Socialist Health Association Scotland

The Reform of Social Care in Scotland

Introduction

In February 2020 SHA Scotland published a discussion paper on the reform of social care in Scotland. Then came the pandemic, which sadly highlighted many of the challenges we outlined in that paper with tragic consequences, particularly for the elderly in residential care. This paper reflects the views we received in response to that discussion paper and our subsequent papers published by the Jimmy Reid Foundation in their '*After the Pandemic*' series[1].

Even before the pandemic, it was clear that the social care system in Scotland was 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 £120m.

The Chair of the Accounts Commission summarised his concerns in their 2018/19 overview[2]:

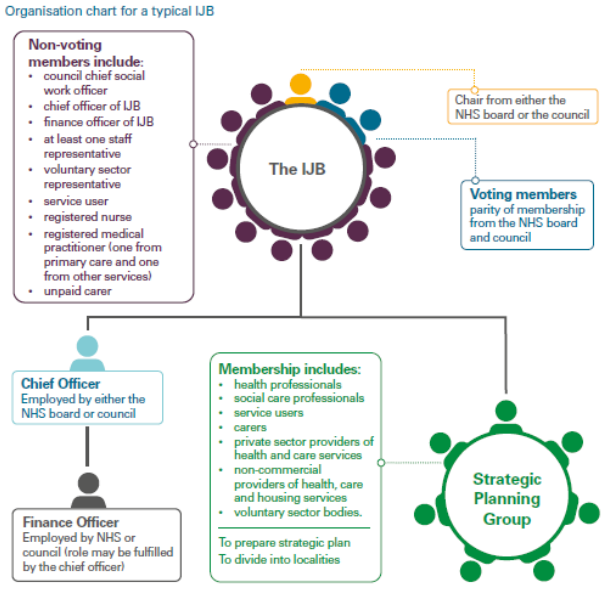
"Of particular note for us this year, Integration Joint Boards (IJBs) continue to face very significant challenges, and they need to do much more to address their financial sustainability. The pace of progress with integration has been too slow, and we have yet to see evidence of a significant shift 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[3], 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, and after the pandemic, 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.



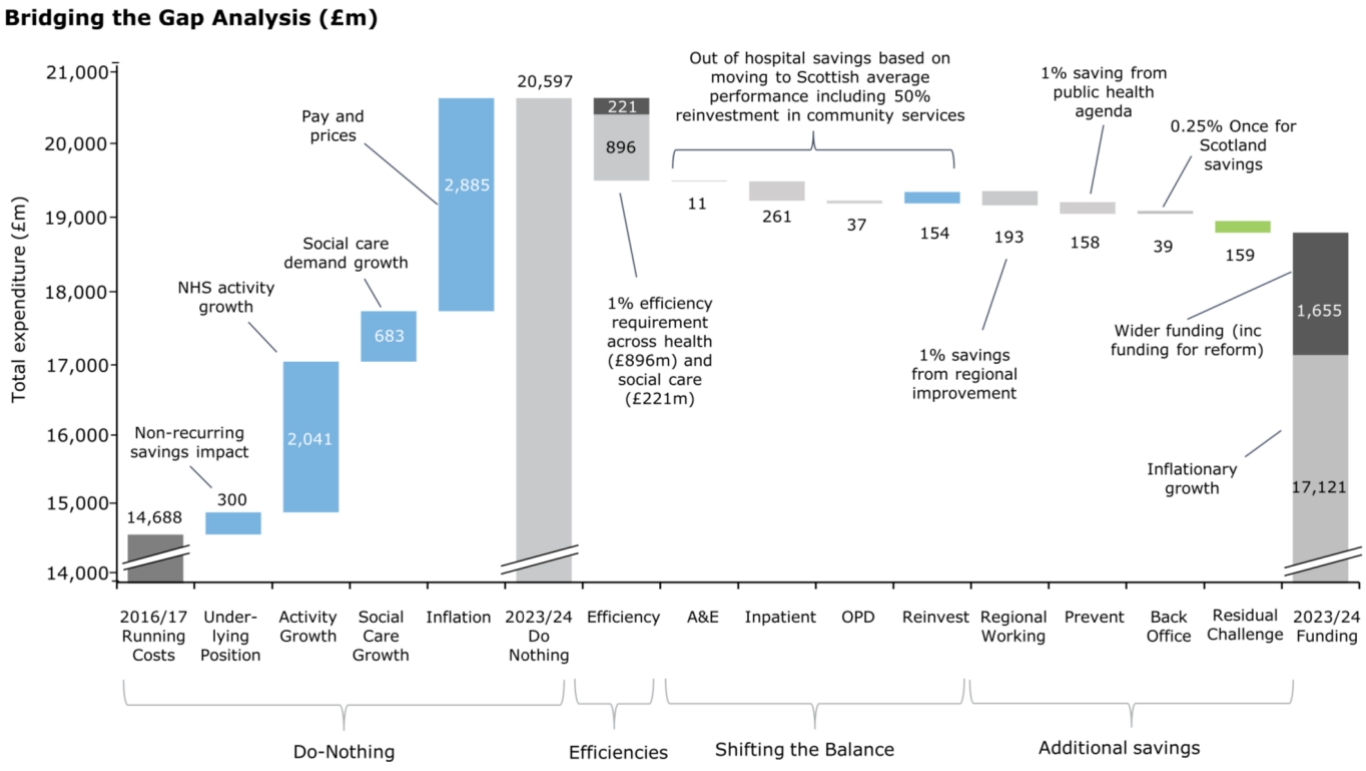
The new structure has arguably delivered better planning and improved engagement between the statutory organisations and stakeholders. However, the evidence on structural integration outcomes has been described by Audit Scotland and others as weak, with little radical change.

