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The role of the adult social care workforce in prevention

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November 2026

This research project was funded by the National Institute for Health and Care Research (NIHR) Policy Research Programme (grant number NIHR200702) as part of the Partnership for REsponsive Policy Analysis and REsearch (PREPARE), a collaboration between the University of York and The King's Fund for fast-response analysis and research to inform the Department of Health and Social Care's policy development (www.york.ac.uk/prepare).

This report is based on independent analysis carried out by The King's Fund. Views expressed and any errors are those of the authors only, and not those of the NIHR or the Department of Health and Social Care.

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Key messages

This research explored how staff working across adult social care understand and contribute to prevention. It focused on how staff support people to maintain independence, wellbeing and quality of life, to identify issues early, and to prevent deterioration or crisis. It also explored the barriers that limit preventive practice.

- Health and social care staff are 'divided by a common language' when it comes to prevention. In health care, prevention is understood in terms of improving health and health outcomes and reducing pressure on health and care services (Gilburt *et al* 2026), whereas in adult social care, there is a stronger emphasis on independence, wellbeing, quality of life and individual choice.
- Prevention is already embedded in everyday adult social care practice, even though it is not always described or measured in those terms.
- Different social care staff groups make distinct but complementary contributions to prevention, including care workers, registered nurses, occupational therapists and registered managers.
- Rather than lack of willingness or confidence to engage in prevention, the adult social care workforce is constrained by significant structural barriers. These barriers include funding pressures across the sector, rigid commissioning, workforce shortages, and fragmentation between health and social care.

To make prevention a success, policy-makers and leaders in the adult social care sector need to recognise adult social care as central to the prevention agenda, and act on the barriers that stop staff doing this work well. For social care to take an enhanced role in prevention across the health and care sector, we recommend the following actions.

- The government must address the systemic barriers that stand in the way of delivering prevention. For adult social care, this can specifically be addressed through the government's ongoing work to implement the 10 Year Health Plan, in the report of the Casey Commission, and in the implementation of workforce reforms by the Adult Social Care Negotiating Body. The challenge for local commissioners is to then encourage commissioning that enables relationship-based preventive practice, stronger integration between health and social care, investment in workforce capability and leadership, and attention to the experiences of staff who face additional barriers at work, including migrant workers and workers from racially minoritised groups.
- For the Department of Health and Social Care (DHSC), there is a need for a broader policy articulation of what prevention encompasses, which makes clear how different health care, public health and social care professionals can each contribute to the shift to prevention so that the aims become shared across the sectors.

- The NHS and social care each need to understand the other's perspective when talking about prevention.
- At the same time, the adult social care sector needs to demonstrate and communicate its effectiveness in prevention. This means going beyond individual-level and anecdotal examples of success, to systematically collecting and sharing data about how adult social care is contributing to measurable outcomes.

This report sets out what needs to change so that the adult social care workforce can be properly supported to help people maintain independence, wellbeing and quality of life.

01 Introduction

The policy context: a shift towards prevention

The 10 Year Health Plan for England was published in 2025 under the Starmer Labour government (Department for Health and Social Care 2025). It is based on making three strategic shifts that will reform health care:

- from hospital to community – shifting the pattern of funding and configuring more connected health care services much closer to where people live
- from analogue to digital – shifting the NHS to a digitally accessible service and introducing technology that reduces the burden of bureaucracy and administration for staff
- from sickness to prevention – shifting from treating illness after it occurs to actively preventing it by reaching people earlier and empowering people to 'make the healthy choice'.

Regarding the latter shift, the aims are to reduce the need for costly acute and hospital-based care by preventing acute illnesses earlier, improving health outcomes at population level, and reducing long-term demand on the NHS and other public services. In this sense, prevention in health care is being seen as a move away from treating illness and managing crises towards more 'upstream' interventions, such as reducing exposure to risk factors and promoting healthy behaviours at population level. This is different to how prevention is framed in adult social care, where the primary goal is supporting people's independence, wellbeing and quality of life.

Although a proactive approach to preventing illness is generally understood as being better than a reactive approach, the workforce implications are typically discussed in relation to the NHS, with limited attention paid to the adult social care workforce. However, delivering a prevention-focused system will require changes not only within health care but also across adult social care too. This understanding of prevention in the context of adult social care becomes all the more relevant when taking into account Prime Minister Andy Burnham's speech in July 2026 about the core principles of a National Care Service, which include: 'the service must start with prevention, supporting people to live independently for longer' (Prime Minister's Office 2026).

Why adult social care matters for the prevention shift in health care

The role of adult social care in prevention should not only be seen as avoiding deterioration, hospital admissions or greater demand for services (as in health care), but also in terms of sustaining people's independence, wellbeing and overall quality of life.

Adult social care plays a critical role in supporting the independence, wellbeing and quality of life of many thousands of people. According to analysis of 2024/25 data, 890,000 people

received publicly funded long-term social care, primarily in care/nursing homes or in their own homes (Bottery and Jefferies 2026). The actual number of people who are in regular contact with adult social care is considerably higher once the number of people who self-fund their care or receive it through direct payments is taken into account (Office for National Statistics 2023a Office for National Statistics 2023b).

Staff employed in adult social care are often in the most regular contact with people who are at risk of deteriorating health, social isolation, or loss of independence. Opportunities for prevention exist across the social care pathway, from supporting everyday wellbeing and social connection through to identifying emerging health issues and preventing crises.

Despite its important contribution, adult social care is often overlooked in discussions about preventive workforce development. Understanding the contribution of the adult social care workforce is essential if policy ambitions around prevention are to be fully realised.

Understanding the adult social care workforce

There are 1.5 million people employed in social care in England. This makes the adult social care workforce almost the same size as the NHS workforce. Roles in the adult social care workforce are diverse. They include:

- those who provide direct care (known as ‘care workers’, ‘senior care workers’ or support workers)
- managerial staff (for example, registered managers of care or nursing homes)
- regulated professionals (for example, registered nurses, occupational therapists and social workers)
- staff in other roles such as ancillary workers or administrators.

(The King’s Fund 2025)

In addition, adult social care is delivered across a range of settings, including residential care homes, nursing homes, supported living units, and people’s own homes (referred to as ‘home care’, as we do in this report, or ‘domiciliary care’). Workforce experiences and opportunities to contribute to prevention vary between settings and across the types of roles.

Background to the research

The team of the Chief Public Health Nurse Office at the Department of Health and Social Care (DHSC) approached The King’s Fund wanting to explore the workforce implications of a health and care system that puts prevention first. The first stage of the work focused on the role of nurses, midwives and allied health professionals in prevention (Gilburt *et al* 2026) (see box below for a summary of the findings from that study).

High-level summary of findings about the role of the health care workforce in the shift to prevention

Prevention is embedded in health care professionals' roles and there is strong support for doing more.

Structural barriers such as workforce shortages, high demand, funding constraints and performance targets make prevention difficult to prioritise.

Health care professionals see prevention as involving person-centred care, early intervention, support for self-management – as well as working more upstream by tackling the wider determinants of health.

A successful shift to prevention requires system-wide change, including aligned incentives, redesigned services, workforce development, and stronger collaboration across services and sectors.

(Gilburt *et al* 2026)

The adult social care workforce is distinct from that of the NHS in terms of its structure and roles and unique contributions to prevention. Therefore, the next stage of the research moved its focus to those employed in adult social care, specifically care workers (who make up around three-quarters of the workforce), registered nurses, occupational therapists and registered managers. To support the work of the Chief Public Health Nurse Office in developing workforce policy, it is important to understand how prevention is currently understood and enacted within adult social care, and what changes may be required to strengthen this contribution in future.

Research aims and questions

This research aimed to understand current experiences, opportunities and barriers to taking an increased focus on prevention within the adult social care workforce.

The research questions were:

1. What do social care workers think about their current role in prevention?
2. What do social care workers think an increased focused on prevention could look like for them? That is, in their day-to-day roles, what could be done differently to increase the focus on preventing ill health and effective management of long-term conditions, and what are the opportunities to do this?
3. What are the main challenges with working preventively, and how can these be overcome (building on what social care workers and providers are already doing)?

Structure of this report

The remainder of this report is structured as follows:

- Section 2 examines the meaning of prevention in adult social care and outlines trends in spending and wider sector pressures.
- Section 3 describes the literature review, qualitative data collection, analysis and study limitations.
- Section 4 explores how staff understand and deliver prevention across roles and settings.
- Section 5 examines system, service, workforce and individual factors that shape preventive practice.
- Section 6 draws together the findings and sets out priorities for policy.
- Appendix 1: summarises the barriers to prevention and the actions that could help address them.

02 What do we mean by prevention in adult social care?

At its simplest, prevention means taking action to maintain health and avoid illness, harm or early death. However, despite prevention being a prominent theme in health and care policy, there is no single agreed definition of what it means. Instead, prevention is used in a variety of ways depending on the context.

A recent report by The King's Fund set out the different ways in which prevention is understood in health. These include one common understanding based on the concepts of primordial, primary, secondary and tertiary prevention (Arnold and Holden 2025) (*see* Figure 1). In this sense, prevention most typically encompasses activities that can be categorised as health promotion and health protection.

