How has the idea of prevention been conceptualised and progressed in adult social care in England?

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Abstract

Over recent years, a preventative approach has been promoted within adult social care policy and practice in England. However, progress has been somewhat inconsistent, in part due to issues around conceptualising what exactly prevention means within this context. Particularly since the financial crisis, there have emerged tensions between seeing prevention as a positive strategy to build assets and capability; as part of a neo-liberal project to roll back expectations for state support; or simply as a technocratic strategy to increase efficiency by deploying resources 'upstream' where they might have greater impact. This paper provides a critical perspective on how policy has unfolded over the last 15 years, which provides the context for an analysis of findings from a national survey of English local authorities and interviews with key stakeholders. These findings demonstrate a substantial commitment to preventative activity, but also some serious confusions and contradictions in how this agenda may be taken forward in the current policy environment.

Keywords: prevention; adult social care; austerity; community assets; strengths-based practice

Introduction

The development of preventive thinking has been relatively recent within the field of adult social care, and its strategic implementation has been somewhat inconsistent – in part due to the lack of any generally accepted conceptualisation as to what prevention might mean within this context. This policy agenda has particular urgency given the failure to implement adult social care reform in England against a backdrop of financial austerity and increasing unmet demand (Glasby et al., 2021).

In this Paper, we will review how ideas around prevention have emerged within English social care policy at a national level, and then present an analysis of survey

and interview findings as to how different local authorities have been responding to and engaging with this agenda. The latter was undertaken before Covid-19 and its impact on service agendas.

We would suggest that prevention policy and practice may be seen as fitting, somewhat uneasily, between more regressive and emancipatory welfare agendas. From a neo-liberal perspective, while market-based models for social care could perhaps serve to drive unit costs down, they provided no mechanism for managing demand within the context of ageing populations and increasing financial pressures – hence an interest in prevention as a possible solution. Alternatively, prevention could be linked to a more progressive agenda of capacity building and devolution of power, in which communities and citizens would be enabled (and resourced) to address social ills such as isolation or lack of opportunity. Positioned somewhat uneasily between these has been a more technocratically framed discourse in which prevention has been promoted as a policy solution by which 'upstream' investment and/or targeted interventions could reap benefits (including financial savings) further down the line.

Prevention in English Social Care Policy

Although thinking around prevention is relatively new in social care, there has been a more longstanding engagement with prevention within health – with a generally accepted conceptual framework that (with minor variation) has also been employed in a number of other policy areas (Gough, 2013). Typically, prevention has been differentiated into:

- Primary prevention – activity to address the circumstances or conditions in which a problem might otherwise occur. This may be universal or targeted towards potentially at-risk groups.
- Secondary prevention – early support to resolve issues at the point when the first signs of a problem start to emerge, so as to minimise longer term adverse impact.
- Tertiary prevention – activity to enable recovery of capability and/or to minimise chances of recurrence of a problem.

However, these distinctions do not describe how prevention may be undertaken, in particular, differentiating between interventions that can be 'done to' people in order to reduce the likelihood of something negative happening (such as health screening or risk assessments), or promoting people's agency, opportunity and capability in ways that enable them to do things that are positive for their wellbeing (such as 'active aging' initiatives) (Ruppe, 2011). Linked to this is a question as to whether prevention should be about mobilising people's individual and collective 'power to' (Tew, 2002), or whether it involves the discursive operation of covert or latent power (Lukes, 2005), in which people are inveigled into taking actions (apparently on their own initiative), that actually serve an ulterior purpose of reducing demand for state support.

The emergence of prevention in relation to social care 2006-10

While prevention featured in the White Paper *Our health, our care, our say: a new direction for community services*, it was still conceptualised in terms of 'building good health and a healthy lifestyle' (HM Government, 2006 p.46) – and it was a year later before the first explicit commitment to prevention in adult social care was articulated in the *Putting People First* Concordat between central and local government:

> The time has now come to build on best practice and replace paternalistic, reactive care of variable quality with a mainstream system focussed on prevention, early intervention, enablement, and high quality personally tailored services (HM Government, 2007 p.2).

Here, prevention was located as a key component of a broadly progressive agenda in which there was a strong emphasis on shifting power relations away from paternalist 'doing to' interactions – and instead enabling people's agency (in terms of control and decision making) and the development of social capital and community resources.

In this document, a tentative 'social care' language emerges, with the terms prevention, early intervention and enablement broadly corresponding to the ideas of primary, secondary and tertiary prevention – although no attempt is made to anchor this terminology in any more substantive way. It is interesting that, implicitly or explicitly, an assumption seems to have been made that importing the language of primary/secondary/tertiary prevention from health to the adult social care sector would not be appropriate or have sufficient traction.

However, any immediate strategic prioritisation of prevention was overshadowed by another policy direction that was promoted in *Putting People First*: the entitlement to a personal budget by which people could arrange their own assistance if they were eligible. As local authorities were only performance monitored on the implementation of the latter (DH, 2010c), this tended to take priority. In one sense, personal budgets were revolutionary – giving people charge of their allocated funding to choose and control their own care. However, in another sense, personal budgets were still located within a marketisation paradigm (Mladenov et al., 2015). Their primary purpose was not to build capability or social capital; instead they were promoted as a way of purchasing ongoing care that could enable people to have better lives at lower cost (Leadbeater et al., 2008).