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[4] 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[5] (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[6] 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 December 2019 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 (outwith the special pandemic funding[7]), but some additional spending is probably inevitable. £1bn of emergency funding was promised for 2020/21[8] 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 before the pandemic discharges, which had tragic consequences. 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[9].

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[10]. 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 organisations have outlined a range of measures to strengthen support for carers including, care breaks, health, employment and end of care support. The New Zealand Labour Government[11] is proposing to pay 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 published[12] 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.

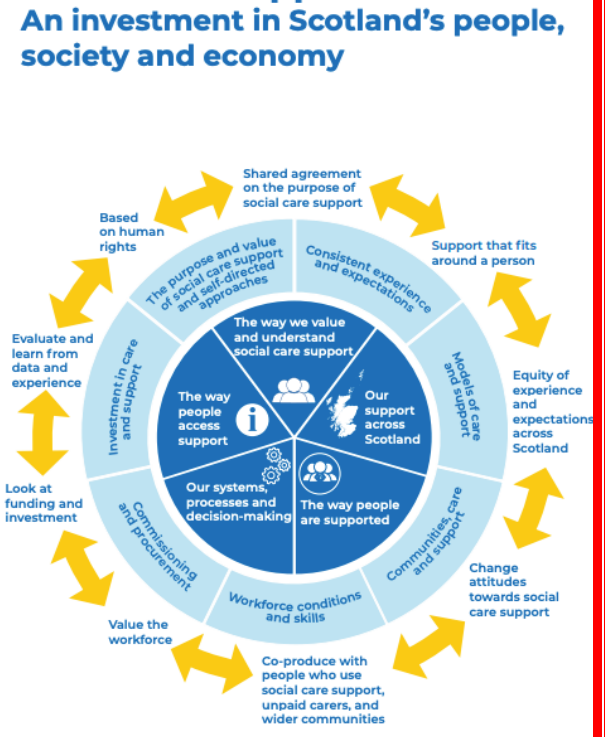
Concerns have also been expressed that IJBs have struggled to engage with stakeholders meaningfully. The agenda and papers of most meetings are often very lengthy with excessive use of jargon. IT systems remain far from integrated, and there are limited links with housing and benefits services. There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

These challenges have been magnified during the pandemic. The lack of Personal Protective Equipment, inadequate testing, minimal sick pay, and use of agency staff, have all contributed to the tragic deaths in care homes and amongst social care staff. A report for Common Weal[13] outlines the series of failures which led to the death toll in Scotland's care homes. The report author describes the handling of this as *"the single greatest failure of devolved government since the creation of the Scottish Parliament"*. Care at home has also been impacted with care packages reduced or abandoned. Informal carers have all too often been left to pick up the pieces.

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



As a consequence of the pandemic and the political pressure led by Richard Leonard and Scottish Labour, the Scottish Government has announced a new review of social care in Scotland[14]. An expert panel has been established, chaired by a former civil servant but with no workforce representation. It aims to report in January 2021.

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. As a consequence, there have been growing calls for the establishment of a national care service and the Scottish Government has now included this in the new review.

The concept of a Scottish or National Care Service (SCS) as part of the solution is not a new one. It has been Scottish Labour policy for a number of years, most recently as a 2019 General Election manifesto commitment[15]. Scottish Labour published a discussion paper and survey this summer, which showed a very high level of support for social care reform, including the removal of the profit motive.