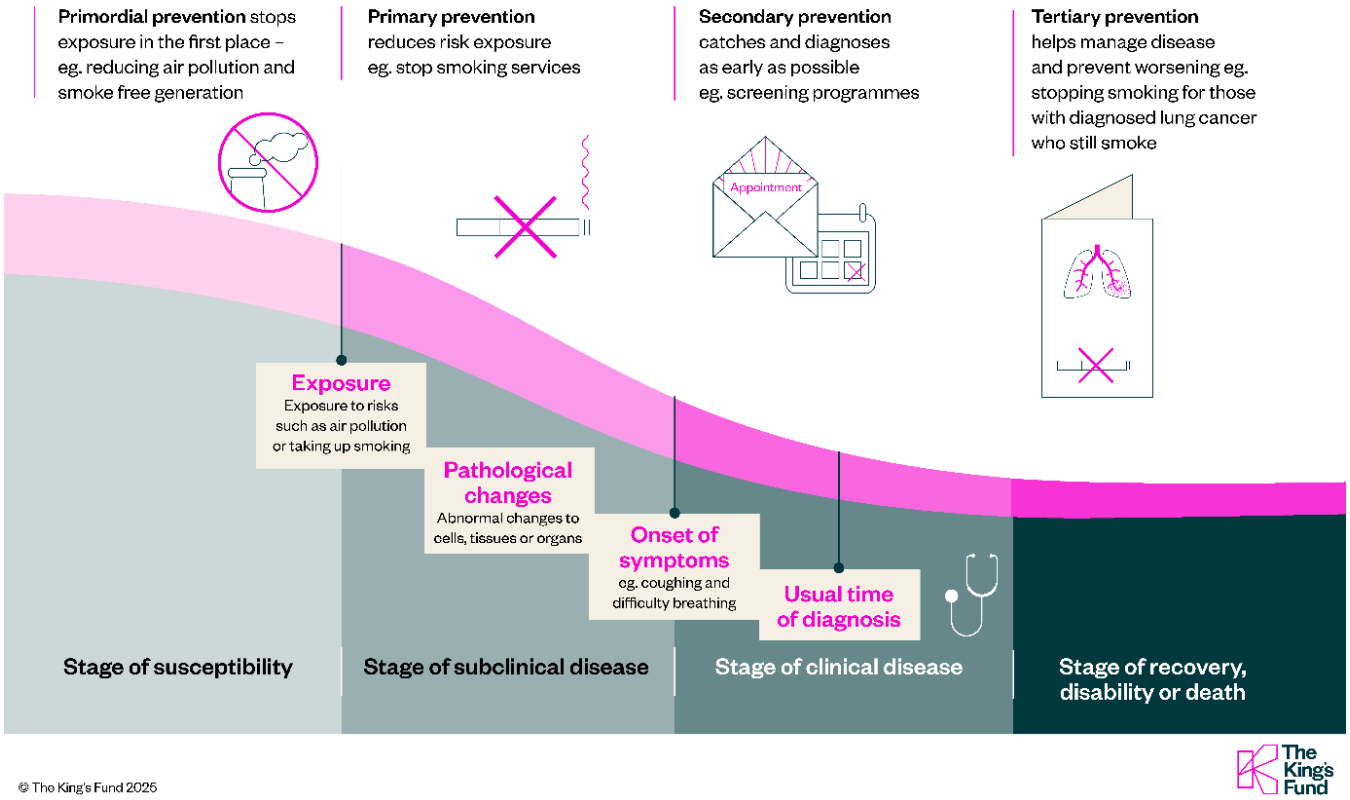
- **Primordial**: actions taken to stop exposure to risk factors in the first place. This involves taking actions that address the wider social, economic and environmental factors that influence people's health and wellbeing. For example, in relation to obesity, primordial prevention might involve restricting the marketing of unhealthy foods to children.

- **Primary**: actions that aim to stop further exposure to risk factors and to prevent a health condition, illness or injury from occurring. Continuing the example above, this level of prevention might include weight management support for those who are overweight.

- **Secondary**: action taken to identify risks, and identify and address health conditions, illnesses or injuries at an early stage and provide support before they escalate. This level of prevention might involve identifying pre-diabetes through screening and intervening early.

- **Tertiary**: action to help people manage existing conditions or support needs, maintain independence, and prevent further deterioration. For example, this might involve managing obesity-related conditions such as type 2 diabetes or cardiovascular disease.

Figure 1 Levels of prevention in health care (Arnold and Holden 2025).



Although this framework was developed around prevention in health, it can also be applied to adult social care, which can contribute across all four levels of prevention. However, much of adult social care is focused on supporting people who already have health conditions, disabilities, or care and support needs. As a result, prevention in social care is often most closely associated with tertiary prevention, supporting people to live well with existing conditions and care needs, while reducing the risk of deterioration or avoidable crisis (*see* Section 4 'What does prevention mean to staff working in adult social care?').

As part of this project, we conducted a rapid literature review to better understand how prevention is defined and discussed in relation to adult social care. Section 2 of the Care Act 2014 requires local authorities in England to take steps to prevent, reduce or delay needs for care and support. However, there is little clarity about how this requirement translates into practice (Marczak *et al* 2019).

From the literature we reviewed, we learnt that prevention is often described in different ways across organisations, professions and local areas (Social Care Institute for Excellence 2021; Skills for Care 2019; Gatherum 2017). Some definitions take a relatively narrow view, focusing on activities such as providing information and advice. Others take a broader perspective, emphasising wellbeing, independence, community connections, and building on people's strengths and assets. The literature also highlights wider debates about whether prevention should primarily be understood as a way of improving people's wellbeing and outcomes or as an approach to reducing demand on services (Tew *et al* 2025; Read *et al* 2023; Verity *et al* 2022).

Despite some differences in definition, there was some consistency in how prevention in practice was discussed in the literature. Preventive practice was often characterised as a way of working rather than a specific intervention (Social Care Institute for Excellence 2021). It tended to be described as recognising early signs of risk or deteriorating needs, and providing proactive support for these issues before they escalate (*see*, for example, Manthorpe and Martineau 2017). It was also described as supporting people to access health care and other services and community support (if needed), promoting independence and reablement, and helping people maintain social participation and community connections.

The literature also highlights the importance of the role of the adult social care workforce in delivering prevention, through their regular contact with people in their homes and communities, which makes them well placed to identify changes in people's circumstances and spot risks early (Royal Society for Public Health 2025; Skills for Care 2019).

Spending on prevention by local authorities has been on the decline

Despite the current focus on prevention in health and social care, and the importance of the role that adult social care staff can play in prevention, investment in preventive activity has faced significant pressures in recent years.

The Association of Directors of Adult Social Services (ADASS) found that the percentage of directors' net budget spent on preventive activities for those ineligible for statutory support (the only budget line where spend on prevention is singled out) had fallen from 8.3% in 2017/18 to 5.6% in 2025/26 (ADASS 2025). Similarly, the proportion who were fully confident of meeting their statutory duties for prevention and wellbeing had fallen from 25% in 2025/26 to 20% in 2026/27 (ADASS 2026). However, there is no available measure of spending on the 'preventive' element of care packages for individuals who are eligible for support.

The King's Fund has highlighted that local authority spending power has increased since 2022/23 but councils do not have the funding to meet all demands on them and their financial positioning is worsening . When under financial pressure, council spending becomes increasingly focused on meeting statutory duties and responding to acute need, rather than on public health and other forms of preventive spending. Across social care, there has also been increasing demand, complexity of need and rising costs (Bottery and Jefferies 2026), which have also added to the financial pressures on local authorities. Resources often need to be prioritised towards meeting immediate care needs, which can make investment in longer-term preventive approaches more challenging (Hoddinott 2025).

Given the important role the adult social care workforce plays in supporting prevention, alongside these wider challenges to preventive investment, it is particularly important to understand how staff perceive prevention, how they see it operating within their roles, and the barriers and enablers that shape preventive practice in their day-to-day work.

Wider context on challenges faced by the adult social care sector

Discussions about prevention in adult social care cannot be separated from the wider challenges facing the sector (Bottery and Jefferies 2026). Demand for support continues to grow, with around 2 million new requests for publicly funded adult social care recorded in 2024/25, as local authorities continue to face significant financial pressures.

Increased spending power has meant that local authorities are spending more on social care, with more people now receiving publicly funded long-term care than at any time in the past decade (Bottery and Jefferies 2026). However, councils still cannot meet all the demands on them and their overall budget position has worsened. In 2024/25, external debt at English councils rose by 10% and useable reserves fell by 4%. The Chartered Institute of Public Finance and Accountancy (CIPFA) said, ‘In 2024/25, English local authorities faced intensifying financial pressures as demand-driven costs and accumulated deficits further eroded already stretched budgets, undermining financial resilience’ (CIPFA 2025). Councils are also having to fund spending on children’s and adults’ social care through cuts in other areas.

The sector also faces significant workforce challenges, particularly with recruiting and retaining staff, and there are persistent challenges in co-ordinating support across adult social care, the NHS and other local services.

Together, these pressures drive councils to focus on delivering their statutory duties to meet immediate care needs, with much less resource and focus available for preventive activities.

03 Methods

Research for this project was carried out between March and April 2026. Ethical approval was obtained from the Health Sciences Research Governance Committee at the University of York on 30 January 2026 before any research activities commenced (reference HSRGC/2026/732/C).

The research was conducted in three phases. The first phase involved a rapid literature review and refinement of the research approach and data collection tools. The second phase comprised six focus groups and one semi-structured interview with adult social care professionals to explore perspectives on the growing emphasis on prevention across health and care systems. The final phase involved thematic analysis of the qualitative data, bringing together findings from the focus groups and interview with insights from the literature review to identify key themes and implications for policy and practice.

Literature review

We carried out a rapid literature review, supported by The King's Fund Knowledge Service, to identify peer-reviewed and grey literature relating to prevention in adult social care. The review explored how prevention is defined, understood and implemented across a range of adult social care settings, including residential care, home care and community-based services.

