Socialist Health Association Scotland

Reform of Social Care

Discussion Paper

Introduction

This paper aims to promote a discussion on the reform of social care in Scotland.

There is a widely held view that the social care system in Scotland is in urgent need of reform. The current system is underfunded, lacks capacity, has major workforce recruitment and retention problems with fragmented delivery through a discredited commissioning process. The system is not just failing those who need social care but is also damaging the NHS with over half a million hospital bed days lost every year because of delayed discharges at the cost of £130m. One in 24 people in Scotland receives funded care support.

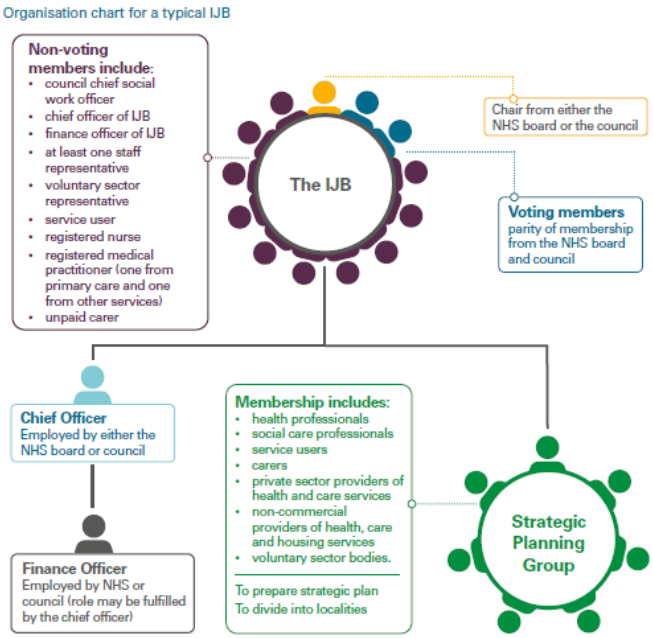
The Chair of the Accounts Commission summarised his concerns in their annual overview:

"Of particular note for us this year, Integration Joint Boards (IJBs) continue to face very significant challenges, and they need to do much more to address their financial sustainability. The pace of progress with integration has been too slow, and we have yet to see evidence of a significant shift in spending and services from hospitals to community and social care. I continue to be concerned about the significant turnover in senior staff in IJBs. This instability inevitably impacts on leadership capacity and the pace of progress."

In October 2015, SHA Scotland participated in the Quality Care Commission, convened by Neil Findlay MSP and chaired by David Kelly, to review the way adult social care is delivered in Scotland. This commission took a detailed look at the issues and made a series of recommendations on the delivery of care, workforce, budgets and long-term funding. Many of these recommendations remain relevant today, but four years on, it is right that we take a fresh look.

Context

Scotland has had a distinctive social care system since the early years of the Scottish Parliament introduced free personal care for the elderly, now extended to those under 65. The system has been through many iterations, aimed at improving the integration of health and care services. In addition, the Self-Directed Support Act (2013) introduced personalisation into the system.



The current structure of Integrated Joint Boards (IJB) involves pooled budgets and strategic commissioning across NHS and local authority services. However, delivery remains with staff employed by the NHS, local authorities and contractors in the private and third sector.

The new structure has arguably delivered better planning and improved engagement between the statutory organisations and stakeholders. However, the evidence on structural integration outcomes has been described by Audit Scotland and others as weak, with little radical change. With almost

