Roundtable

The critical issues in social care and social work

Introduction

This note is a supplement to the IJB finance and performance report, published in June 2024. It is a summary of issues and messages captured from a roundtable discussion held 15 February 2024, hosted by the Accounts Commission sponsors and the Audit Scotland team leading on the work.

The aim of the roundtable was to hear from a range of people, in strategic roles, from across the sector about the issues currently affecting social services in Scotland. The purpose was to help inform the work for the report and to contribute to deliberations about the potential scope and focus of future pieces of work.

We would like to thank the participants for their time and the valuable contributions made to the very full and informative discussion.

Overarching messages from the discussion

Collaborative thinking is shrinking at a time when it is most needed

- We know what better/good looks like, but it is difficult to take the actions to fix it. More radical change is needed.
- Instead of collaborative thinking, we are seeing more protectionism and a silo-based culture. Funding pressures and accountability processes are intensifying this. This is happening at a time when organisations need to work collaboratively to alleviate pressures in the system.
- We recognise that we need more holistic services based around the needs of users with a focus on prevention and early intervention. While this would reduce dependency on expensive, acute care these kinds of services are most at risk of being cut as public bodies try and balance their budgets. It is difficult to work in a way that is consistent with a whole systems approach when resources are so tight.

We need to demonstrate the value of investing in social care across the whole system

- The case for investment in social care needs to be clearly set out demonstrating how the money spent on social care will achieve better outcomes for people across Scotland and save money spent on more expensive, acute care. Many people in the health sector recognise that they would spend less money and achieve better value for the taxpayer if there was more investment in social care.
- The case for investment should be supported by an evidence-base. Data across the whole system is key to a whole system approach.

We need an honest debate in public and with the public about the challenges and solutions

- We need 'permission' to have an open and honest dialogue in public and with the public about the difficult challenges across the whole system and potential solutions. Need to get all partners 'around the table' and have a national conversation.
- It is difficult to have these conversations as the media frame what they see as things the public will tolerate and politicians can apply pressure if something is seen as unpalatable.

We need a better forum for and culture around sharing and learning from good practice

- Important to bring hope during extremely challenging times and supporting improvement and innovation.
- There are opportunities to draw out good practice and share it.

Themes from the discussions

People	
Public bodies need to better understand demand for services and how this is changing across Scotland.	• Demand is changing and varies across different parts of Scotland. • Scotland has an increasingly older population, and this is leading to an increased demand for services. Needs are also becoming more complex as people often live with co-morbidities. Demographic changes also include young people leaving rural areas and moving to urban areas for work, while older people may move to rural areas to retire. • Overall, there is a growing level of unmet need.
Instead of care in the right place at the right time we are seeing a shift towards a crisis response.	• Everyone is entitled to support that protects their human rights and is offered in a destigmatised way. • Services should be seamless around the needs of people. Instead, people often find that they get batted between different professionals in health, social work and social care. • People often don't get the care they need at the right time in the right place – this can lead to poorer outcomes for people as well as being costly for example: – Unable to leave hospital due to a lack of access to appropriate social care packages. – Presenting at A&E or primary care with challenges rooted in more social issues for example housing. – Escalating mental health issues that involve the police. • Joined up, early intervention/preventative approaches within community settings can help alleviate pressures on acute care by stopping things reaching crisis point. These approaches are best when we go to the places where people are in the community. However, services aimed at prevention /early intervention are most at risk of being cut. We are seeing this with cuts to community link worker funding; a tightening of health and social care eligibility criteria; and increasingly risk-averse approaches in social work where the risk is removed rather than good support provided. • Services vary across the country. While this may seem unacceptable, it can also reflect local need. • While there are pockets of good practice across the country, these are not widely shared or understood.
An open and honest dialogue needs to take place with the public on the future of health and social care.	• We need to create a space for a public discussion on the future of health and social care and sell the importance of good social care so that it becomes a higher priority for the public. Otherwise, people will always be reliant on high-cost treatments in acute settings. This includes conversations on the type of care people want in the future for example, should care be focused on preserving life or improving quality of life? • Public bodies need to engage with people honestly on how services can be changed to support this.