The search focused on UK literature published between 2016 and February 2026 and was conducted across Emcare, MEDLINE, Social Policy and Practice, and The King's Fund database. Targeted searches of relevant policy, practice and sector publications were also undertaken to identify grey literature. Following screening and deduplication, a total of 56 sources were included in the review.

The review sought to examine whether there is a shared understanding of prevention in adult social care, how preventive approaches are being applied in practice, and the barriers and enablers affecting their implementation. Findings from the review informed the development of the discussion guides used in the focus groups and interview.

Qualitative data collection and analysis

Following the rapid literature review, we conducted six focus groups and one semi-structured interview to explore how prevention is understood and delivered across adult social care settings. We sought to capture a broad range of perspectives and recruited participants from a variety of professional roles and care settings.

Focus groups were organised to bring together professionals working in similar roles and settings, enabling participants to share experiences and discuss how approaches to prevention vary across contexts. Recruitment was supported by partner organisations. Skills for Care helped recruit registered managers and registered nurses through its networks, as did the Royal College of Occupational Therapists. Also, The Care Workers' Charity supported recruitment of professionals working in four settings: residential care supporting working-age adults; residential care supporting older people; home care supporting older people; and those working in supported living with working-age adults.

We used a purposive sampling approach to achieve diversity in participant characteristics, including geographical location, and sought to minimise the number of participants recruited from the same organisation where possible.

In total, 48 participants took part in six focus groups: 7 registered managers, 11 registered nurses, 12 occupational therapists, 6 care workers working in supported living services for working-age adults, 3 care workers working in residential care for older people, and 9 home care workers supporting older people. We had originally planned a focus group with care workers supporting working-age adults in residential care settings. However, due to limited recruitment, this was replaced with an in-depth interview with a single participant.

Focus groups lasted approximately 90 minutes and the interview approximately 45 minutes. Participants were offered £50 in accordance with our policy for remuneration of research participants. All sessions were video-recorded, transcribed and analysed using a thematic approach, as described below.

All sessions were video-recorded, transcribed and analysed using a thematic approach. A coding framework was developed and applied in MAXQDA to systematically code and analyse the focus group and interview transcripts. Themes identified through the analysis were synthesised with findings from the rapid literature review to identify areas of convergence and divergence across the data sources.

Analysis explored themes across the dataset as a whole, as well as differences and similarities between care settings and professional groups. Analysis was carried out and checked entirely by the research team; artificial intelligence (AI) was not used during this process.

Limitations

It is important to note several limitations of our research. First, the rapid literature review was designed to provide a focused overview of relevant evidence rather than a comprehensive assessment of all available research, so some relevant studies or perspectives may not have been captured.

Second, the study involved a relatively small number of participants, with varying levels of participation across settings and stakeholder groups. This means that the findings may not reflect the full range of experiences and perspectives around prevention.

Third, participation was by those who chose to volunteer, so those individuals may have had a greater interest in the topic or stronger views than those who did not participate, which may have influenced the themes identified. The findings are also based on self-reported experiences and perceptions, and so while these accounts provide valuable insights into how individuals understand and experience the research topic, they may be influenced by personal interpretation, recall, or the specific contexts in which participants work. The findings must therefore be considered with these factors in mind.

04 What does prevention mean to staff working in adult social care?

We asked adult social care professionals about what prevention meant to them in their day-to-day work, and how they would define preventive practice, with the aim of gathering insights into how prevention is understood across the sector.

Across the focus groups and interview, there were some consistent themes in how prevention was understood and talked about. Prevention was generally understood as providing the right support at the right time, in order to avoid health deterioration, maintain independence and wellbeing, and prevent needs from escalating. However, different professional groups emphasised different aspects of prevention in their roles, highlighting their differing responsibilities.

This section outlines how prevention was defined by the adult social care staff who took part in this research, and what their preventive day-to-day work looks like. Three main themes came through strongly, which we describe below. We then move on to discuss how staff from different professional groups emphasised different aspects of preventive practice.

What prevention means to adult social care staff across settings

Prevention involves acting early and escalating issues to avoid health deterioration and crisis

Prevention is seen as proactive rather than reactive: This was a common theme we heard from participants. Across settings and professional groups, prevention was commonly understood as identifying concerns early and taking action before they develop into crises. The goal of this proactive approach was to prevent deterioration, avoid hospital admissions, and ensure that people receive support before their needs escalate. This understanding extended both to preventing new problems from arising and preventing existing health conditions or support needs from becoming worse.

> **… prevention, to us, would be making sure that everyone's accessing the health care services that we all access, but also, hopefully improving conditions that they might already have, as well as preventing… avoidable hospital admissions.**
>
> (Focus group, registered manager)

Actions taken by staff to support prevention: Participants described a range of activities that support this early intervention approach. These included monitoring changes in a person's health, behaviour or circumstances. Often this was done by carrying out assessments, using screening and risk assessment tools, putting alarms, sensors and monitors in place, and regularly reviewing care plans. For example, one care worker described using an app to collate day-to-day notes, food and liquid intake, and which had a body map to log information about injuries or falls. This helped them to quickly and digitally assess each individual's health and notice any changes that may need attention. Another care worker described the use of Earzz monitors, which detect sounds and movement and alert carers, to help prevent falls or other injuries.

Care plans were also seen as particularly important tools in supporting preventive work, helping staff monitor changes over time and ensuring that concerns could be communicated and acted on consistently, and allowing for more joined-up preventive work between staff supporting someone being cared for.

Prevention in practice example 1: preventing swallowing problems and malnutrition in a care home

Care workers described how their close daily contact with residents allows them to spot subtle changes early. One care worker noticed that a resident was repeatedly coughing and choking while drinking. They raised the concern with managers, documented it in the care plan, and triggered a review of the person's diet and fluids. Adjustments were then made to the type of food and drink provided, helping to reduce the risk of choking, aspiration and further deterioration.

The importance of continued care and relationship-based support: Participants described that prevention relies on staff being able to recognise when something has changed from the person's usual pattern, so a central part of this preventive approach was knowing the people being supported well enough to recognise when something had changed. Participants across settings described relationship-based care as an important foundation for prevention, enabling staff to identify subtle changes that might otherwise go unnoticed, and flag or escalate these concerns for earlier action. Ultimately, prevention was described as an ongoing process of assessing someone's needs, rather than a one-off intervention.

The importance of referring early: Prevention was also understood as ensuring that concerns are escalated quickly to the right people. Participants described flagging issues to GPs, community services and other professionals, as well as using multidisciplinary approaches to co-ordinate timely support. In this sense, prevention was not only about identifying risks, but also about ensuring that appropriate action is taken before problems worsen.

> **… we have the GP round, we do a weekly GP round. So the GP comes in to see the resident, especially with early detection. If we see any resident that maybe is unwell, or the blood pressure is high, or any… we put them up for the GP to see on that week. And our own GP, we have an app called askmyGP, that would do a consultation. If we notice any changes in our residents, we then send for a consultation. In that consultation, you will say if it's urgent, and if it's urgent, you click urgent, so the GP will call you back, to do that by video call, or they will come in.**
>
> (Focus group, registered nurse)

Prevention is also about maintaining independence, wellbeing and quality of life

Prevention is understood as being broader than health: Although participants frequently discussed prevention in relation to health and avoiding deterioration, prevention was often understood more broadly than health alone. Across the focus groups and interview, participants often described prevention as helping people maintain their independence, wellbeing and quality of life for as long as possible. Rather than focusing solely on preventing illness or managing risk, prevention was often framed as supporting people to continue living safely, independently and meaningfully in their preferred environments, and avoiding greater dependency on services.

Actions taken by staff to support prevention: In practice, this included a wide range of support. Occupational therapists described providing equipment, home adaptations and assistive technology, alongside reablement, therapeutic interventions, and support to engage in meaningful daily activities. Other staff, particularly those supporting older people in residential settings, also highlighted that prevention involved practical measures to reduce the risk of harm and deterioration, including the use of fall protection mats, hoists, wheelchairs and walking aids.

Participants also emphasised the importance of meeting basic needs through support with nutrition, hydration, personal care and mobility, viewing these everyday activities as essential for maintaining health, wellbeing and independence. Supporting carers, facilitating social connections, and helping people access wider services were also described as preventive activities.

The tension between prevention and autonomy: Participants also highlighted tensions that can arise when trying to balance prevention with quality of life and individual choice. While participants often described prevention as aiming to support independence and improving quality of life, they also recognised that measures intended to prevent harm or ill health can sometimes come at a personal cost, in that they may restrict people's autonomy, privacy or ability to engage in activities that are important to them.

Preventive interventions can disrupt established routines or intrude on privacy – for example, if a care worker needs to carry out regular checks during the night that can disrupt sleep. Other limitations may reduce people's freedom or opportunities to make their own choices – for

example, by preventing them from leaving care settings. These discussions reflected a broader tension within adult social care between protecting people from harm and supporting them to live the lives they want to lead.

> **So, in all, we have to balance between both, because inasmuch as we say 'okay, it's affecting their personal life,' there are some people that you find dead in their room in the morning. So, we need to balance the two and see what is best for them. At the end of the day, care is about for the good of the residents, it's not just for you. So, we have to balance to see the ones and say 'okay, this one is good, and this one we need to check'.**
>
> (Focus group, care worker supporting older people in residential care)

The importance of tailored support and individual choice: Participants frequently emphasised the importance of tailoring preventive support to the individual and preserving independence, choice and control wherever possible, even where this involved an element of risk. Discussions highlighted that the potential unintended consequences of prevention were often perceived to be less about physical health and more about impacts on mental wellbeing, quality of life, dignity, and a person's sense of identity. Some participants also reflected that the balance between prevention and other priorities may shift over time, suggesting that in certain circumstances – particularly towards the end of life – comfort, emotional wellbeing and quality of life may become more important considerations than preventing further decline.