Nevertheless, a number of prevention-oriented initiatives were being taken forward that were relevant to social care – although these were not necessarily framed in 'prevention language'. Interestingly, much of this innovation was promoted, not by the Department of Health (which had responsibility for adult social care), but elsewhere in government. Using the language of community capacity building rather than primary prevention, the Department for Communities and Local Government launched the White Paper *Communities in Control: Real People, Real Power*, arguing that 'Strong social networks, good community spirit and a local sense of belonging and place are foundations for confident and healthy communities' (DCLG 2008 p.21). Alongside this, with a similar

focus on social capital, were the LinkAge Plus pilots (2006-2008) funded by the Department of Work and Pensions. These 'active ageing' projects sought to co-produce with older people a combination of social action, networking and local services that promoted wellbeing and independence (Dalziel and Willis, 2015). Implicitly critiquing the narrowness of current thinking in social care, it was envisaged that these 'services should focus on early intervention and a preventative approach which goes beyond traditional health and social care functions' (DWP, 2013 p.1).

A major shift in the discursive positioning of prevention occurred in 2009 when, in the context of more challenging economic circumstances following the global financial crisis of 2007–8, it became subsumed within an agenda of 'efficiency savings' in Department of Health guidance – coming seventh (and last) in a list of priority actions (DH, 2009). This both de-prioritised prevention as a policy goal in its own right, and linked it to a more explicit neo-liberal agenda. Nevertheless, this guidance still embraced some elements from the earlier empowerment and capacity building agendas, inviting local authorities to 'develop the use of social capital, including through user-led organisations, so that people can meet their needs with the least recourse to specialist services' (ibid. p.10). However, there remained a yawning gap between an exhortation to local authorities to save money in the longer term by investing in 'upstream' prevention, and the lack of any funding mechanism whereby to do this while still meeting current statutory obligations to those in immediate need of care services. In subsequent guidance, it was acknowledged that, 'at a time when resources are tight … it will not be possible for councils to invest large amounts in prevention and early intervention schemes' (DH, 2010a, p.10).

The Big Society

This confusion as to whether prevention offered a new vision to enable people to live more connected and empowered lives, or whether it was just a strategy for saving money under the guise of 'efficiency', may be seen to be the final contribution of New Labour in government. The lack of any clear conceptualisation of (and financial mechanisms for) prevention allowed it to become subsumed within the incoming Coalition Government's aspiration for a 'Big Society'. In this, communities were (implicitly) expected to already have the resources by which to 'look after their own', with much less recourse to formal care services – if only the State backed off and released their potential: 'A Big Society approach to social care means unleashing the creativity and enthusiasm of local communities to maintain independence and prevent dependency' (DH, 2010b, p.10). Although situated within a context of unprecedented funding cuts to local authorities, prevention was now articulated in terms of 'dependency' prevention through 'empowered people and strong communities' and it topped the list of seven principles underpinning the new Vision for Adult Social Care (DH, 2010b, p.10). Instead of being the purchaser of care services, it was proposed that 'local government can be a catalyst for social action' (ibid p.12).

As has been discussed in more detail elsewhere, the Big Society project was riddled with contradiction between apparently progressive social intentions and

regressive neo-liberal economic policies which undermined the very social capital upon which the project depended (Tam, 2011; Reynolds, 2020). In the absence of sufficient resources at a local level to pull this off, what might look like a real opportunity for people to develop their own 'power together' could easily transmute into an operation of latent power in which people were subjected within an expectation that they should actively *want* to 'look after their own' (at whatever personal cost) rather than seek to access social care services. Similarly, the rhetoric of social action stood little chance of transforming the organisation of social care as long as financially pressured local authorities were having to operate within a statutory framework which only prioritised 'downstream' services for those in immediate need – leading many councils to disinvest in the very community infrastructure which might have supported people outside of formal care services.

The Care Act 2014

It is perhaps no surprise that the collective response to austerity from local authorities did not foreground prevention (or social action), and tended instead to feature initiatives couched in terms of demand management and increasing efficiency, with only a few taking any explicitly preventative approach (LGA, 2012). Indeed, scepticism was expressed that preventative approaches could demonstrate any 'direct impact on demand for social care' (ibid p.21). However, despite this initial lack of enthusiasm, a greater number of local authorities were beginning to think more explicitly in terms of prevention in the lead-up to the Care Act in 2014. This first wave of preventative activity tended to comprise practically focused 'doing to' interventions, rather than wider strategies to develop community assets. They were often closely linked to practical or health-related issues, and included initiatives around falls prevention, technology assisted care and homecare reablement (Allen and Glasby 2013).