Workforce	
Long-standing issues with pay and job dissatisfaction continue to affect recruitment and retention in social care and social work.	• Issues in social care and social work include: – Lack of parity of esteem. NHS pays more than social care for same job level. NHS and social care pay deals are negotiated separately and differently. It is difficult for IJBs to challenge SG on these decisions. Social care workers lack a strong national voice advocating pay as they are not unionised in the same way as health. – Poor and uncompetitive pay for social care workers. Across social care, pay is often lower in the third and independent sector than the council. In general, the pay doesn't compete with other jobs in less demanding roles such as hospitality and retail. Paying the living wage isn't enough. It is a skilled job and SG needs to significantly invest in social care workers pay after years of underfunding. – Low retention rates. Average time working in social care at home is 24 months. – Needs to be a better understanding of the complex/professional role of social workers. – Poor public image of the roles, unattractive to join or stay in the roles. – Workers are doing the best they possibly can and often doing very well, despite systemic problems. – Many staff leave because they can't do the job they set out to do (referred to as moral injury). – Workers aren't sufficiently empowered to make the changes they know need to be made. – Experience low morale, feelings of frustration and anger.
We don't have a workforce fit for the future.	• The overall size of the workforce is shrinking especially relative to the scale of demand. • The current workforce is ageing, it is unstable with a high turnover and rural areas can't recruit enough staff. • We need to plan for a workforce for the future but instead roles are being reconfigured in crisis response for example: – 80 per cent of drug and alcohol people are doing community link work because there isn't the funding of link roles. – Children's social workers are being moved to adult services in a 'crisis approach'. • We need to reconfigure the workforce in a long-term, planned way that will improve outcomes for people for example: – More nurses in care homes instead of hospitals. – Roll out developments in technology. At present, leaders lack the bravery/resource to implement some of the good work on roles in social care such as care technologists. – Decide, with the public, if the focus is on preserving life or quality of life.

Shared leadership	
The relationship between health and social care needs redefined.	• The debate about social care 'versus' health is contrary to the intention and ethos of the legislation that underpins health and social care integration, which was about collaboration with a focus on the needs of service users. The relationship needs to be rebalanced with health and social care treated as equals. • The message about what IJBs were set up to do and deliver has not been clear enough. Scotland still has two systems of health and social care defined by historical legacies, gender imbalance, lack of parity of esteem. It was hoped IJBs could bridge this. But there is an inability to give up power and control and trust others. • The IJB model isn't fixing the fragmented system and maybe it needs to be a different model. The impact of delegating children's services is unclear and there are variations in the interpretation of duty of services. • Lots of barriers to shifting the balance of care – governance structures, regulatory, union, political, organisational barriers. • Drivers in the current system contribute to a continued focus on acute services: – Politicians intervening in ways that aren't consistent with strategic plans. – Downgraded Chief Social Work Officer role – more operational than strategic role. – Mental health is not prioritised to the same degree as physical health. – Strategic decisions can be driven by clinicians rather than by equity/ most vulnerable. – Constant focus on delayed discharges. – Key performance measures that are collected and reported on are health driven.
Leaders need to agree a long-term plan that supports a whole system view.	• We all share the same overall vision of wellbeing and good outcomes but need a shared understanding on what the problem is, and a shared plan on how to get there. We need to look at the whole system, not go back into silos. There are challenges in all parts of the system. We need to reach a shared view on transformation for an area and understand early intervention. • Planning needs to be longer term and strategic with incentives and rewards for partnership working. People with direct operational experience need to be involved in shaping the new system. • There hasn't been a strategic approach across the whole system since the ministerial group that recommended IJBs. There is no senior, open mechanism where health and social care comes together – bits and pieces happen behind closed doors.

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Shared leadership	
Financial pressures are leading to more focus on protectionism rather than a whole system view.	• Financial pressures lead to: – Organisations looking inward rather than shared priorities and resources. – Firefighting and pulling back from longer-term strategic thinking. – Protectionism gets worse with less resources but it's more important than ever to take a whole system view. • The health sector can see that it would spend less money and achieve better value for the taxpayer if there was more investment in social care, but it would be a courageous leader to say this money is better spent elsewhere. • Every part of the system is under pressure. People are pulling back from things they would have done but this has implications for the rest of the system. When people have issues accessing services, it drives demand into acute care.
The debate on the NCS is losing focus on improving outcomes.	• NCS is moving further away from Feeley recommendations. Concern is it won't deliver Christie ambitions. • We're dealing with the legacies of how organisations were set up and evolved and now bolting things on to this. • Frustrations about the time, energy and cost being taken up by planning and engagement around the NCS, about the way reform seems to be focused on who has power and control rather than on improving services and outcomes. Focusing on structures instead of tackling need and it has become a proxy battle for accountability and organisational and structural priorities/interests/incentives. • Perceived lack/loss of trust between government and others. • Planning inertia created by uncertainty has implications for organisations plans to invest and reshape services. • Need to consider accountability and assessment of performance in NCS if/as it evolves.