UNISON Scotland has also published[16] what it describes as a 'road map' towards the creation of a national care service. It also identifies a number of immediate actions including, national procurement, sectoral bargaining, enforcing clinical standards and a national workforce plan. This would lead to proper funding, improved pay and conditions, a workforce strategy and ethical commissioning.

While there is growing support for the principle of a Scottish Care Service, many in the sector have reasonably asked what it means in practice.

There seems to be a consensus in favour of a national framework rather than a service delivery organisation or making it part of NHS Scotland, not least to recognise the different models of care. But that leaves open what the SCS would undertake directly and what would be the governance arrangements. A national framework approach must end the current marketisation of social care. It could set consistent standards, contracts and charges for services not covered by free personal care. Most importantly, it would include a statutory workforce forum to set minimum terms and conditions, organise effective workforce planning and put a new focus on training and professionalism.

On governance, the usual approach would be to create a new Non-Departmental Public Body (NDPB). This would leave the SCS with a similar democratic deficit to NHS Scotland and would undoubtedly be populated with the 'usual suspects' by ministers. As the service will be delivered locally, another approach would be to create a joint board from councils across Scotland. This was a solution UNISON Scotland proposed for police and fire, which had the added advantage of keeping the VAT exemptions. The joint board could have places for relevant stakeholders.

A national service would also need to address regulation. The Care Inspectorate's 'light touch' response to rising complaints has highlighted the need for reform. In fairness, they have been constrained by the Scottish Government's 'Better Regulation' code, together with inadequate powers and resources. There would also need to be a review of workforce regulation currently administered by the Scottish Social Services Council and UK professional regulatory bodies.

If the service is going to be delivered locally, this leaves open the question of local governance and ownership. As the Accounts Commission noted in its annual overview (see above), the current system of Integrated Joint Boards has struggled to deliver integration or a shift in spending from hospitals to community care. There have been many attempts to improve integration in Scotland since the joint finance arrangements of the 1970s and all have struggled. It may be that this iteration will eventually deliver, but many will argue that it requires stronger democratic accountability to make difficult decisions, and that means a bigger role for councils. This happens in other parts of Europe, but they haven't always shifted resources from hospitals to community services.

Greater integration doesn't require staffing integration. Professional barriers have been broken down in recent years, and joint teams have shown that they can work effectively together, particularly when physically working together in community hubs. A huge staffing reorganisation would create stasis, just at the time when we need to free up staff to innovate.

The fragmentation in service delivery is a significant problem that does need to be addressed and the scandal of care home firms registered in tax havens. In the short-term, the pandemic has highlighted the need for greater coordination on issues like procurement. Abolishing the market, standard contracts and common workforce standards will help shift resources to the front-line. In the medium-term, there should be greater common ownership, particularly in residential care. Even former Conservative ministers are openly talking about the nationalisation of care homes[17]

Common ownership does not preclude innovative voluntary sector operators who can meet the new standards as the best in the sector already do. The private sector likes to make a false link between personalised care and marketisation. All care should be personalised, and that requires a range of services, driven by the needs of service users, not care budgets. It doesn't require a range of ownership models. Local delivery should also be about greater innovation in service delivery, trying new models of care that integrate people with care needs into communities.

Finally, there is the tricky issue of funding. We cannot simply hope for the Barnett consequentials of reform in England to plug the current funding gap, let alone future demographic pressures. It requires an adult conversation with citizens about taxation. If we want to go further and fund care on the same basis as the NHS, then the conversation shifts to proposals like the former health minister Andy Burnham's care levy[18], which involved a form of inheritance tax. Calling it and similar plans a 'death tax' is not an adult conversation.

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. It needs to be seen in the context of building stronger communities, an issue addressed in a recent Jimmy Reid Foundation paper[19]. That paper points to a wealth of evidence that place impacts on health and wellbeing and contributes to creating or reducing inequalities. Communities with strong social capital and infrastructure are always better insulated against a health crisis.

Conclusion

In this paper, we outline the challenges the social care system in Scotland faces – exacerbated by the pandemic. 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.

The creation of a Scottish or National Care Service with proper funding could be the start of a new approach to social care. Turning it from a concept into a practical solution requires more work and some difficult conversations. If we are to 'Build Back Better' an integrated health and care service, with national standards and local delivery should be the highest priority.

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This paper is published by SHA Scotland, a campaigning organisation which promotes health and well-being and the eradication of inequalities through the application of socialist principles to society and government. We believe that these objectives can best be achieved through collective rather than individual action. We campaign for an integrated healthcare system which reduces inequalities in health and is accountable to the communities it serves.

www.shascotland.org

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