The Care Act 2014 duly delivered on the promise to make a focus on prevention a statutory requirement on local authorities – and one which applied to all adults irrespective of whether they were likely to have needs (and financial circumstances) that could make them eligible for funded services. While the Act provided legitimation for local authorities to move beyond the 'tunnel vision' of just assessing people in relation to the provision of formal care services, it came with no prescription of what this should entail in practice. There was no dedicated funding to 'pump-prime' innovations where higher up-front costs might deliver substantial subsequent savings. While the accompanying statutory guidance (DH, 2014) provided a useful overview of potential preventative activity, it did not provide any clear specification as to what level of activity was to be expected. This apparent vagueness was in stark contrast to the explicit statement of eligibility criteria for social care services which appear in the same Act, giving an implicit (but probably unintended) steer to local authorities that the 'real action' had to be downstream in providing care services to people whose needs were assessed as being critical.

Perhaps in order to sell the idea of prevention to councils that were facing the impact of austerity, a new sector-specific definition was used in which prevention was defined as activity designed to 'prevent, reduce or delay' the need for social care. This represented a significant shift from conceiving of prevention as a catalyst for

social action (as in the previous Vision for Adult Social Care), and reflected a wider retreat from the language of the 'Big Society' in other areas of public policy. Unfortunately, whereas the 2007 language of 'prevention, early intervention and enablement' translated relatively straightforwardly into the more widely understood terminology of primary/secondary/tertiary prevention, 'prevent, reduce or delay' did not – despite the attempt in statutory guidance to conflate the two terminologies (DHSC, 2014, p.14). This introduced further conceptual confusion: for example, trying to equate 'reduce' with secondary prevention made little sense, given that early intervention may just as easily obviate the need for any longer term service ('prevent') or postpone such a need ('delay').

Assets and strengths

While many local authorities continued (at least in the short term) to see prevention in relatively narrow terms as interventions linked to demand management, a vanguard of local authorities was beginning to introduce a second wave of prevention activity that was predicated on a more fundamental revisioning of the role of local services and the relationships between services, citizens and communities. This new 'deal' involved shifting from the inherent paternalism of a service provider orientation to more co-productive engagements around enabling opportunity, support and social connectivity (Bovaird et al., 2015; Miller and Whitehead, 2015; TLAP, 2019; Naylor and Wellings, 2019; Tew et al., 2020). There was a renewed interest in community assets and capacity building (see, for example, Miller and Wilton, 2014) and/or on providing an easily accessible 'strengths based' conversation at the point where people were starting to run into difficulties (Kirin, 2016; DH, 2017). However, such a shift in power relations required no small degree of commitment and reflection-on-practice in order to shift ingrained cultures and ways of working (Farr, 2017). As Naylor and Wellings argue, 'asset-based working should not be seen as a technocratic quick fix – it is ... a culture to be grown' (2019 p.5).

Interestingly, although preventative in intent, such initiatives were rarely badged as 'prevention'. It seemed that the language of prevention was insufficiently positive to galvanise vision and action at a local level, whereas 'stronger communities' or 'strengths-based practice' could achieve more traction. Instead, 'prevention' was perhaps now too strongly associated with the perceived defensiveness and negativity of demand management. However, emerging alternative discourses around assets and strengths were not without their concerns and contradictions. Some local authorities were not achieving the much vaunted reductions in expenditure on longer term care that they had anticipated (Slasberg and Beresford, 2017). More fundamentally, an over-optimistic view of the untapped potential within communities could be at odds with the realities of resource-starved families and neighbourhoods within an increasingly divided society. Such approaches could lack 'meaningful engagement with macro issues such as the need to reorganise our societies so that we can better meet the growing need for care' (Daly and Westwood, 2018) – reflecting a legacy of issues that were unresolved since the demise of the Big Society project.

Public health

In parallel with these developments in social care, ideas around prevention were also being promoted in public health – now co-located within local authorities. The Local Government Association had earlier observed that 'It will be interesting to note whether the Public Health approach within local government will enable councils to target better health outcomes for the population which will reduce demand for social care' (LGA 2012 p.21) – thereby signalling the possibility of a more 'joined up' approach to prevention between social care and public health. However, this was not straightforward in practice. The narrow and idiosyncratic framing of prevention in the Care Act as 'preventing, reducing or delaying the need for social care' did not always sit easily with wider population-level health agendas. Alongside this, the steer from Public Health England wavered from enthusiastic sign-up to a collaboration around promoting stronger communities (Miller and Wilton, 2014) to a much more parochial focus on 'doing to' interventions relating to specific health targets such as smoking cessation or reducing obesity (PHE, 2016).

Tensions and contradictions

By 2018-19, prevention had significantly moved up the official local authority agenda – but as a mechanism whereby to achieve a third of their required budgetary savings (ADASS, 2019 p.17), rather than any more strategic commitment to social action and strong communities. Furthermore, it was recognised that councils were 'trapped in a vicious circle of having insufficient funds to be confident they can meet all their statutory obligations, whilst being unable to release funding to invest in approaches that might reduce the number of people with higher needs in future' (ibid. p.25). There was acknowledgement that, while the term 'prevention' could denote a positive commitment to build resources and capability, there was a danger that it could be presented as 'cover' for swingeing cuts in services that could be risky and potentially unlawful.