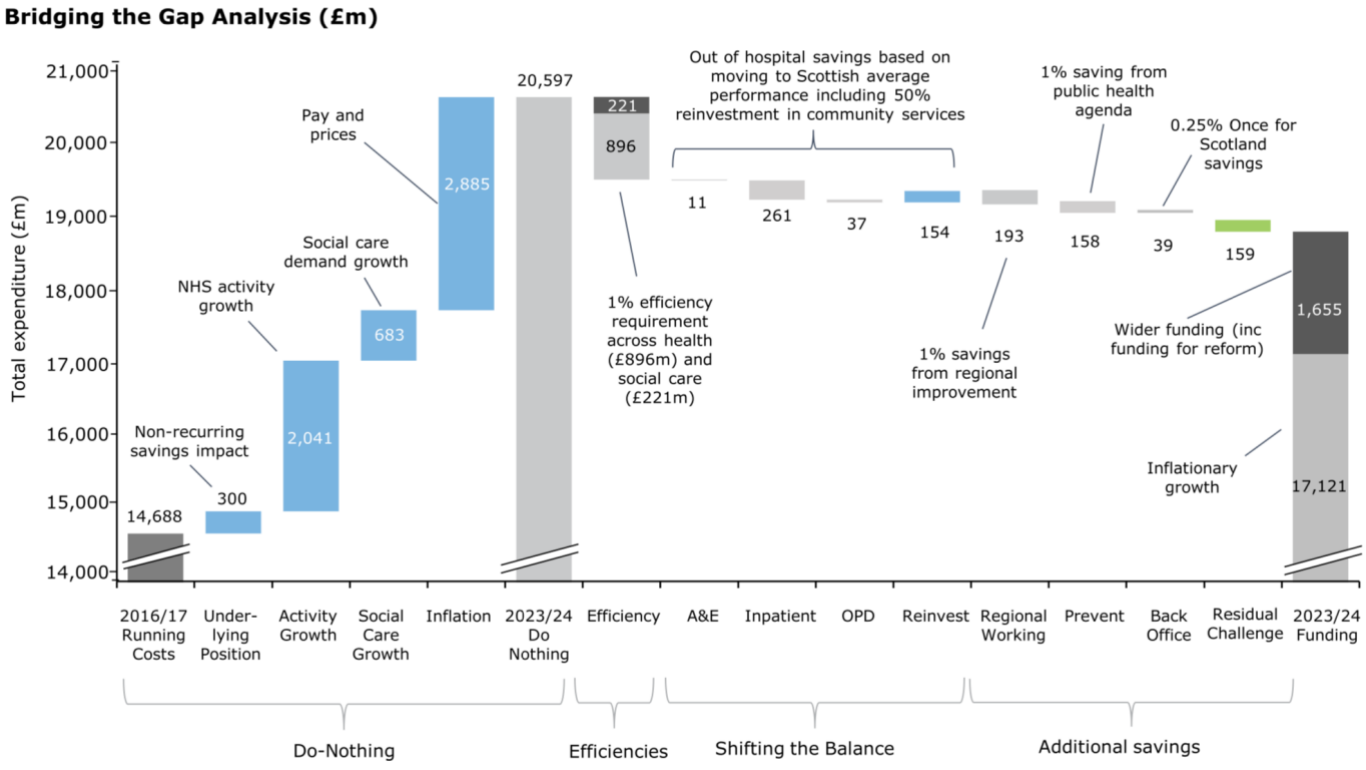
1500 hospital patients in hospital every day who should be cared for a community setting, the system is clearly not delivering as it should.

Funding

IJBs control budgets totalling over £8bn, with £5bn coming from the Scottish Government and £3bn via local authorities. 60% of frontline NHS budgets are delegated to IJBs, and all council adult social care budgets are included, together with some children's services. Spending on community services has increased over the past ten years at a rate somewhat higher than hospital services, but there has not been a significant shift in the balance of care. There has been a 10% increase in care at home hours while residential care home places have remained the same. Most hospital activity metrics have increased over the past ten years.

International studies conclude that the demand for health and care will increase faster than the rate of growth in the economy. This will result in increased costs driven by price inflation, an ageing population and the cost of new technology, drugs etc. An IFS study calculated that this is likely to require a real term increase of 3.9% per year. If there is no system change, there will be a net increase of £1.8bn over 15 years.

Scottish Government policy assumes that shifting the balance of care, greater productivity, better collaboration and improved public health will help to bridge the gap. Although this is by any standards challenging, if not optimistic, the medium-term financial strategy (see below) details their bridging analysis, and this identifies £683m for social care demand growth.



In addition, the Scottish Government is committed to abolishing the remaining social care charges. While this is likely to be welcomed, not least because of the local variations in charging, it is an additional cost, on top of the £30m needed for the extension of free personal care to the under 65's.

There is no consideration in the Scottish Government's current plans of any additional funding streams dedicated to meeting the growing cost of social care. The Quality Care Commission did outline some options, including an increase in National Insurance contributions.

In England, the Dilnot review also looked at funding but was more focused on protecting assets than delivering first-class social care. The new UK Government has shown little urgency to address this issue

other than a commitment to a Green Paper. However, the problem will not go away, and they will be under increasing pressure to find a solution.

This is important for Scotland because of the Barnett consequentials of any increase in English public spending. The recent UK Labour manifesto allocated £4bn for growing demand and matching Scotland's free personal care system at a further £6bn. The Barnett consequentials of this would deliver around £950m extra funding for Scotland. This scale of funding seems unlikely in the current UK political and fiscal environment, but some additional spending is probably inevitable. £1bn of emergency funding has been promised and implementing the Care Act cap on residential care a further £4bn. The Health Foundation says that simply to return social care in England to the same standard and spending per head as in 2010 would now cost another £10bn.