> **Things like dementia sometimes, maybe rightly or wrongly, maybe tell a little white lie just to put that person at ease. Say if somebody has passed away and they're adamant they're still alive, but then for you it's quite difficult, you know, you wouldn't fully go in there and just say to them 'no, no, they're not alive'. But for me I would probably suggest, I'd get a picture and talk about them as a reference. It's a really grey area I think, and it's having the correct tools with obviously the individuals, that's my perspective on it.**
>
> (Focus group, care worker supporting older people in home care)

Overall, participants suggested that effective prevention is not simply about reducing risk wherever possible, but about finding an appropriate balance between safety, wellbeing, independence and personal choice.

Prevention is person-centred support that respects choice, not 'one size fits all'

Prevention is not 'one size fits all': Participants consistently described prevention as being highly individualised, rather than a single intervention or a one-size-fits-all approach to care. Instead, participants described prevention as highly personalised, reflecting an individual's needs, preferences, abilities, circumstances and goals. Across settings, participants viewed tailored support as central to effective preventive care.

Actions taken by staff to support prevention: Participants emphasised that prevention can look very different from one person to another and that approaches that are effective for one individual may not be appropriate for another. To plan this personalised support, participants highlighted the importance of personalised care plans, Positive Behaviour Support (PBS) plans, and hospital treatment plans and assessments (eg, occupational therapy assessments) to determine need.

We also heard that not only does prevention look different person-to-person, but it also changes over time. Prevention was described as an ongoing process of putting support in place, monitoring how well it is working, and adapting it when needs change. Reviewing and updating care plans in response to changing circumstances was described as an important part of day-to-day preventive work, often informed by the observations of frontline care staff and discussions within multidisciplinary team meetings.

Strengths-based approaches to prevention: Many participants linked prevention to person-centred and strengths-based approaches. They described prevention as enabling and supporting people to make choices and maintain independence wherever possible, rather than simply directing behaviour or imposing solutions. Although some participants acknowledged that more directive approaches can sometimes be necessary in settings where risks are high or people have higher support needs (such as residential care for older people), there was broad agreement that preventive support should be centred around the individual and their preferences.

Prevention in practice example 2: supporting independence through occupational therapy

Occupational therapists described working with people over several months to identify goals that matter to them and develop personalised plans to achieve them. This might include helping someone regain confidence with daily activities, providing equipment or adaptations, or connecting them to community support. The focus is not simply on managing current difficulties but on maintaining independence, preventing future deterioration, and enabling people to continue living fulfilling lives in their own homes.

Different professional groups emphasise different aspects of prevention

Although participants shared a broad understanding of prevention as supporting people before needs escalate, different professional groups emphasised different aspects of preventive practice. These differences appeared to reflect the distinct responsibilities and perspectives associated with different roles.

- **Occupational therapists** were particularly likely to define prevention in terms of maintaining independence, supporting people to live safely in their own homes and avoiding future escalation of need. In practice, this included activities such as risk assessments, early

assessment of needs, provision of equipment and adaptations, education, signposting, advocacy, and linking people to wider support. Compared with other groups, occupational therapists placed particular emphasis on independence, continued functioning, and avoiding future service use.

- **Home care workers supporting older people** often described prevention as encouraging healthier behaviours and identifying concerns before they become more serious. Their role was frequently characterised as being the 'eyes and ears on the ground', observing changes, providing advice and encouragement, and escalating concerns to other professionals when needed. Compared with other groups, their accounts focused less on delivering interventions directly and more on monitoring, relationship-building and timely escalation.

- **Supported-living staff working with working-age adults** tended to understand prevention through the lens of personalised support. Prevention was described as highly individualised and shaped by people's preferences, goals and circumstances. Participants frequently discussed the importance of care plans and PBS plans in helping staff understand triggers, respond appropriately to changes in behaviour, and ensure that the right support is in place.

- **Residential care staff supporting older people** generally focused on preventing deterioration and physical harm. Discussions centred on falls prevention, nutrition, hydration, personal care, medication management, and monitoring changes in health and wellbeing. Participants described a range of practical measures (including sensors, hoists, fall protection mats and mobility aids) that were viewed as important preventive tools.

- **Staff working in residential services for working-age adults** tended to place less emphasis on physical deterioration and more on preventing ill health, promoting wellbeing and supporting healthier choices. Participants highlighted the importance of knowing individuals well, providing emotional support, and ensuring that support plans reflected people's changing needs and preferences.

- **Nurses** typically framed prevention in more clinical terms than other groups. They emphasised maintaining health, managing long-term conditions, identifying deterioration early, and preventing avoidable hospital admissions. Nurses and managers both spoke more than other groups about their work focusing on trying to keep people out of hospital when possible, and planning for the end of life. Compared with other groups, nurses' accounts focused on activities such as monitoring nutrition, hydration, skin integrity and hygiene, using screening tools, and working with GPs and other professionals to manage health concerns.

- **Registered managers** commonly defined prevention as intervening before problems reach crisis point. Discussions focused on ensuring that appropriate care packages were in place, reviewing support arrangements, co-ordinating services, and acting quickly when risks

emerged. Compared with other groups, managers spoke most explicitly about preventing escalation and ensuring timely intervention.

Overall, although prevention was understood through different professional lenses, there was a common view that it involves providing proactive, personalised support that helps people maintain their health, independence and quality of life, while reducing the likelihood that needs will escalate.

05 Barriers described by staff working in adult social care

During focus groups and interview, participants described a range of challenges, many of which are not unique to prevention but reflect wider challenges to working effectively in a personalised way in adult social care. Participants described various barriers to working well in general that could make it harder to create the capacity and flexibility needed to focus on prevention.

These barriers operate at three separate – and sometimes interconnected – levels:

- the system – the social care sector (including social services), the NHS, other public services (eg, housing), private companies that supply equipment, and the voluntary, community, faith and social enterprise (VCFSE) sector. Sometimes this level included the Care Quality Commission (CQC) as the regulator, as well as national government in terms of its policies and funding decisions
- the service – the social care providers (eg, care homes), companies or local authorities where participants worked
- the workforce or individual – the participants themselves.

In this section, we examine the barriers discussed by participants at each of these three levels. Although there were many commonalities across all participants' experiences, their exact nature and impact were different depending on the type of care setting and/or the type of worker (*see* Appendix for an overview of barriers and corresponding actions that could help at each level).

System-level factors that shape prevention

Participants described prevention as being shaped by wider system-level factors that sit beyond the direct control of individual teams, services or provider organisations. These factors could either constrain preventive work or create the conditions that enable it to happen. In this section, we discuss barriers and enablers in two key areas: funding and commissioning; and fragmentation between adult social care and the NHS.

Funding and commissioning barriers

There was an implicit sense that the sector is severely challenged by a lack of funding and the ability to employ as many staff as needed. One significant consequence of this is the workforce shortage across the sector, which in turn restricts the time and capacity for care work. Lack of funding was also associated with care homes and nursing homes not being able to buy or properly maintain equipment needed for residents' care.

Another consequence of the funding challenge in adult social care is that commissioning was seen as very narrow and based on units or tasks that allow very little flexibility for all types of staff to deliver holistic and person-centred care. For example, home care workers described their visiting time being limited to 15- or 30-minute blocks (because local authorities pay for home care visits in units of time), which meant there was not enough time to carry out personal care tasks (such as helping the person get dressed), as well as spending enough time to listen and show compassion and empathy before needing to rush to the next home visit. These actions all play an important role in supporting people's health and wellbeing, albeit directly and indirectly.

> **You can't do so much in 15 minutes… sometimes when a client is refusing… care and you're trying to pacify the client and you're trying everything possible to explain how you've got a duty of care towards the client and the client is refusing… Like I said, shortage of time… How are you supposed to provide care in 15 minutes? So, I'd say that is one of the factors that is also affecting us.**
>
> (Focus group, home care worker for older people)

Several care workers made the point that their relatively low pay contributes to a situation in which they need to limit the amount of time they spend with people who access care (since workers are paid hourly but not paid for travel or waiting time) or turn up for shifts when they are unwell, which can run counter to the idea of prevention.

Commissioning constraints were a dominant theme in the occupational therapists' focus group discussion. There was a significant amount of frustration expressed about commissioning being based on equipment or adaptations – as opposed to giving occupational therapists the time and flexibility to work with people in a more holistic way.

> **But the commissioning, and the perception of [occupational therapy]… we are constrained by that commissioning envelope… Our OTs… are really geared up to want to support people, to make sure that they are focusing on living well in their lives... Because we've got such fabulous skills in both mental health and physical health… And therefore, we're really key placed to be pushing forward and leading on this prevention agenda… But I think our wings are clipped sometimes by commissioning.**
>
> (Focus group, occupational therapist)

Fragmentation barriers

A second consistent theme was that the disconnect between health and social care creates a significant impediment to preventing ill health and keeping people out of hospital. Different participants experienced the fragmentation in different ways.

Registered managers described fragmentation between health and social care as a practical barrier to prevention. They reported that people were sometimes discharged from hospital to care homes without sufficient planning for the equipment or support they need, leaving providers to resolve issues after the person had arrived. They also pointed to siloed working, unclear responsibilities, and limited flexibility for professionals to work together, often because of rules around what services will do depending on complexity of needs and a lack of clear guidance to support joint working across sectors. Out-of-hours support from health care services (ie, outside of normal opening hours in primary care) was also described as being inconsistent and sometimes unresponsive, making it harder for care homes to respond quickly to crises and avoid deterioration.