Overall, it may be seen that the genesis and progression of preventative approaches in adult social care has been far from straightforward, with policy aspirations not always matched by delivery mechanisms, and unresolved confusions as to what exactly prevention means in a social care context. In turn, this conceptual confusion reflected underlying tensions, with the idea of prevention being articulated within very different discursive contexts. Was it part of a neo-liberal project to shrink the scope of welfare provision, or was it tied up within a more emancipatory project about building the capacity and capability of citizens, families and communities to improve their social conditions? Or could it be located in a more politically neutral discourse about the more effective targeting of resources 'upstream' so as to achieve better outcomes *and* lower longer term care costs? Was it about technical solutions and 'doing to' interventions (such as telecare or falls prevention), or was it about a more fundamental shift in the terms of the relationship between citizens and the local state? All of these moves to anchor the meaning of prevention were being negotiated within a volatile context engendered by unprecedented cuts to local authority budgets.

While the 2014 Care Act gave statutory recognition to the importance of prevention, it also did little to resolve conceptual confusion or provide a pathway towards its implementation across the sector. Our research therefore focused on how local authorities were responding to the challenge of prevention in this changing national policy environment.

Methodology

This paper draws upon data collected as part of a larger research study funded by the Department of Health and Social Care to explore how prevention has been progressed following the Care Act 2014 (Tew et al., 2020). The research comprised a national online survey (April-June 2018) and interviews with stakeholders from seven local authority case study sites undertaken in 2018-19. Ethical permission was obtained from the Social Care Research Ethics Committee.

In the national survey, senior leaders in all 150 authorities in England with responsibilities for adult social care were asked about what preventative or capacity building initiatives were taking place, what they were seeking to achieve, and what were seen as barriers or facilitators in relation to this. Respondents were also invited to submit any relevant strategy documents. The survey responses themselves were anonymous to encourage honest reporting. 48 responses were received, with responses from across all Association of Directors of Adult Social Services (ADASS) regions – but this sample may not be representative of the sector as a whole, as those local authorities undertaking little prevention activity may have been less likely to respond.

Alongside this, interviews and focus groups were conducted in a sample of seven local authorities which were selected on the basis of undertaking a variety of different 'second wave' preventative approaches (see Table 1). They comprised a mix of urban and rural local authorities from different regions in England. 84 interviews and four focus groups were conducted with relevant stakeholders, both internal and external to the local authorities.

Survey results were analysed using descriptive statistics. Data from the interview and focus group transcripts and the free text survey responses were independently analysed by members of the research team in order to identify salient themes (Braun and Clarke, 2006).

Findings

The Survey provided a snapshot of how local authorities were thinking about and implementing preventative activity after the Care Act had been given time to bed in – but before the impact of Covid-19 (and the consequent disruption of strategic thinking and activity) was felt across social care and health services. Findings from both survey and interviews/focus groups are presented thematically – exploring how prevention was articulated, what were seen as the drivers and barriers in relation to implementing preventative activity and how social care prevention fitted within the wider care and health system. All figures relate to survey data only.

While we are only able to report on the strategic activity being undertaken by the third of local authorities who provided a survey response, it is notable that most

Table 1. Sample of local authorities

Site	Location	Urban/rural	Socio-economic profile	Preventative and capacity building initiatives
A	North	Urban	City including areas of high deprivation	Neighbourhood Networking; Asset Based Community Development
B	South	Urban	Borough including areas of high deprivation	Local Area Coordination
C	Midlands	Urban	Mixed but including substantial area of high deprivation	Local Area Coordination
D	Midlands	Rural	Includes significant pockets of high deprivation	Strength based conversations
E	South	Rural	Little deprivation	Strength based conversations
F	South	Urban	Substantial recent migration and some areas of high deprivation	Family Group Conferencing; Strength based conversations
G	North	Urban	Borough including areas of high deprivation	Peer Support; Targeted use of personal budgets

respondents were able to describe one (and frequently more) prevention-oriented initiatives that they were undertaking (see Figure 1). Perhaps not surprisingly, the most commonly reported prevention activities were those that had been part of the first wave of prevention activity – signposting, assistive technology and reablement. However, not far behind these were a variety of second wave initiatives including strengths-based social work approaches, social networking and community development.

