for their child.

After five years as special school head, the author went on to set up an advocacy service funded by Aberdeenshire Social Work Department and Grampian Health Board. Most clients of this service were adults with an intellectual disability and/or their families. The author found this role one of the most professionally satisfying he had experienced. After four years he reluctantly left because of an increasing erosion of the operational independence of the service. Resulting from his experience as an advocate, he co-edited the book *Advocacy and Learning Disability* (Jessica Kingsley, 2002).

Moving on from the advocacy service, the author obtained the post of Development and Training Co-ordinator for Camphill Scotland - a body representing the 10 Camphill communities in Scotland. He had two principal tasks: (1) making co-workers in the Camphill communities aware of the importance of obtaining an appropriate care qualification and (2) helping to convince the Scottish Social Services Council (SSSC) that the in-house B.A. in Curative Education (later B.A. in Social Pedagogy) run by Camphill School in association with the University of Aberdeen was an appropriate care qualification. A particular feature of Camphill practice that impressed the author is that it is largely based on a social pedagogic model: a transdisciplinary professional activity in which aspects of care, education, therapeutic and medical activities, the use of crafts and creative arts are all brought together to form a holistic approach in supporting children with special needs. It is

an approach that the Department for Education has recently shown some interest in promoting.

Another role at Camphill performed by the author was making known to as wide a professional and public audience as possible the essential nature of Camphill's philosophy and practice, as it has been generally poorly understood and frequently misrepresented. This prompted the publication of two books: *Holistic Special Education: principles and practice* (Floris Books, 2006) and *Discovering Camphill: new perspectives, research and developments* (Floris Books, 2011).

The author has a particular interest in exploring the meaning of community inclusion as it relates to people with an intellectual disability. He guest reviewed a special issue on this topic for the *Journal of Intellectual Disability Research* (2011) and guest edited a special issue on the same subject for the *International Journal of Developmental Disabilities* (2015). A more extensive exploration of this theme was explored in a book co-edited with Maria Lyons entitled *Community Care and Inclusion for People with an Intellectual Disability* (Floris Books, 2016). In 2015 the Centre for Welfare Reform published a report written by the author entitled *Who Cares? The impact of ideology, regulation and marketisation on the quality of life of people with an intellectual disability* and in 2017 *Back to Bedlam. What kind of future faces people with a learning disability?*

Centre for Welfare Reform

The Centre for Welfare Reform is an independent research and development network. Its aim is to transform the current welfare state so that it supports citizenship, family and community. It works by developing and sharing social innovations and influencing government and society to achieve necessary reforms.

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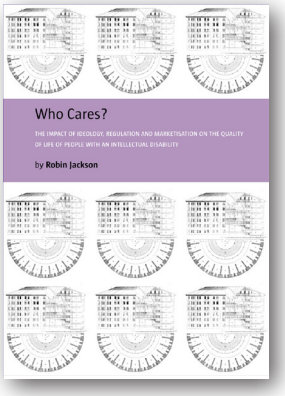

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Robin Jackson offers a devastating critique of the current system of social care, particularly its impact on people with learning disabilities.

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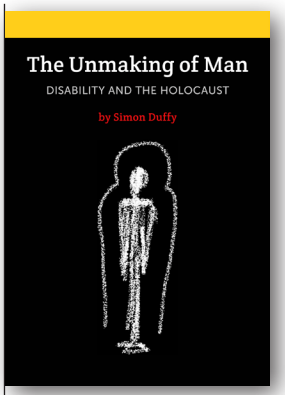

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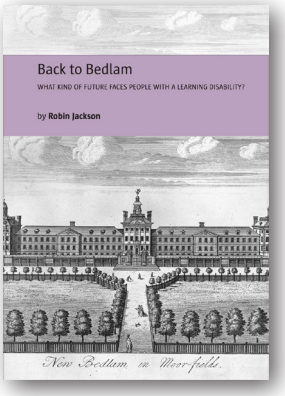

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Robin Jackson describes how support of people with a learning disability is heading backwards in the UK because of austerity and the complicity of civil society.

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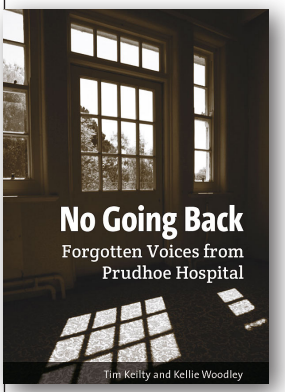

NO GOING BACK

People with learning disabilities tell their own stories about life inside one of England's last institutions. They explain in their own words why there can be no going back.

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