Health and Sport Committee Draft Budget 2018-19 Call for Views Response from Social Work Scotland

Social Work Scotland is the leadership body for the social work and social care professions. We welcome the opportunity to respond to the *Call for Views on the Draft Scottish Budget 2018* issued by the Health and Sport Committee of the Scottish Parliament. Our responses are confined to health and social care budgetary issues – we acknowledge both the contribution that participation in sports makes to physical and mental health, and of course the keen interest than many people have in watching and supporting sports; however, sports matters are generally not within our competence.

Question 1: *Do you consider that the Scottish Government's health and sport budget for 2017-18 reflects its stated priorities (as set out in the National Performance Framework, the LDP standards and the National health and wellbeing outcomes)? If not, how could the budget be adjusted to better reflect priorities?*

No, the inevitable consequence of UK public expenditure "austerity"[1] is that the total quantum of spend on health and social care is not keeping pace with increased demand due to demography and other factors with the result that the care system as a whole is under significant strain. In Scotland, the Accounts Commission[2] noted last year that:

> Councils' social work departments are facing significant challenges because of a combination of financial pressures caused by a real-terms reduction in overall council spending, demographic change, and the cost of implementing new legislation and policies. If councils and IJBs continue to provide services in the same way, we have estimated that these changes require councils' social work spending to increase by between £510 and £667 million by 2020 (16–21 per cent increase).

The submission from the Royal College of Physicians of Edinburgh helpfully discusses the impacts of these pressures on the nine National Health and Wellbeing Outcomes; Social Work Scotland also wishes to raise concerns about the impact of austerity on the National Performance Framework strategic objective, particularly 6 ("**We live longer, healthier lives**").

The greatest population increases have been for people aged 85 years and older, and this group has the highest needs for NHS and social care services. Most people aged 85+ are female (66% in 2016), a percentage which is somewhat higher (72%) for social care service users[3]. But it is in this group that the increase in life expectancy appears to have faltered in recent years.

In all four UK administrations, the previously increasing life expectancy for women at age 85 has levelled off or decreased since 2011, as the Office for National Statistics chart[4] shows overleaf.

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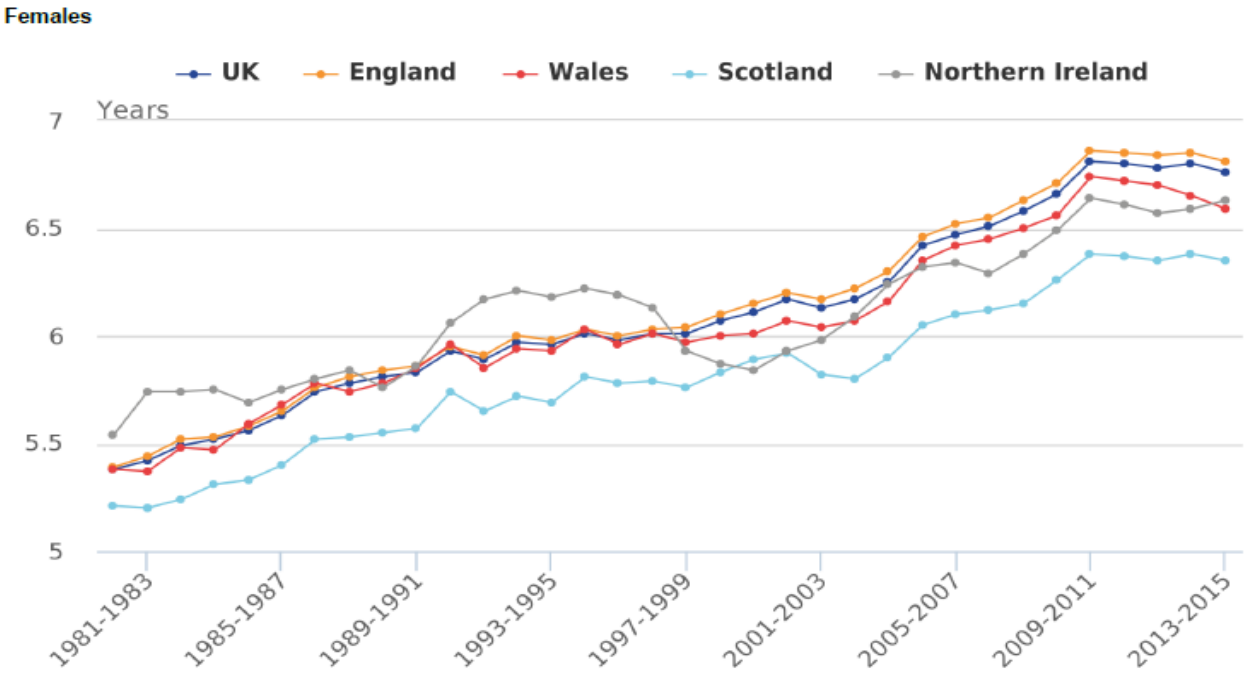
[1] Since 2010, the UK Government has pursued a policy of reducing public expenditure as a proportion of GDP in order to reduce the large deficit incurred in resolving the banking crisis of 2008-09. We note that the economic case for austerity continues to be challenged by a large number of economists, many of whom argue on neo-Keynesian grounds that austerity delayed recovery from the economic recession, a recovery that itself remains weak and is sustained by growing volumes of personal debt. We believe their arguments for alternative macroeconomic policies deserve wider public debate and more informed media coverage.