Articulating the vision

Perhaps the most striking finding from the research was a reluctance across the sector to embrace 'prevention' (however defined) as a key organising principle for their strategic vision. Prevention (if espoused at all) tended to emerge more as something that could be subsumed within other policy directions. One Council set out a 'second wave' vision foregrounding a different relationship with its residents in which they would have more power and capability:

> *We see a local economy where all of our residents feel more in control of their lives and more confident to draw on their own personal resources, and those of their families and communities, not only when problems arise but to prevent them from happening.*
>
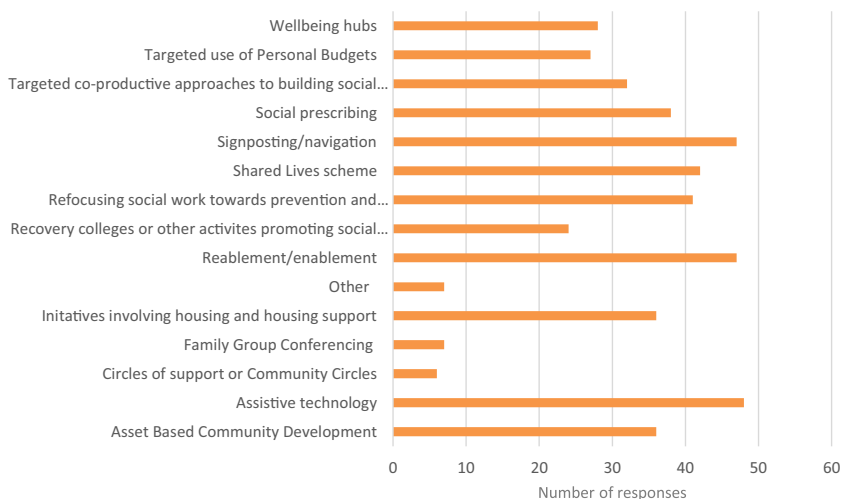> *National Survey – Vision Statement*

Figure 1. Prevention-orientated approaches (where local authorities had undertaken some preventative activity, up to 3 key initiatives per local authority).

This new 'deal' between the local state and its citizens was somewhat reminiscent of the original Big Society vision – but its commitment to social action was more securely underpinned by an understanding of the need to shift resources in order to enhance the necessary local community infrastructure.

More common was subsuming prevention within the more positive sounding language of strengths-based social work and social care:

> It's not about 'doing to' or 'doing for'; it's around working with people and promoting whatever their strengths are. It's building on those strengths and supporting them to do as much as they can. (Site E – Senior manager)

However, for other local authorities, the wider material and discursive context of austerity led them to situate prevention more defensively as part of their ongoing attempts to manage demand for services. For them, the Care Act's language of preventing, reducing or delaying the need for social care simply reinforced a conflation of prevention with demand management:

> [Borough] has had a strategic approach to … prevention/demand management for a number of years and pre-dated the Care Act. (Free text response, National Survey)

Relatively few of the responding local authorities had produced an overall prevention strategy for social care – although prevention would be mentioned in a range of other strategic documents. In some instances, this was deliberate, with one respondent stating that 'We have purposely not taken the route to have a prevention strategy – but move toward 'prevention' being implicit in everything' (Free text response, National Survey). Underlying this was a sense, as stated by another survey
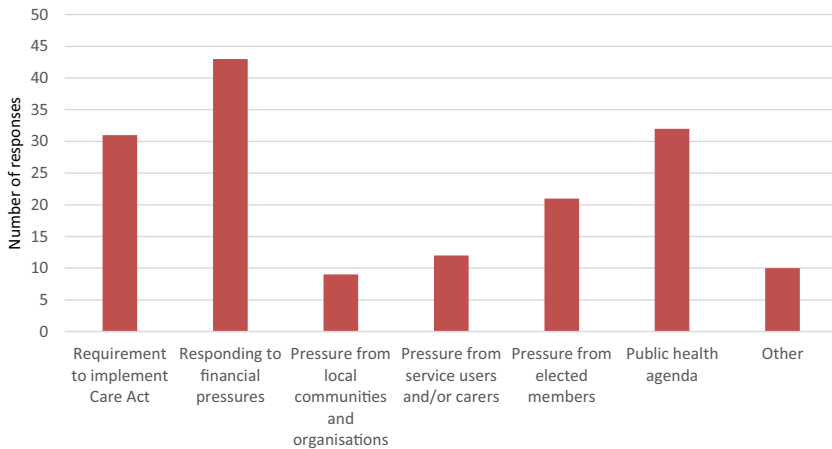
Figure 2. What were the major factors driving prevention activity.

respondent, that '*the use of the word prevention can be problematic*'. Two main reasons for this were given.

Firstly, was the widely held view that current conceptualisations of prevention within social care could be confusing:

> '*Prevention' is a term frequently used across health and social care … but with no clear-cut definition and no consensus as to what constitutes 'prevention'.* (National Survey – internal strategy document)

Secondly, both for staff and external stakeholders, the word 'prevention' could be seen as '*just another name for cuts*'. However, if prevention was reframed within an emerging language of asset or strengths-based practice, '*generally people really liked the core concept of less power differential, more involvement, more relationship building, more looking at what people want to achieve*'. (Site F – Strategic manager)

Overall, the Care Act was seen as providing a helpful context in which to take forward preventative activity – more as an enabler of what they wanted to be doing anyway, rather than as the main driver for change (see Figure 2). Although one National Survey respondent framed their strategy as a response to '*a new statutory principle*' in the Care Act, most of the sector responses saw the legislation as rather less prescriptive. One respondent noted the '*lack of detail in the Care Act on the services required to fulfil the prevention duty*' and hence did not see investment in prevention as a statutory requirement that had to be acted upon. Nevertheless, some councils were able to use the Care Act to underpin new approaches in which '*prevention and early intervention are two parts of a holistic new operating model for adult social care*' (Free text response, National Survey). Another saw the Care Act '*very much as [an] enabler of changing people's thinking about what social care is about and finally putting the care management model to bed* (Site E – strategic manager, social care).