> **A barrier we really commonly face is there being no clear process between the hospitals and the community teams. So, a lot of the time what we hear is, 'oh they're so complex, that… they don't fall under us, but I can't advise you as to who they do fall under…'. No one will step up and go, 'oh they are a very complex individual, we'll work together with the hospital or the community team, and see what we can all work together to achieve'. Our [residents] end up just left in the middle.**
>
> (Focus group, registered manager)

Registered nurses spoke about poor co-ordination and communication between nursing homes and health care services. This was seen as especially challenging during out-of-hours periods, when support could be harder to access and delays could increase the risk of deterioration. They also pointed to fragmentation *within* health care itself, with specialists not always communicating with each other or with GPs in a timely way. In some cases, nurses felt that clinical decisions could override a resident's own wishes (including at the end of life), pushing them down a route that might not be best for their physical health, mental wellbeing or overall quality of life.

> **… time delay… is really frustrating for the prevention side of things … somebody will have a medication review by a consultant, they'll make changes to the medication. We can't implement those changes until the GP has seen that letter of confirmation… We've had delays of up to six weeks before the GP actually receives the letter, so that medication change can take place. In the meantime they have had more hospital admissions that actually could have been prevented if they'd have had the medication change that the consultant's prescribed.**
>
> (Focus group, registered nurse)

Care workers also talked about barriers in information-sharing with health care professionals and social workers. For example, a home care worker spoke about a lack of clarity regarding professional boundaries – with district nurses assuming that care workers can undertake certain tasks they do not feel they have the authority to do. We also heard that delayed responses from district nurses, occupational therapists and social workers can have knock-on effects for the

care that care workers are able to provide to people who access care. Among all types of care workers, it was striking that none of them talked about having direct communication links to wider multidisciplinary teams. Instead, the information they collected through their roles as the 'eyes and ears' was fed to managers of care homes or social care providers, with the assumption that they would then relay that information to social workers or health care professionals.

Enablers

- Participants were strongly in favour of joined-up approaches and collaboration across social care and the NHS.
- Prevention worked at its best when different professionals supported each other as a multidisciplinary team.

Prevention in practice example 3: safe hospital discharge through trusted assessors

Registered managers highlighted the role of trusted assessors who follow individuals throughout their hospital stay and maintain communication with care providers. By ensuring that equipment, support and care arrangements are in place before discharge, they help reduce the risk of unsafe discharges, readmissions and avoidable crises. Participants described this as a practical example of prevention through better co-ordination between health and social care services.

Service-level factors that shape prevention

At the service level, participants described prevention as being shaped by how care services are organised and managed. These factors influenced the extent to which participants could work proactively, respond to changes in people's needs, and provide person-centred care. In this section, we discuss barriers and enablers regarding: workforce capacity and time; care planning, communication and information-sharing; leadership and culture; and equipment and resources.

Workforce capacity and time barriers

A shared experience across all types of workers was the impact of staffing shortages. This meant high workloads and a lack of time to dedicate to developing relationships with people who access care, and for delivering person-centred care. Care workers felt this time pressure in care homes, supported living units and in home care. For those working in supported-living units, looking after multiple residents with complex needs limited the amount of time available for each individual. Home care workers felt that the fixed amount of time they had to visit each person meant that they could do little more than the basics.

A strong theme in the focus group with occupational therapists was a lack of capacity to keep up with the very high demand for their services. Managing waiting lists and the administrative burden meant there was little time for them to deliver holistic care. This pressure was often compounded by the time taken to obtain specialist equipment, including sometimes having to

make the case for that with local authority commissioning teams. There was considerable frustration that occupational therapists (OTs) not having the time to bring the full breadth of their expertise and skills to bear was a missed opportunity to do more in-depth preventive work.

> **I think in terms of the OTs that are going out and assessing for equipment and adaptations, I do think sometimes they could look a little bit more holistically at the whole person's needs. I think they are very focused, just because we're under so much pressure to get visits done [to] get down the waiting lists, they are just literally going out and focusing on what equipment somebody needs, or what adaptation would make their life more independent, safer. But they're not really in a position to look any wider than that.**
>
> (Focus group, occupational therapist)

Enablers

- There was a very strong consensus among focus group participants – particularly care workers – that sufficient staffing levels would support them to work more effectively and be more thorough about prevention.
- Furthermore, participants felt that to be able to use their time effectively, it is helpful to have the necessary equipment and materials to hand when they are needed, as well as having timely responses from managers, social workers and health care professionals.

Care planning, communication and information-sharing barriers

An individual's care plan was felt to be the key guidance for how a care worker uses their time. However, in care workers' experiences, care plans were felt to be out of date or not in sync with their own observations of the current situation. Home care workers in particular felt that this affected their ability to attend to current or pressing needs. They also felt it limited their ability to prevent emerging needs from escalating in an agile way because home care providers are not permitted to change or flex time allowance without explicit permission from social care services. This was compounded by not having quick access to social workers who could update care plans based on real-time information.

> … *like you said, people's needs do change. That's why I really do push and push to get care plans, maybe even updated* [every] *two months maybe…*
>
> (Focus group, care worker for older people in home care)

Another challenge for care workers regarding care plans was the sense that they did not have particularly strong influence over what is planned. A care worker for working-age adults in supported living gave an example of making a suggestion for a bed frame for an individual to prevent falls, but this was overridden by the social worker's judgement that the individual has 'got capacity', so it was not put in place.

Enablers

- Good communication and timely information-sharing were repeatedly mentioned by focus group participants as enablers of preventive working.

Prevention in practice example 4: using data to reduce falls

We heard a good example of a care provider organisation sharing data about falls rates across a group of care homes. One care home was given data to show it had a higher falls rate than others in the group. This prompted the care home to take actions that would bring its rate down to a target of 5% or less. They introduced sound monitors and fall protection mats in residents' rooms, and set an expectation that care workers should respond to call bells within minutes – to reduce the risk of residents falling when trying to get out of bed without assistance.

This led to a reduction in the rate of falls from 15% to 8%, highlighting the benefits of using routinely collected data to identify risks and take practical steps to reduce avoidable harm.

Leadership and culture barriers

It was striking that leadership and organisational culture played a significant role in care workers' ability to deliver preventive care well. Essentially, care workers' experiences at work affected their capacity to care for others:

> *Because this is a job that is very sensitive and you need to be at your best. You need to be taken care of before you could take care of others.*
>
> (Focus group, care worker for older people in residential care)

Several factors shaped care workers' experiences of the workplace. Some felt that managers did not support them when they faced issues such as verbal or racist abuse from people who access care. Others felt that their work was not always recognised or valued, and that managers showed little flexibility when they were unwell.

Most strikingly, some care workers appeared genuinely worried about getting into trouble at work. They described feeling closely scrutinised and expected to complete every task or answer every call bell despite heavy workloads and competing demands. They feared that if something went wrong or a service user came to harm, responsibility would fall primarily on them. As a consequence, care workers were very cautious about being seen to prioritise task completion – which could perhaps be at the cost of having the time and flexibility to exercise their individual professional judgement about person-centred, preventive care.

> **It could take you 40 minutes to change one pad… And you have to, because if you don't, if they are wet, and their family comes in, they're going to blame you… why the change has not been done yet, especially when you're using the app, which it comes up every three hours, you have to change the pad… And when we have eight service users to deal with… But if anything like that happens, the care worker will be blamed.**
>
> (Focus group, care worker for working-age adults in supported living)

Enablers

- In the falls reduction project described above, managers did more than introduce new equipment and response targets – they made staff recognition part of the approach. They praised care workers for responding promptly to call bells and introduced monthly 'falls champions', alongside champions for infection control. For the care worker who shared this example, the recognition showed that managers noticed and valued staff members' contribution to keeping residents safe.
- In another example, a care worker described her current employer as 'wonderful' because the organisation provided paid training, enabling staff to build their skills without losing income.

Equipment and resources barriers

Equipment such as walking aids, hoists and bed frames is essential to supporting people safely in adult social care. However, a major challenge for all types of workers was not having ready access to such equipment. A lack of equipment could lead to harm for people who access care as well as staff themselves.

We heard care workers express frustration about their managers not ensuring the equipment was in place, and when their suggestions for putting in additional pieces of equipment were dismissed by social workers. In turn, we heard registered managers and nurses and occupational therapists also expressing frustration about the high cost of certain types of equipment, and delays in getting hold of equipment and in maintenance. Additionally, managers and nurses had to challenge attempts to discharge people when hospital or social care teams wrongly assumed that residential and nursing homes had the necessary equipment.

> **We've got another lady who is [at the] end of life, who was discharged from an oncology setting, to us for end-of-life care, who's got really difficult to manage lymphoedema. But because she's come to a nursing home, the lymphoedema team won't take over her care… So, you know, from a prevention point of view, her legs broke down within a matter of days, because we didn't have the right dressings, we didn't have the right equipment, and we didn't have the right advice.**
>
> (Focus group, registered nurse)

Enablers

- On the other hand, we also heard examples in which equipment such as raiser chairs, pendant alarms, digital devices and apps were helping workers with different aspects of preventive care.
- However, all of the examples came from residential care; none of the care workers doing home care shared examples such as these – although this could reflect the experiences of this particular sample.

Workforce and individual-level factors that shape prevention

At the workforce and individual level, focus group participants described prevention as being shaped by capability – ie, the knowledge, skills and confidence to work preventively. At the same time, they also told us about how their wider experiences of work could impact on their motivation and sense of reaching their full potential in prevention. This included the nature of relationships with colleagues and people who access care, recognition of the workforce's expertise, and whether staff felt valued, supported and secure in their roles. In this section, we discuss barriers and enablers regarding: knowledge and skills; relationships; recognition of expertise; wellbeing; and balancing prevention, autonomy and quality of life.