[2] Accounts Commission (2016): *Social work in Scotland*; at: http://www.audit-scotland.gov.uk/report/social-work-in-scotland. Edinburgh: September 2016.

[3] Data from the Scottish Government's Social Care Census suggests that around 72% of service users aged 85+ are female. This is because while fewer males survive into older age those who do tend to have fewer disabilities than women of the same age.

[4] Office for National Statistics, *National life tables, UK: 2013–2015,* (September 2016), page 6: available at: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/lifeexpectancies/bulletins/

Figure 2b: Life expectancy at age 85, UK and constituent countries, 1980–1982 to 2013–2015



Source: Office for National Statistics

The chart shows the average additional years of life expected at age 85 averaged across a rolling three year average from 1980-82 to 2013-2015. From 2011, life expectancy suddenly levelled off in all four parts of the UK, and in Wales particularly, but also in England, life expectancy at age 85+ has fallen. The graph also shows the long term trend for life expectancy in Scotland to be lower than elsewhere in the UK; this is also true for life expectancy at birth, and at age 65.

These trends are driven by death rates, which have been higher than expected in 2011-15. In February 2017 two papers[5] were published in the Journal of the Royal Society of Medicine examining possible causes for higher deaths rates among older people in England and Wales. Data collection changes, colder winters, and influenza-related mortality were not found to be the causes. The authors considered that the most plausible explanation could be "a general failure of care" for older people with unmet health and social care needs due to the underfunding of the NHS and social care reductions, noting that "cuts to local authorities' budgets have resulted in the withdrawal of many services that older people depend on". While further research is needed, the authors believe there is already "a strong case for arguing that more staff and funding for both health and social care are required urgently to prevent further avoidable mortality".

In July 2017 Professor Sir Michael Marmot also expressed concern that the increase in health improvement in the UK, as measured by life expectancy, "has more or less ground to a halt". Much higher rates of life expectancy are still being achieved in other developed counties. While not yet

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nationallifetablesunitedkingdom/20132015. Life expectancy rates for males aged 85+ show a reduced increase over this period. Males are still less likely to survive into old age than women, but those who do tend to be fitter than females, age for age.

[5] Lucinda Hiam, Danny Dorling, Dominic Harrison, Martin McKee, Why has mortality in England and Wales been increasing? An iterative demographic analysis. *Journal of the Royal Society of Medicine*. DOI: 10.1177/0141076817693599; Lucinda Hiam, Danny Dorling, Dominic Harrison, Martin McKee, What caused the spike in mortality in England and Wales in January 2015? *Journal of the Royal Society of Medicine*. DOI: 10.1177/0141076817693600

accepting policies of austerity had been determined as the definitive cause, he concluded "that less generous spending on social care and health will have adverse impacts on quality of life of the elderly. It is urgent to determine whether austerity also shortens lives"[6].

We conclude that the National Performance Framework strategic objective 6 is also at risk from the difficulty in funding NHS and social work and care services at a sufficient level to meet rising demand.

Social Work Scotland welcomed the commitment to funding the Getting It Right for Every Child Looked After strategy in the 2017-18 budget. This needs to continue to ensure, in particular, that positive legal and practice developments such as continuing care, after care, and kinship care are adequately resourced to meet better permanence outcomes for children.

Social Work Scotland also welcomed the increased investment in Child and Adolescent Mental Health Services.