Whatever the level of enthusiasm for prevention, the language of 'prevent, reduce or delay' did not readily provide a conceptual framework by which most councils

could think through a coherent strategy that addressed all the domains of primary, secondary and tertiary prevention. Some focused mainly on a community capacity asset-building perspective – a primary prevention approach. Others focused on secondary prevention, typically using the language of strengths-based practice or, in some instances, the alternative discourse of 'early help' that was being used in children's services, promising *'to ensure people in our communities get the right support, at the right time, in the right place to tackle problems early. Early help minimises the risk of problems becoming severe and entrenched.* (National Survey – All Age Early Help Annual Plan).

Some included elements of both primary and secondary prevention in their strategies, but typically one or other perspective would be dominant. Most councils had not developed any strategic approach to tertiary prevention, with homecare reablement often being the only activity taking place within this space – usually in a 'bubble' that was conceptually and organisationally separate from any other prevention or capacity building initiatives. However, going against this trend, a few councils chose a tertiary focus for their vision, reviving the term 'enablement' as first proposed in the Putting People First concordat:

> *Our philosophy is based on the belief that the best approach is to focus on helping people to regain as much control over their own lives, as quickly as possible. Ways of working that are grounded on the principle of enablement form the foundation of this. (National Survey – Adults and Wellbeing Plan)*

For some local authorities, it was the Care Act's principle of promoting wellbeing, rather than the requirement to prioritise prevention, that offered a more useful way of framing their activity. One council established a Living Well team to *'work with individuals (and their carers) who are on the cusp of becoming regular users of health and social care services by helping them access their local community and supporting them to find their own solutions to their health and wellbeing goals'.* (National Survey – Council Plan)

Another council articulated a broader vision in terms of a broad commitment to promote wellbeing, with three underpinning themes of:

- *Better Lives through better conversations*
- *Better Lives through better living*
- *Better Lives through better connections*

(Site A, Public Strategy)

Within this strategy, the word prevention is relegated to subsidiary importance – only appearing as one of eight priorities linked to the 'better living' theme.

However, in a number of instances, the idea of wellbeing had come to be linked, not to the more emancipatory language of 'better connections' and/or 'finding their own solutions', but to a discourse of responsibilisation. Framed in this way, people became charged with the duty of managing their own wellbeing – and could then implicitly be blamed if they failed to be sufficiently proactive in looking after themselves. One local authority senior manager framed their strengths-based approach to prevention as *'supporting people to take responsibility for their own health and*
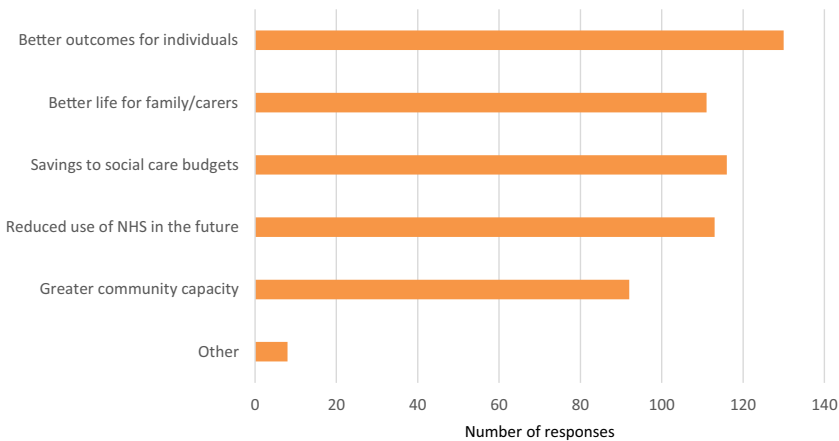
Figure 3. Anticipated outcomes of prevention activities.

wellbeing . . . It's all about promoting self-help'. This language of individualised 'responsibility' seemed to fit more with a neo-liberal trope of seeking to roll back the 'nanny state', rather than a more co-productive approach, enabling people to mobilise wider resources whereby to achieve their aspirations or find solutions to their difficulties.

What tended to be missing from the responses or strategic documents presented in the national survey was any serious recognition of how austerity had led to widening social divisions and inequalities (Marmot et al., 2020) – and how these were, in turn, impacting both on people's wellbeing and social needs, and on the availability of resources (individual and collective) by which these issues could be addressed. A more progressive, social action and capacity building approach to prevention may still be limited in its impact if it does not also address the wider social conditions affecting people's lives and opportunities, and the structural determinants of this.