Knowledge and skills barriers

Several care workers talked about inadequate training and refresher training limiting the extent to which they felt fully confident to undertake all of their tasks and support the health and wellbeing of people who access care. In some instances, care workers said they had not been properly trained in standard aspects of care work such as 'moving and handling' or how to use different types of equipment. In other instances, they talked about specific (and possibly not universally offered) training such as knowing how to support people who access care receiving percutaneous endoscopic gastrostomy (or 'PEG feeding') or how to deal with people's challenging behaviours.

Noticeably, registered nurses, registered managers and occupational therapists did not talk about knowledge and skills barriers at all.

Enablers

- Based on what participants said, it was clear that providing paid induction, role-specific training and regular refresher training sessions would support staff to feel more confident in their work.
- Training should be tailored to the varied needs of people who access care.

Relationship barriers

In care workers' focus groups in particular, we heard that a lack of strong or trusting relationships with people who access care could impede their efforts to support them. There

was an acknowledgement that relationships and communication are key, especially when prevention often depends on people who access care accepting that care workers need to (for example) disturb sleep with regular observations (to minimise the risk of falls) or carry out personal care (for hygiene and to prevent infection). However, sometimes care workers were on the receiving end of hostility from the people who access care and their family members, which affected their morale and sense of job satisfaction:

> **… sometimes… the family will see the carer like an enemy, the employer see you like an enemy, the service user you are taking care of, rather than seeing you as a helper, as their carer, or as their support.**
>
> (Focus group, care worker for working-age adults in supported living)

Enablers

- We also heard instances where care workers, registered managers and registered nurses had built good relationships over time with the people who access care and their family members, which was a strong enabler of care. Knowing people well and building trust supports person-centred care and strengths-based approaches, as well as early identification and proactive action.
- Good working relationships between services and professionals were also identified as an enabler, particularly during out-of-hours periods.

Recognition of expertise barriers

Across all types of focus groups, we heard participants express frustration that their expertise was not being recognised and valued by other professionals. As already mentioned, care workers did not always feel that their input was welcomed by managers and social workers in care planning. Similarly, occupational therapists, registered managers and registered nurses all felt that their expertise was frequently dismissed or undermined.

Occupational therapists often felt that the perception of their role by others – that they only arranged equipment and adaptations – overlooked the full breadth of their abilities to do more with people to keep them well and independent for as long as possible. As one occupational therapist observed, being pigeon-holed in this way can lead to the workforce feeling ‘deskilled’ and ‘not confident to deliver some of these preventive elements of what they would have been trained to do’.

Enablers

- As a counter-point to the lack of recognition, we heard registered managers and registered nurses share experiences where their professional judgement had been valued and respected. This suggests that they may may feel more able than some other staff groups to use their knowledge of people who access care to advocate for them with NHS teams.

Wellbeing barriers

One of the most surprising challenges we heard about was staff wellbeing. This theme was most prevalent among care workers across all settings, but was also discussed by registered nurses to a lesser extent. Care workers did not always feel able to give their best to people who access care when they were feeling low, overwhelmed with the volume of work, and having negative experiences at work. As one care worker (supporting older people in home care) told us: 'It's very difficult to serve from an empty cup'.

Care workers talked about things that undermine or threaten their sense of wellbeing – for example, lack of recognition of their skills and expertise, low pay, encountering racist abuse, and concerns about their job security. At the time of the research (and for a long time beforehand), the issue of immigration had become the subject of fierce debate in society, politics and the media, with many people in the UK holding the view that there are too many migrants – including those employed by social care providers.

> **… you go to some homes and people have developed that kind of mentality that they don't want an immigrant to come in, even to provide care for them, they tend to meet you with very bad and negative energy. So, when that happens, that [care worker] is also not going to give you that compassionate care that you need.**
>
> (Focus group, care worker supporting older people in home care)

Care workers supporting older people in home care spoke about the emotional toll of doing their work in relative isolation from colleagues, as they often do their home visits alone. Those caring for working-age adults in supported living talked about feeling blamed for incomplete tasks but receiving little recognition for what they had achieved.

Enablers

It is important to note here that supporting staff wellbeing should not be seen as separate from prevention; we heard that care workers who feel valued, supported and secure are better able to provide consistent, compassionate and preventive care. The Skills for Care Workforce Strategy notes that care workers can be in poor health but lack the capacity or resources to improve it (Skills for Care 2025). The strategy sets out several commitments aimed at improving staff wellbeing – for example, a coalition of organisations supporting employers with guidance on prioritising wellbeing and tackling workplace harassment, as well as recommending that the CQC considers staff wellbeing in its assessments.

Unique barrier and enabler: balancing prevention, autonomy and quality of life

A distinctive challenge in adult social care is that prevention is not a straightforward case of minimising risk. Unlike the fundamental approach of safety first in health care, social care requires staff to balance safety with people's autonomy, rights and quality of life. Participants

described this as an area that often calls for careful judgement in the moment, rather than the automatic application of rules or restrictions.

This tension was particularly evident when:

- people living with dementia, or who lack capacity to make a particular decision, may not understand why restrictions have been placed on them
- people refuse personal care or other support intended to protect their health and wellbeing
- staff are asked to support choices they know may not be the healthiest, such as buying cigarettes
- staff want to support positive risk-taking to preserve independence and quality of life
- staff advocate for a person's end-of-life wishes, including a preference not to be admitted to hospital for treatment.

These examples show that preventive practice in adult social care is not always about choosing the safest option. It involves person-centred decisions that weigh potential harm against a person's wishes, dignity, independence and quality of life.

The barriers described in this section show that prevention depends not only on the actions of individual workers, but also on the wider conditions in which care is commissioned, organised and delivered. The next section considers the implications of all of the research findings.

06 Discussion and recommendations

Our research highlights both the opportunities and challenges in aligning the adult social care workforce with the policy ambition to shift to prevention. We found that prevention is already deeply embedded in everyday practice in adult social care; in fact, it appeared that good prevention went hand-in-hand with good care. Moreover, the importance of supporting people to live well and independently and avoid crises was very well understood across all care settings and types of workers, which reflects a very high level of engagement with the principle of prevention being better than responding to crises. However, participants also described several key challenges, and it is clear that more support is needed at different levels to help create the conditions that will enable the workforce to do more in the prevention space.

We have grouped our insights under four concluding points, with the aim of helping policy-makers to understand: what prevention is in adult social care, how the workforce contributes to prevention, what the key constraints are, and what needs to change. Our conclusions are that:

- prevention in adult social care is different from how prevention is understood in health care
- prevention is already embedded in adult social care
- staff in adult social care contribute to prevention in different ways
- barriers are experienced across multiple levels.

Understanding of prevention in social care is different from that in health care

Our literature review found that there is no single, universally accepted definition of prevention in adult social care, and understandings vary depending on the setting, job role and context. However, we did find a consistent understanding among staff that prevention is associated with:

- maintaining and improving wellbeing and independence
- supporting quality of life
- preventing deterioration and crisis
- providing specific support for an individual rather than a group or at population level.

Our findings suggest that adult social care staff contribute across all prevention levels. However, tertiary prevention was by far the most dominant framing of prevention across participant groups, reflecting the reality that much preventive work in adult social care focuses on supporting people with existing health conditions, disabilities and care needs to live well and maintain their independence. This is understandable, given that most people accessing care already have diagnoses for various conditions (such as dementia, frailty and learning disabilities) and associated care plans to manage those. Participants' accounts highlight the significant preventive value of helping people live well with existing conditions. In addition,

participants told us they sometimes need to balance the need to minimise risk with respecting people's choices and autonomy, which reflects a unique capacity to 'meet people where they are'.

Arguably, this is in contrast to health care, where nurses, midwives and allied health professionals talk about prevention in terms of improving health and health outcomes and reducing pressure on health and care services (Gilburt *et al* 2026). In that sense, health and social care staff are divided by a common language when it comes to talking about prevention.

Another contrast with prevention in health care was the inherent tension within adult social care between working preventively to reduce risk, and supporting people to live the lives they want to lead. Participants frequently described the need to balance safety with choice, control, quality of life, and a person's sense of identity. This points to a wider understanding of prevention within adult social care where staff have to weigh up whether or not working preventively is always the 'best' thing to do for each individual.

For the NHS, the 10 Year Health Plan sees prevention as including population-level activities to create a smoke-free generation, tackle harmful alcohol consumption, end the obesity epidemic, and address the wider determinants of health such as air quality and employment (Department of Health and Social Care 2025). These are not aspects of prevention that social care staff discuss, nor do they talk about this work in the context of broader public health issues (unlike health care staff, who do).

The 10 Year Health Plan does also say that 'social care professionals' will be part of neighbourhood teams focusing particularly on rehabilitation, recovery and frailty prevention, and will carry out health care activities such as blood pressure checks. This is more familiar territory for social care staff, but even here it does not cover the full range of activities they would see as being 'preventive' and therefore offers only a limited perspective on the potential of adult social care in delivery of day-to-day tertiary prevention. Furthermore, the care workers we heard from did not appear to have direct or formal involvement in neighbourhood teams, which would be a missed opportunity for teams to hear real-time information about local people who access care.

Overall, this suggests that policy needs to adopt a broader understanding of prevention that captures the outcomes valued within social care (particularly independence and quality of life), not solely reductions in health service utilisation. In addition, it is essential that tertiary prevention is not framed as a 'lesser' form of prevention, with all time, energy and resource pointed upstream. It does, however, also suggest that there is a need for a broader discussion between the NHS and social care. This discussion should consider whether there is scope to increase the role of social care in primary and secondary prevention. In particular, it should consider the extent to which the 1.5 million-strong adult social care workforce might be seen as part of a 'make every contact count' approach to public health, while being sensitive to the unique approach in social care of supporting people to live the lives they want to lead.