Question 1 also asked: ***How could the budget be adjusted to better reflect priorities?*** The short answer is by prioritising social care funding alongside that of the NHS. Contribution to better outcomes for older people by social care is critical. It is important that the twin approach of investment in social care and health outlined in the 2017-18 budget continues.

Question 2: *For the health and sport budget for 2018-19 where do you suggest any additional resources could be most effectively deployed and where could any further savings be found? What evidence supports your views?*

There are **three main priorities for any additional funds**: (a) ensuring that pressure points in the health and social care system do not result in the collapse of key parts of the system; (b) ensuring that unpaid carers are adequately supported; and (c) resourcing further prevention and shifts in the balance of care.

The **first priority** includes ensuring that are sufficient community-based services to prevent admission to hospital and to support early discharge and rehabilitation wherever possible. This also includes issues such as resourcing the Scottish Living Wage, ensuring that social care is an attractive career choice for school leavers, dealing with the threat of Brexit to social care staffing, as well as many other challenges that may vary between parts of Scotland.

The **second priority** is to ensure that there is adequate funding within the Spending Review for local authorities, IJBs, health boards and the third sector to implement the **Carers (Scotland) Act 2016**, which comes into force in April 2018. Social Work Scotland recognised that the publicly funded volumes of social care are more than equalled by unpaid care provided by mainly partners and family members, and some friends and neighbours. Providing adequate support to these carers is the first task of any prevention strategy in health and social care.

The Financial Memorandum (FM) for the Carers Bill identified additional funding requirements of £19m in Year 1, rising to nearly £90m in Year 5. We believe that at a minimum these sums should be protected in the Spending Review. However, Social Work Scotland, with COSLA and national carer organisations represented on the Carers Bill Finance Advisory Group[7], believe that the Carers Act is underfunded. Relatively few carers currently have a break from caring, and while there is some money in the FM to fund additional breaks, none has been provided for additional "**replacement care**" for the person cared-for to enable the carer to take a break. This is the most expensive item currently in local authority support to carers (at c. £200m per year). From April 2018, carers will have new rights to an assessment of their needs, including their need for a break,

[6] Michael Marmot, 20.7.17, at: http://www.huffingtonpost.co.uk/michael-marmot/the-rise-in-life-expectancy_b_17535686.html

[7] The report of the Carers Bill Finance Advisory Group has recently been finalised but has not yet been published.

and LAs will have new duties to meet eligible assessed need. It is inconceivable that the intended increase in short breaks provision for carers will not also result in increased need for replacement care.

The Carers FM cost estimates also have not been updated from the 2013-14 values used in calculations, so do not include inflation or the costs of implementing the Scottish Living Wage. The FM also does not include the cost of waiving charges for carers, estimated at up to £16m per year. These gaps undermine any argument that there are sufficient "flexibilities" within the Carers Act funding to cover increased demand for replacement care.

The **third priority** is further investment in **prevention** and in **shifting the balance of care** from reactive, acute care, to community based services. Social Work Scotland covered these issues in greater depth in our submission[8] to the Committee's *Call for Views on Preventative Spending* earlier this year, including these comments:

> In an ideal world a reduction in acute services would be undertaken after investment had been made in replacement services in the community, or in primary prevention, within sufficient timescales for their effect in reducing demand for acute services to be manifest. That would mean double running costs for varying periods depending where on the prevention continuum the investments were being made. That clearly is not possible given the macroeconomic policy of the UK Government and the approach being taken to the deficit created by the response to the global financial crash in 2008. The Scottish Government did provide some change funds for health and social care, which were initially largely used to fund prevention initiatives, but as budget pressures grew such funds were increasing used to support mainstream care services and have now been incorporated within normal funding.
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> It is extremely difficult for Integration Joint Boards, Health Boards and Local Authorities to accumulate sufficient funds for prevention while at the same time meeting acute needs which might have been prevented by earlier intervention. There is now no obvious way to break this vicious circle without casualties. A wider public debate is needed about how society should meet the increasing costs of health and social care, due to mainly to the ageing population but also affected by rising inequalities; inevitably this means debating the form and scale of taxation, the role of the state, economic policy, and what sort of society we wish to live in. Political leadership is therefore essential.

Within children's services, local areas are also shifting resources to early help and prevention to support children remain safely at home or return from care. However, as in adult services pressures continue for children currently in high cost provision and children coming into care require increasingly complex packages of support. Adequate funding to shift the balance of care is needed.