Other Challenges

Funding increased demand for social care is not the only challenge facing social care services.

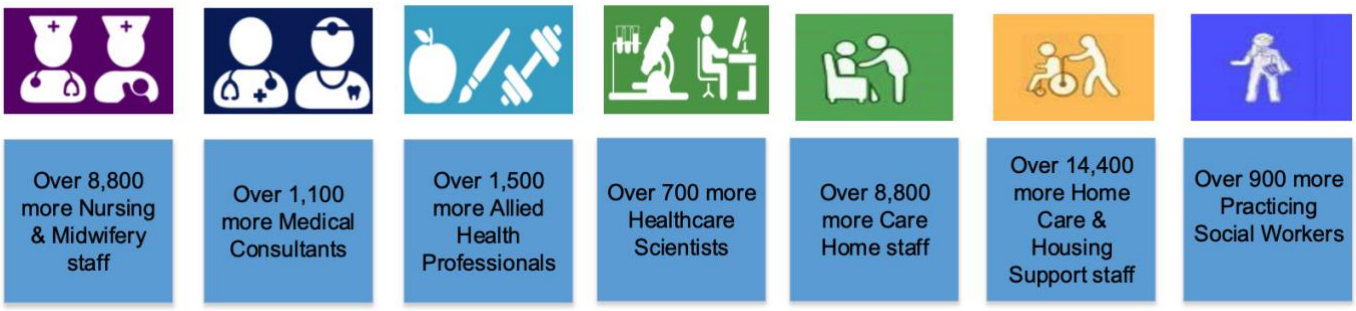
Despite significant effort, the data shows little progress in tackling delayed discharges. While capacity and funding are the main issues, there are also substantial differences between IJB areas, which may point to best practice not being applied consistently.

Scotland's population is projected to age at a faster rate than the UK as a whole. The retired population is likely to increase by up to 240,000 in the next 25 years, while the working population will decrease by 7,000. This not only raises funding issues but also where the workforce will come from. Brexit and a replacement immigration system are significant uncertainties over these projections.

For a small country, Scotland has a large number of social care providers, including more than 1000 care at home providers registered with the Care Inspectorate. As a consequence, we have a fragmented service delivery with a wide range of duplicated management and back-office functions. The Scottish Government and local authority commissioners have attempted to 'nudge' the sector into rationalising services or at least to consider shared services. However, there has been very little progress, and given the vested managerial interests, few expect that to improve quickly.

There are at least 759,000 carers aged 16 and over in Scotland and 29,000 young carers. The value of care provided by carers in Scotland is over £10 billion a year. Three out of five of us will become carers at some stage in our lives and 1 in 10 of us is already fulfilling some sort of caring role. Support for carers is at best patchy despite the intentions of the 2016 Act. Carers need support with employment, mental health and finance. The New Zealand Labour Government is proposing paying carers and others have suggested a Minimum Income Guarantee or Basic income scheme.

Some 200,000 people work in the social care sector. The Scottish Government has recently published its first integrated health and social care workforce plan. There are quite detailed plans for health staff, reflecting long-standing workforce planning systems. For social care staff, the plan is focused more on the process, reflecting the difficulties in delivering workforce planning over such a fragmented service.



The headline estimate is that Scotland will need 20,000 WTE more health and care employees in the period up to 2023/24, which they hope will be reduced by up to 10,000 WTE through mitigating actions like efficiency savings, technology and redesign. The significant number is over 14,400 home care staff, a group that is likely to be impacted by Brexit and the UK government's immigration policies. This is a sector

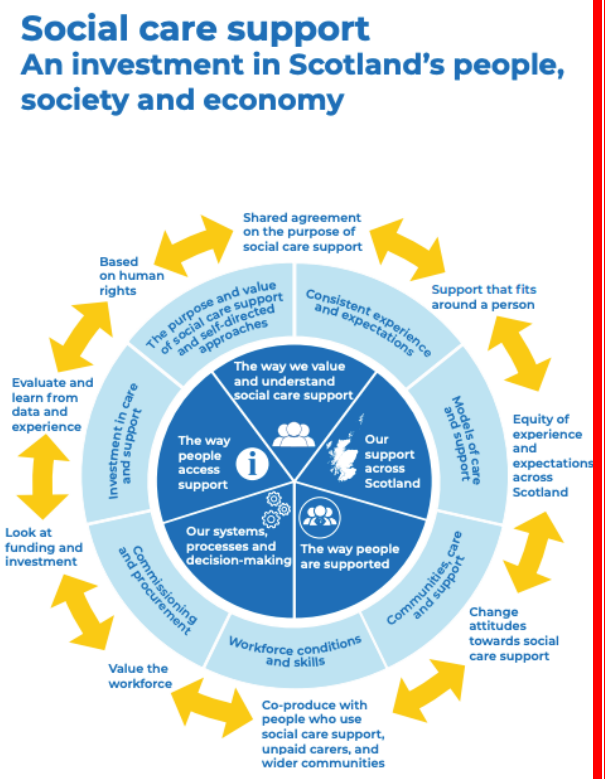
that already has high turnover rates. The overall vacancy rate in social care is almost twice the Scottish average.