This distinction between prevention in health care and social care has practical implications too. In England, many forms of low-intensity support (eg, cleaning and cooking) that could help older people stay well and independent are not part of publicly funded care unless people meet the

Care Act eligibility threshold. Australia provides an example of a broader model, where low-intensity home support is available *before* people need more formal care packages (Townson 2025).

Prevention is already embedded – though not widely articulated – in adult social care

It was striking that participants found it difficult to separate prevention from good social care – in other words, supporting people's wellbeing and independence was how they described preventing deterioration or minimising risk. Through this, social care staff suggested that the same building blocks support both good prevention and good social care, ie:

- relationship-based care (knowing people well)
- continuity of care
- responding early
- tailoring support.

This suggests that strengthening prevention is, to some extent, synonymous with strengthening the fundamentals of high-quality social care by ensuring that staff have capacity to carry out their roles fully. For example, we heard from occupational therapists in particular that they often are not able to bring their full knowledge and skills to bear on holistic, person-centred care when they are restricted to time-limited support that is dominated by equipment and adaptations.

However, a corollary of seeing prevention as a core element of social care practice, indivisible from other elements, is that prevention is rarely discussed in its own right – it is just part of 'doing' social care. As a result, there is rarely a focus on identifying and measuring its impact, and preventive benefits are not necessarily understood, recorded or communicated. In a health and care system where resources are inevitably under pressure, this may prevent the level of investment needed for prevention in social care from being prioritised or even considered.

Staff in adult social care make different contributions to prevention

Another key insight from our research is that different types of staff are responsible for different activities that support prevention, ie:

- care workers often act as observers; they build relationships with people who access care and they can identify risk and deterioration early on
- registered nurses contribute more to clinical monitoring and the management of health conditions (including advocacy at the end of life)
- registered managers co-ordinate support and intervene before a crisis
- occupational therapists focus on supporting independence (and are frustrated that they could do more, as we have mentioned).

In that sense, there is no single job role in adult social care that supports prevention. Staff support prevention in different but complementary ways.

It follows that supporting the workforce in adult social care to make the shift to prevention cannot be a ‘one-size-fits-all’ approach. Instead, it would be beneficial to build on the distinct contributions of different staff groups and take a whole-system approach to workforce planning that recognises the distinct but complementary contributions made by different professional groups (Naylor *et al* 2024). In addition, staff working in adult social care may themselves find it useful to have a clearer understanding of how their unique contributions align and fit with what others do – including in the wider health care workforce.

Barriers are experienced across multiple levels

At an individual level, our findings highlight the role of staff wellbeing in enabling staff to give their best to their work. As we have said before, prevention in adult social care is very much about being compassionate, forming bonds, and knowing people well enough to notice even the smallest of changes. However, as care workers pointed out, having compassion for others depends on receiving compassion too, and relationships are harder to nurture or sustain when those delivering care feel exhausted, unsupported or unappreciated. As The King’s Fund has argued, improving the wellbeing of the health and care workforce and compassionate leadership are prerequisites for the success of the level of reform set out in the 10 Year Health Plan (Arnold *et al* 2025).

Although our research did not specifically explore protected characteristics or inequalities within the workforce, some participants highlighted experiences of racism and working in environments that feel hostile due to their racial identity, immigration status or both. Our findings suggest that workforce inequalities may act as an additional constraint on prevention by affecting staff wellbeing, retention, and their ability to build the trusting relationships that underpin preventive care.

Overall, participants told us that in reality, good prevention (and good social care) is heavily constrained by systemic factors such as inadequate funding of the sector, commissioning limiting what staff are able to do, and the lack of joined-up working across health and social care (and other public services). Some of the strongest barriers reflect the problems created due to lack of integration between health and social care, such as poor hospital discharge planning, lack of timely information-sharing, and challenges in accessing specialist advice and support. Prevention is highly dependent on systemic conditions, and we heard that staff were doing what they could in very difficult circumstances. These findings are consistent with existing analysis of the social care sector (Buckingham and Purbrick-Thompson 2026; Bottery 2025).

Because these challenges are well known and systemic, it follows that making significant improvement requires large-scale system change. Currently, and for the first time in at least a decade, this sort of systemic change in social care is being considered as part of the Casey Commission and by the widespread discussion about a 'national care service' that has been

galvanised by the incoming prime minister. This includes potential reform of the social care workforce, taking in not just pay but also terms and conditions and training.

There is therefore a real opportunity not only to evaluate the role of social care in prevention but also to reform and realign it (where appropriate) to most effectively contribute to that agenda, as well as delivering on its wider goals of ensuring freedom, independence, dignity and choice for older people and working-age adults with disabilities.

Recommendations

A question raised by the findings, though not directly tested in this research, is whether there is scope for the adult social care workforce to contribute more deliberately to primary and secondary prevention in line with the 'make every contact count' approach. Any such discussion would need to be grounded in social care's distinctive focus on independence, wellbeing, choice and quality of life. Thus, commissioning of adult social care should take into account the potential for social care staff to identify behaviours that could adversely affect people's health (eg, poor nutrition), to identify signs of health conditions that could be treated, and the potential to link people into services such as social prescribing. This would, at the same time, have to recognise that where people have capacity, it is the individual's decision as to how to respond to advice and/or referral.

We note two key underlying issues that can constrain systems, services and people from working more preventively:

- The lack of a common understanding of prevention, both within adult social care itself and between social care and the NHS.
- Even more broadly, systematic barriers, including commissioning/funding, integration of health and care services, and the workforce.

Therefore, we have focused our recommendations on these areas, and it follows that they are mostly aimed at national policy and adult social care sector levels. There is strong overlap with the recommendations made in The King's Fund's companion piece of research about health care professionals and the shift to prevention – specifically regarding the need to address structural barriers, align financial incentives to preventive practice, and develop more joined-up ways of working (Gilburt *et al* 2026).

Readers are reminded that Appendix 1 sets out actions that could help address barriers at service and workforce/individual level – although these are untested (and out of scope for this research) and so we cannot attest to their effectiveness.

Develop a common understanding

1. There is a clear need for a consistent definition – building on the statutory duty to prevent, reduce and delay needs set out in the Care Act 2014 – that places social care activities in the context of the wider narrative and debate about prevention. The Modern Service Framework for Frailty and Dementia would be a potential place to embed this, as it is due to

be published in 2026 (according to the 10 Year Health Plan commitment). The DHSC should meet this need. For staff working in adult social care, this definition needs to show how their work 'fits' within the commonly understood taxonomies of prevention that are widely used in the NHS and particularly in population health. For staff outside of adult social care, this definition needs to demonstrate the value and scope of social care work as a holistic preventive activity, rather than it being seen in a narrow perspective. The NHS and social care each need to understand the other's perspective so that they are no longer 'divided by a common language' when talking about prevention.
The DHSC should commission and communicate this work.

2. There remains a need for social care to more effectively demonstrate and communicate its effectiveness in prevention. The work should relate not just to the impact on individuals – though these are paramount – but also on the wider health and care system – for example, avoided hospital admissions or readmissions, reduction in delayed discharge days, reduction in falls, and delayed entry to residential care. Though staff are confident that social care activity is preventive on many levels, the evidence for this belief is often anecdotal. As such, it stands less chance of attracting the level of attention and resourcing that the sector argues is necessary.
Social care commissioners, providers and the DHSC should scope and commission this work.

Address the systemic barriers

3. The barriers that stand in the way of delivering more prevention work in adult social care need to be specifically addressed in the government's ongoing work to implement the 10 Year Health Plan, in the report of the Casey Commission (due in 2027), and in the implementation of workforce reforms by the Adult Social Care Negotiating Body. Specifically, these programmes of work need to make it easier to take the types of actions set out in Appendix 1, including:

    - Commissioning that funds and enables long-term outcomes by allowing the time for holistic, relationship-based preventive practice.
    - Joined-up working between the health and social care sectors. Key opportunities to do so include: multidisciplinary neighbourhood teams, shared information systems, improved discharge planning (including thorough assessments for equipment and support needs), and co-ordination by local oversight bodies (such as integrated care boards and health and wellbeing boards) of prevention strategies across public health, health care and adult social care.
    - Any future workforce reforms should consider the experiences of staff who may face additional barriers at work, including migrant workers and workers from racially minoritised groups – recognising the importance of inclusion, wellbeing and psychological safety in supporting preventive practice.
    - Supporting prevention also requires investment in workforce capability and leadership that supports staff to perform at their best. Although participants did not

identify a need for an entirely new set of skills, they did highlight the importance of role-specific training, having opportunities to make full use of the knowledge and expertise they already possess and being motivated to keep focusing on prevention.

Without these specific measures, there remains a real concern that the potential of adult social care to play a more significant role in prevention, both for individuals and the wider health and care system, will continue to be unfulfilled.

Appendix: Barriers at system, service and workforce/individual levels, and actions to address them

Table 1 sets out the wide range of factors that focus group participants said get in the way of delivering good prevention (and/or good care in general), and the actions that could help deliver more effective preventive services.

Integrated care boards, health and wellbeing boards, integrated health organisations, commissioners and providers should assess local services against these factors and take action to address gaps in the conditions needed for the adult social care workforce to work preventively.