Drivers and barriers

Asked what they hoped would be achieved through preventative activity, national survey respondents gave similar weight to a better life for individuals, families and carers as against potential cost savings to the council or the NHS (see Figure 3). A number used the language of it being '*the right thing to do',* in terms of best outcomes for the population:

> '*It's not all about cost effectiveness. Cost effectiveness comes into it but it is about . . . a strengths-based approach, working on their skills and maximising their independence'.* (Site E – Senior Manager)

As shown in Figure 2, the major drivers for change were predominantly top-down, with bottom-up' pressures from citizens, service users, and carers being seen as of lesser significance. Despite expressed commitments to better outcomes for citizens,

Figure 4. What were the major barriers to implementing Prevention activity?

it was financial pressures (coupled with demographic pressures) that emerged as the biggest driver towards implementation of prevention activity – as continuing with current practice was increasingly being seen as untenable:

> *Local Authority funding from central government is likely to be under continued downward pressure at the same time that demographic pressures for the county, such as an ageing population, are on the increase. The scale of these pressures that the council and its partners face means that we will need to do things differently* (Site D – Position Statement)

However, somewhat paradoxically, financial pressures also emerged as the most frequently cited barrier to implementing preventative initiatives (see Figure 4). While investing in prevention might seem the right way forward in principle, this was not always seen to be feasible within an immediate financial situation which could be '*All about trying to survive*' and where '*the Care Act did not provide any additional funding to take forward preventative approaches*' (Free text responses, National Survey). What was seen as problematic was not just the scale of cuts in government funding, but also the uncertainty around future funding settlements which could make strategic planning much harder. One respondent reported that they were actually having to scale back their preventative activity due to immediate financial pressures and the perceived imperative to respond to the current level of presented need.

Thus, the picture that emerged is of quite complex interplay between the capacity building and austerity agendas – both in terms of discursive framing and the drivers for activity on the ground. This echoes the concern expressed in the ADASS Budget survey (ADASS, 2019) that there was potentially a very thin line between promoting prevention as enabling and empowering people to have better lives, and this agenda becoming subverted as a legitimation for potentially harmful cuts in services. This concern, together with issues around conceptual confusion, and the lack of any up-front funding from central government for preventative activity, would seem to have limited the take-up of prevention as a strategic objective within adult social care. Although similar concerns have been expressed in terms of strengths or asset based approaches also being 'cover' for cuts, this language has more appearance of positivity – and hence has become the preferred framing within many local authorities.

Social care prevention within the wider care and health system

Whatever the value (or otherwise) of the Care Act's conceptualisation of prevention in galvanising a new strategic purpose in social care, this was not always helpful when seeking to integrate this within wider health and care strategies at a local level. One survey respondent complained about how difficult it was to work strategically with health and other partners when '*definitions [are] different in each sector for prevention*', and another stressed the difficulty in making a social care definition of prevention '*real and substantive for partners*' (Free text response, National Survey). In one strategy document, there was an uneasy compromise in which public health owned the 'prevent' agenda and social care was left to focus on what might 'reduce' or 'delay' the need for social care services.

As well as definitional differences between sectors, there could also be conflicts in relation to operational priorities, reflecting competing pressures both in terms of policy and in terms of the local health and social care economy (see Figure 4). Most frequently cited was the potential conflict with a health priority to prevent delayed discharge (and 'bed-blocking'), which could sometimes translate into hasty decisions to place people in residential care beds in order to facilitate early discharge – which, once set up, could easily turn into the longer-term default option.

An interesting finding from the National Survey was how the emerging public health agenda within local authorities was perceived as at least as important as the Care Act in driving a preventative approach (see Figure 2) – perhaps because public health had a better established discursive position (and accepted language) from which to articulate such an approach. However, the more detailed evidence from survey respondents and interviewees suggested a complex picture in terms of aligning social care and public health agendas. In practice, where social care was included in a joint local authority strategy for prevention, this could often be led by public health, with a tendency to foreground prevention in relation to specific health conditions, rather than any potential need for social care services. This mirrored similar difficulties reported by local authorities in gaining recognition for social care prevention priorities within wider collaborative strategies with health organisations, such as place-based (but health led) *Sustainability and Transformation Plans* (STPs). At a national level, there has been little evidence of this voice coming through, with health priorities and language remaining predominant (Ham et al., 2017).

In local authorities where public health focused on the wider social determinants of health and wellbeing, it could be seen as an effective ally for social care in rallying the wider system around an agenda framed in terms of opportunity, connectivity and social inclusion – an agenda that could potentially deliver both better population health and reduced needs for social care. In one local authority, public health was seen as providing a '*glue*' which enabled the joining up of local authority and health agendas at a local level:

> *I think the reason why we started to open some doors is we've got a wonderful director of public health that we didn't have to start with ... And through that we've been able to sell our message far more.* (Site B – Senior Manager, social care)

Underneath this was a shared commitment to invest in building '*welcoming commu-nities*' which could reduce demand on both health and social care services through '*divert[ing] people from statutory or formal services through local, flexible, commu-nity solutions wherever possible*' (Site B – Position Statement).