The needs of vulnerable children can only be met through partnership working, in accordance with the GIRFEC approach. Social Work Scotland welcomes pupil equity funding, empowering teachers, parents and children through proposed new governance arrangements and the focus on assisting universal services respond to neglect. Social Work Scotland members want to ensure, however, that new arrangements and budget decisions recognise that improvement in attainment can only be achieved by partnership working with social work and others, embedded in the GIRFEC approach.

Question 2 also asked about savings. Next year will be the seventh or eighth year of austerity and the scope for large savings is now very much diminished. Increasingly, improvements delivered by "transformational change" also include real service reductions. It is also true that the benefits of

[8] http://www.parliament.scot/S5_HealthandSportCommittee/Inquiries/PA063_Social_Work_Scotland.pdf

prevention are often not cashable, and when they are may not yet be available in the short term, and therefore cannot significantly offset a current funding deficit.

Question 3: *Is sufficient information available to support scrutiny of the Scottish Government's health and sport budget? If not, what additional information would help support budget scrutiny?*

Generally, we support the greater focus on outcomes in the last decade; however, this does not mean that information on "outputs" (services), and "inputs" (staffing, resources, etc) are not also needed, together with a clearer causal picture of how resources and services impact on the desired outcomes. Without such information, our knowledge of "what works" is impaired, and we cannot be sure that the distribution of spend is optimal in relation to government or local objectives.

The available information about social care nationally has many gaps, and budget cuts in local authorities have reduced both the volume and quality of data. This is because it is preferable to cut "back office" functions more deeply than front-line services. Nevertheless, we are now at a stage where a review of the national data on social care needs and services is required, including data required on the needs of unpaid carers, on the impact of various measures being taken to "manage" increasing demand and develop community supports, and on the preventative agenda more generally.

Question 4: *What impact has the integration of health and social care budgets had on ensuring resources are directed at achieving the Scottish Government's desired outcomes?*

Social Work Scotland is very positive about medium- and longer-term benefits of health and social care integration, in terms of better outcomes for people using services, and more effective and efficient use of joint resources. But, all stakeholders are still at a very early stage in integration and need to focus on the many practical issues involved in establishing the integration authorities, including their relationships with health boards and local authorities for whom integration presents significant changes in behaviours and accountability. Audit Scotland forthcoming report (2018) on integration will help all stakeholders take stock on progress to date.

Integration Joint Boards need to be supported in commissioning acute NHS services in such a way as to reduce in-patient bed complements over time, so that resources can be re-directed to the expansion of those primary care, community health, and social care services that are necessary to reduce demand for acute in-patient bed admissions, and for which the evidence shows have the greatest effects. The Committee may wish to invite Integration Joint Board Chief Officers to supply information on such developments within their localities, and to evidence the opportunities as well as identify obstacles and barriers that need to be overcome.

Finally, there requires to be clarity about the implications of changing governance for all social work services, which have always sought to be responsive to the holistic needs of families and communities. This includes children's services and justice services. Some children's services are located within Health and Social Care Partnerships, while others are located in local authorities. This means that the funding of children' services is now less clear. Given our shared concerns about child poverty and the educational attainment gap, the funding of services to children who are most vulnerable requires to be prioritised. The health, social, emotional and learning needs of children require to be considered in a coherent way, if we are to tackle inequalities and aspire to be the best place for children to grow up. This will mean investment in integrated and collaborative partnership approaches, with Integrated Children's Partnerships being a key mechanism for achieving this. While social work services are strongly focused on protecting children and supporting those in the greatest need, they also have a role to play in early intervention (across the age span) and prevention. In particular, we need to consider the learning from the Adverse

Childhood Events research, and consider how we can invest in supporting vulnerable children to prevent expenditure in mental health, addiction and justice services in the future.

We have an ambitious approach to community justice in Scotland, and we need to reflect on the evidence base about the effectiveness of community disposals, and to consider whether social work justice services are being funded in a way which enables them to adopt preventative and early intervention approaches, while also meeting statutory requirements in assessing and managing risk, and in resourcing the justice system.

Submission prepared by:

Mike Brown, Treasurer, Social Work Scotland
mike.brown@socialworkscotland.org

Susan Taylor, President, Social Work Scotland
susan.taylor@east-ayrshire.gov.uk

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