Concerns have also been expressed that IJBs have struggled to engage with stakeholders meaningfully. The agenda and papers of most meetings are often very lengthy with excessive use of jargon. IT systems remain far from integrated, and there are limited links with housing and benefits services. There is inadequate investment in preventative services, and some innovative voluntary sector projects receive only short-term funding.

Reform

The Scottish Government launched a national reform programme last year with the following priorities:

- a shared agreement on the purpose of adult social care support, with a focus on human rights
- social care support that is centred on a person, how they want to live their life, and what is important to them – including the freedom to move to a different area of Scotland
- changing attitudes towards social care support, so that it is seen as an investment in Scotland's people, society and economy
- investment in social care support, and how it is paid for in the future
- a valued and skilled workforce
- strengthening the quality and consistency of co-production at the local and national level with people with lived experience and the wider community
- equity of experience and expectations across Scotland
- evaluation, data and learning



Structural Change

Few would disagree with the principles outlined in the reform programme, but so far, it falls somewhat short of the radical change required to tackle the crisis.

The SHA and Scottish Labour has argued that now is the time to establish a Scottish Care Service, which sets a national framework for services leaving delivery at the local level. This would end the market in social care and shift to a planned service. Also, there should be statutory workforce forum which would address workforce planning and staff governance as well as provide sectoral collective bargaining for those not currently covered.

This outline needs further work on the following issues:

- Clarifying roles between national and local.
- How prescriptive should National Care Standards, including registration and inspection be?
- Locality planning and devolved delivery, including locality budgets.
- Role of family and community – rebuilding social infrastructure to address isolation.
- How the service user voice is heard.
- Human rights framework.
- How to achieve a real focus on prevention.

The workforce elements also need to consider the balance of provision between the local authority and other providers. The SHA believes there needs to be a strengthening of in-house capacity, but there should be room for other providers who are willing to adopt the new workplace and governance standards.

The reform of social care should also recognise the pressure on NHS primary care services, particularly GP services. The SHA has long supported the full integration of GPs into the NHS.

None of the structural solutions is straightforward. In several European countries, community health is part of unitary local authorities, and this creates unified governance and management. However, it can also create barriers to the transfer of resources from acute to community services, undermining preventative action. It will also be unpopular with NHS staff who identify with the NHS ethos and a stable industrial relations model.

Some have argued that social care should be unified under the NHS. The problem with this approach is poor local accountability in the NHS with its quango appointment model. Removing services from local democratic control would not be consistent with our overall policy approach.

This could be addressed by a different local governance model with an integrated organisation accountable to councillors, possibly with an element of directly elected members. The current advisory board structure for stakeholders could be retained. The number of health boards would be reduced and would focus on acute and other regional services. The risk is that these organisations would become detached from the NHS and the broader local authority services that are essential to addressing health inequalities.

Self-Directed Support

While we support the principle of personalisation, it should not be conflated, as the private care sector does, with marketisation. Self-directed support works better for some groups than others, and there are capacity challenges for some families. It has also been used as a means of cutting services or merely dumping responsibilities on families. Workforce standards also need to be maintained, and the same standards should apply as the rest of the social care sector.

A range of care options are possible without the extensive outsourcing and commissioning approach of recent years. This should be delivered within integrated local care teams, which can include the best of innovative voluntary sector provision.

Wider policy implications

Social care is not delivered in a silo. Joined up services need to recognise the role of housing, social security, public transport and leisure services. There are also issues of discrimination and access to services.

Conclusion

In this paper, we outline some of the challenges the social care system in Scotland faces. There have been many attempts to reform the system since joint finance plans in the 1970s. While progress has been made, the service is still falling far short of the seamless service we need. We would welcome views on the reform proposals and questions raised in this paper.

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Comments on this paper can be sent to: The Secretary, SHA Scotland – socialisthealthscotland@gmail.com

By 5 June 2020.

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