Similarly, another local authority articulated their overall vision in universalist terms as '*Everyone in [ ] to have three good friends*':

> *Ultimately everything we do is about reducing isolation. I feel that is the major factor in preventing ... decline in [people's] health and decline in their well-being ... It is about that constant contact and giving people ... a reason to get up in the day and get dressed and come out.* (Site A – Senior manager)

However, strategic collaboration could be undermined by contradictory under-standings of prevention both *within* and *between* public health and social care – in particular between the co-productive language of *promoting* community capacity through encouraging agency and leadership from and within communities, and the very different professionally driven language of interventions aimed at *preventing* particular negative health or social outcomes.

Conclusions

While a preventative approach in relation to adult social care is seen to command broad support in principle, both its conceptualisation and its application in practice remain inconsistent and unclear in the English context. What emerges from the research is that, despite the Care Act having had time to bed in, there was no commonly held strategic vision or understanding across the sector as to how to take this agenda forward. In particular, the language of 'prevent, reduce or delay' may have seemed expedient in gaining traction for prevention at a time of financial pres-sures, but has created its own problems in terms of a potentially damaging confla-tion of prevention with demand management and a 'cuts' agenda – and hence a broader association of prevention with the vestiges of a neo-liberal policy agenda.

Although a limitation of the research is that we only had responses from around one third of local authorities in England, we found that, among these, a surprisingly broad range of prevention-related activity was taking place. While this may not necessarily have been branded as prevention, it was nevertheless designed to promote wellbeing, capability and social connectivity (and hence potentially support people to have better lives with less recourse to care services). Within some local authorities, we found a clarity of vision in terms of moving away from care management as their operating model and instead seeking to construct a new and more co-productive relationship between local government, citizens, families and communities.

While we have characterised such approaches as comprising the second wave approach to prevention, the term 'prevention' was often subordinated within alter-native discursive constructions of policy at a local level. Typically, the preferred language has been a positive framing in terms of capacity building or wellbeing, or of asset or strengths-based practice – and this has come to be reflected

increasingly at a national level, as in the Strengths-Based Roundtable that was convened by the Chief Social Worker (DH, 2017). By using such language, prevention-oriented activities and practices have been discursively distanced from a neo-liberal 'demand management' agenda. Our interviews with some local leaders evidenced a genuine commitment to devolving power and resources to citizens and communities in a meaningful way. However, in other instances, strength-based rhetoric, and/or a tactical responsibilisation of citizens in relation to their health and wellbeing, may provide cover for an agenda of withdrawing support from those who are vulnerable.

From the national survey, it was interesting that the biggest driver for implementing preventative approaches turned out not to be government policy or legislation, but the impact of a very substantial reduction in government financial support for local authorities, which made it unfeasible to continue with existing approaches to care management. Within this context, the Care Act was seen as important – but more as an enabler rather than a driver for change. Its focus on wellbeing and prevention released local authorities from a duty just to preside over assessment and provision of care services. However, alongside this, financial constraints and uncertainties emerged as the greatest barrier to a strategic shift of resources towards 'upstream' preventative activity when budgets already appeared insufficient to meet current demand. With hindsight, had the government offered local authorities ring-fenced funding for prevention as part of an implementation package for the Care Act, a much stronger momentum towards prevention might have been achieved, with more consistency across the sector.

The early reluctance within the sector to develop explicit and overarching prevention strategies had perhaps undermined councils' ability to give consistent weight to primary, secondary *and* tertiary prevention – although all of these may increase the capability of individuals, families and communities, and hence reduce demand for long-term or more intensive service provision. Alongside this, confusions as to what was meant by prevention (and the idiosyncratic language of 'prevent, reduce or delay' used in the Care Act) could make it harder to give social care a voice within any collaborative development of preventative approaches with public health or the wider health economy.

More fundamentally, there remained a lack of clarity as to whether or not prevention involves new ways of doing power relations – is it simply a new set of upstream interventions that may be 'done to' citizens and communities, or does it represent a more radical break in which people may be enabled to mobilise power and co-produce resources for themselves? Linked to this can be a lack of join-up between the social care prevention agenda and wider initiatives to address poverty and social exclusion – and to rebuild community resources and infrastructures that have been depleted by funding cutbacks and, more recently, by the impact of Covid-19. This could usefully be a focus for further research.

Despite its somewhat chequered history in social care, prevention as a strategic organising principle may have something positive to offer if it can be decisively decoupled from a narrowly defined demand management agenda. Building on the experience of those local authorities that have pioneered a 'second wave' approach to prevention (with a real devolution of power and resources to people and their communities), there is an opportunity, post-Covid, for social care to

engage as part of a wider policy agenda around empowering citizens within the context of social regeneration and a 'levelling up' of opportunity. Although recent policy debates have tended to focus on the financing of long-term care, a renewed focus on prevention would need to form part of a more sustainable strategy, if potentially unnecessary admissions to long term care are to be avoided. There is potential for alliance with other agendas from public health to economic development – but only if prevention is recast more proactively in terms of building capacity and connectivity (and hence creating genuine opportunities for better lives for vulnerable citizens), rather than holding on to its narrow conceptualisation as 'preventing, reducing or delaying' the need for social care services.

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