Table 1 Overview of barriers, and actions that could help address them

Level	Barrier	What could help
System	**Funding and commissioning**	• Sufficient funding for staffing, training and equipment. • Commissioning that is flexible and factors in the time needed for different professionals to develop relationships with people who access care, and to be creative about their care. • Commissioning that is focused on long-term outcomes rather than units of time or equipment that provide short-term relief but without addressing underlying health and wellbeing issues.
	Fragmentation between adult social care and the NHS	• Establishing clear routes for joint working across hospitals, community health services and social care. • Improving discharge planning, including early agreement about equipment and ongoing support. • Providing timely and reliable out-of-hours clinical support.

		• Using shared information systems and multidisciplinary working to co-ordinate care.
Service	**Workforce capacity and time**	• Maintaining staffing levels that reflect people's needs and the complexity of their care. • Protecting time for relationship-building and preventive work. • Reducing avoidable administrative burdens. • Ensuring that staff can obtain prompt advice, equipment and management support.
	Care planning, communication and information-sharing	• Reviewing care plans regularly and updating them when people's needs change. • Involving frontline staff and the people receiving care more fully in care planning. • Using service data to identify risks and guide practical improvements.
	Leadership and culture	• Creating a supportive culture that learns from problems rather than assigning blame. • Recognising staff contributions to preventive care. • Providing paid training, supervision and opportunities for development. • Responding when workers experience abuse or unsafe conditions.
	Equipment and resources	• Making essential equipment available promptly and maintaining it properly. • Planning an individual's equipment needs before hospital discharge or changes in their care. • Giving staff the training and time needed to use equipment confidently. • Improving access to suitable technology across care settings, including home care.
Workforce or individual	**Knowledge and skills**	• Providing paid induction, role-specific training and regular refreshers. • Tailoring training to the varied needs of people who access care.
	Relationships	• Giving staff continuity and time to build trust with people and families. • Supporting respectful communication and shared decision-making.

		• Strengthening working relationships between social care and health professionals.
	Recognition of expertise	• Involving frontline staff in care planning and decisions. • Recognising the wider preventive expertise of care workers, nurses, managers and occupational therapists. • Supporting professional judgement and proportionate, person-centred risk-taking.
	Wellbeing	• Ensuring that staff feel valued, supported and safe at work. • Providing reliable management support and responding to abuse or discrimination. • Improving job security, recognition and access to peer support.
	Balancing prevention, autonomy and quality of life	• Focusing on shared decision-making. • Supporting positive risk-taking where appropriate by providing clear guidance and timely access to professional advice.

References

Arnold S, Holden J (2025). 'What is prevention in health?' The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/what-is-prevention-in-health (accessed on 4 August 2026).

Arnold S, Wallbank S, Bailey S (2025). 'Securing the NHS workforce for the future: our recommendations for action'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/securing-nhs-workforce-future-recommendations-action#start-with-a-focus-on-health-and-wellbeing-and-addressing-the-core-needs-of-staff- (accessed on 21 August 2026).

Association of Directors of Adult Social Services (2026). *2026 spring survey* [online]. ADASS website. Available at: www.adass.org.uk/document-types/surveys/ (accessed on 27 August 2026).

Association of Directors of Adult Social Services (2025). *2025 spring survey* [online]. ADASS website. Available at: www.adass.org.uk/document-types/surveys/ (accessed on 27 August 2026).

Bottery S (2025). 'Fixing social care: the six key problems and how to tackle them'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/whats-your-problem-social-care#3.-workforce-pay-and-conditions:-underpaid,-overworked-staff (accessed on 24 August 2026).

Bottery S, Jefferies D (2026). 'Social Care 360'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/social-care-360#expenditure-and-providers (accessed on 27 July 2026).

Buck D, Jefferies D (2026). 'Measuring a moving target: the complex story of public health and prevention spending in local government' Blog. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/blogs/public-health-prevention-spending-local-government (accessed on 4 August 2026).

Buckingham N, Purbrick-Thompson K (2026). '"No man's land": the experience of patients at the interface between health and social care'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/long-reads/experience-patients-interface-health-social-care (accessed on 24 August 2026).

CIPFA (2025). 'Findings from the Financial Resilience Index 2025'. Chartered Institute of Public Finance and Accountability (CIPFA) website. Available at: www.cipfa.org/services/financial-resilience-index/resilience-index (accessed on 27 August 2026).

Department of Health and Social Care (2025). *Fit for the future: 10 year health plan for England* [online]. GOV.UK website. Available at: www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future (accessed on 27 July 2026).

Gatherum B (2017). *Bringing home care: a vision for reforming home care in Scotland*. Ayr: Scottish Care. Available at: https://scottishcare.org/wp-content/uploads/2019/11/Bringing-Home-Care-A-Vision-for-Reforming-Home-Care-in-Scotland.pdf (accessed on 27 August 2026).

Gilburt H, Ross S, Chikwira L (2026). *The role of the workforce in the shift to prevention: perspectives of nurses, midwives, allied health professionals and NHS managers*. London: The King's Fund. Available at: www.york.ac.uk/prepare-reports (accessed on 5 November 2026).

Hoddinott S (2025).' Performance tracker 2025: adult social care'. Institute for Government website. Available at: www.instituteforgovernment.org.uk/publication/performance-tracker-2025/local-services/adult-social-care (accessed on 4 August 2026).

Manthorpe J, Martineau S (2017). 'Home pressures: failures of care and pressure ulcer problems in the community - the findings of serious case reviews'. *The Journal of Adult Protection*, vol 19, no 6, pp 345–56.

Marczak J, Wistow G, Fernandez J-L (2019). 'Evaluating social care prevention in England: challenges and opportunities'. *Journal of Long-Term Care*, pp 206–17.

Naylor C, Cream J, Chikwira L, Gowar C (2024). *Realising the potential of integrated care systems*. London: The King's Fund. Available at: www.kingsfund.org.uk/insight-and-analysis/reports/integrated-care-systems-workforce#overview (accessed on 24 August 2026).

Office for National Statistics (2023a). 'Estimating the size of the self-funding population in the community, England: 2022 to 2023'. Office for National Statistics website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/bulletins/estimatingthesizeoftheselffunderpopulationinthecommunityengland/2022to2023 (accessed on 14 October 2026).

Office for National Statistics (2023b). 'Care homes and estimating the self-funding population, England'. Office for National Statistics website. Available at: www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/socialcare/datasets/carehomesandestimatingtheselffundingpopulationengland (accessed on 14 October 2026).

Prime Minister's Office (2026). 'PM sets out new path to fix social care together: 29 July 2026'. Press release. GOV.UK website. Available at: www.gov.uk/government/news/pm-sets-out-new-path-to-fix-social-care-together-29-july-2026 (accessed on 29 July 2026).

Read S, Verity F, Llewellyn M, Tetlow S, Richards J (2023). 'Problematising "fused principles" in discourses of preventative social care: interpreting the implementation of national social services legislation in Wales, UK'. *The British Journal of Social Work*, vol 53, no 4, pp 2331–2351.

Royal Society for Public Health (2025). *Caring about health*. London: RSPH. www.rsph.org.uk/our-work/publications/caring-about-health/ (accessed on 27 August 2026).

Skills for Care (2025). 'A workforce strategy for adult social care in England'. Skills for Care website. Available at: www.skillsforcare.org.uk/Workforce-Strategy/resources/Supporting-resources/A-Workforce-Strategy-for-Adult-Social-Care-in-England.pdf (accessed on 16 September 2026).

Skills for Care (2019). *Prevention in social care: where are we now?* Leeds: Skills for Care. Available at: www.skillsforcare.org.uk/resources/documents/Support-for-leaders-and-managers/Integration/Role-of-prevention-in-social-care.pdf (accessed on 27 August 2026).

Social Care Institute for Excellence (SCIE) (2021). 'Prevention in social care'. SCIE website. Available at: www.scie.org.uk/download/25339/?tmstv=1700067737 (accessed on 27 August 2026).

Tew J, Duggal S, Carr S (2025). 'How has the idea of prevention been conceptualised and progressed in adult social care in England?' *Journal of Social Policy*, vol 54, no 2, pp 429–47.

The King's Fund (2025). 'Key facts and figures about adult social care'. The King's Fund website. Available at: www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-adult-social-care#how-many (accessed on 27 July 2026).

Townson JK (2025). 'Homecare reform in Australia'. London: Homecare Association. Available at: www.homecareassociation.org.uk/resource/homecare-reform-in-australia.html (accessed on 17 September 2026).

Verity F, Richards J, Read S, Wallace S (2022). 'Towards a contemporary social care "prevention narrative" of principled complexity: an integrative literature review'. *Health and Social Care in the Community*, vol 30, no 1, pp e51–e66.

Acknowledgements

First and foremost, we would like to thank all the focus group and interview participants for sharing their experiences with us so generously and openly.

In setting up the research, we are very grateful for the support of various organisations and individuals:

- Involvement@York for reviewing an early draft of the topic guide, and Rachel Cunningham-Burley for co-ordinating the review.
- Olivia Firth (Policy and Projects Manager) at The Care Workers' Charity for supporting us with the recruitment of care workers.
- Natalie Scarimbolo (Central Engagement Lead) and Lucy Gillespie (National Professional Lead) at Skills for Care for supporting us with the recruitment of registered managers and registered nurses.
- Dr Gillian Ward (Head of Research and Innovation) at the Royal College of Occupational Therapists for supporting us with the recruitment of occupational therapists.

We would also like to thank colleagues from the Chief Public Health Nurse Office for the information and support they have offered.

At The King's Fund, we would like to thank Alex Baylis, Chris Naylor, Clare Sutherland, David Buck, Kathy Johnson, Lynsey Hawker, Megan Price and Ros West.

And finally, our thanks to Jane Brightman (Director of Workforce Strategy, Skills for Care) and Dr Jane Townson (Chief Executive, Homecare Association) for their reviews of an earlier draft of the report.

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