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Shared leadership

Shared accountability requires good performance data across the whole system.

- Shared accountability is important but isn't happening.
  - Accountability is upwards in an organisation rather than to partners, the communities they are serving and users.
  - There's too much emphasis on data from an organisational viewpoint. This feeds into protectionism.
  - Data is key to a whole system approach – we need to redefine performance management to reflect this.
- We don't have good data across the whole system and this impacts on decisions and priorities.
  - Lack good measures on shared outcomes that reflect the whole system.
  - Need more focus on citizen data and wider population health.
  - Lack good data on population shifts.
  - Lack good data on primary care.
  - We haven't managed to define best outcomes in social care which leads to a lack of transparency on social care performance.
  - Best data is on acute care. But the focus here is on inputs, waiting times, financial returns.
  - Lack the data which shows the issues across the system, for example, people have access issues and aren't seen in the right place.
- We need to get better at sharing data.
  - Sharing data is critical in responding to significant events with people.
  - Who does the data belong to? Should it be the citizens?
  - Public perception that all health data is shared across all of health system.
  - Primary care data sharing is voluntary but it's mandatory elsewhere in the UK.
  - Data duplication issues.
  - Consider sensitivities around personal data.
  - Dashboard now being used across IJBs that shows some early progress, allows some national/regional comparisons.
- Organisations aren't held to account on learning.
  - This links to the lack of a good improvement culture.

Money	
Financial pressures mean that critical need is prioritised at the expense of prevention yet the impact of this is not being fully assessed.	• IJBs are struggling to balance their budgets. – Inflationary pressures. – Vacancies are saving IJBs financially. – Reliance on reserves/non-recurring sources of finance. – Councils' and NHS boards' financial situations are very visible; IJBs' finances are much less visible. • IJBs are concentrating on critical need but the impact of this is not being clearly assessed and risks placing more demand on the acute system. – Concentrating on critical need only to balance the budget. This comes at the expense of prevention and early intervention. – Easier to necessitate the case for retaining money and services in acute services as they have more data. Lack of data makes it harder for some services to argue for additional investment. – Decisions to cut services are not always based on equality impact assessments and an understanding of impact on demand on other parts of the system. Community link workers is an example here. – The right care isn't happening in the right place. It is expensive treating people in the wrong place for example inappropriate admissions to A&E, delayed discharges, presenting to GP with social issues. Current system creates more demand. – Money spent on prevention/early intervention is less expensive than costly, acute care later on.

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Money

- Funding streams make it harder to do things differently.
  - No budget for transformation.
  - IJB reserves allowed transformation and testing new ways of working. Much more challenging to do that now with current financial pressures.
  - Trying to do everything we used to do pre pandemic with less resource.
  - Political/public pressure not to close hospitals/care homes etc.
- Protected spend, fragmented funding streams.
  - Extra money from SG is earmarked and not available for flexible, innovative spending.
  - Some ringfenced budgets can be too prescriptive.
  - Fragment funding for example small pockets allocated to specific areas such as drugs and alcohol.
  - Risk to sustainability of unprotected services. Can't protect prevention spend but prevention is more important than ever.
  - Those working within services have a better understanding of costs and how to get value for money.
- Lack long-term funding.
  - One-year funding. Having to make decisions in the short term without understanding what's going to happen longer term. Things are only going to get harder.
  - Insecurity over future spending.

Commissioning and procurement	
Current commissioning and procurement processes do not promote collaborative, outcome focused care.	• The priority should be delivering the best outcome for supported people, but this part of the conversation is often missing in current processes which are not centred around individual choice and control. • We need to think more holistically about supporting a person's complex needs and outcomes and social care as part of this. • Procurement processes tend to be transactional processes and reflect inputs of social care rather than the outcomes they want to achieve. • The frequency of procurement processes/tendering impacts on the scope to take a longer term, strategic approach. • In some remote/rural areas, there is no real market for social care as there are so few suppliers. • The procurement processes don't give enough weight to a professional assessment of eligibility and need but rather reflect a tightening of eligibility criteria. • Can be a race to the bottom, going for the cheapest provider given pressure on commissioners to make savings. • Internal audit can focus on controlling the risks associated with self-directed funds, but this can be too punitive and miss the wider picture.
We need better relationships with external providers.	• Third/independent sector need a seat at the table. • There can be a reluctance to engage and collaborate with the private sector. Despite high usage of external providers there can be a lack of trust with more scrutiny of the private sector. This may be linked to local media scrutiny and coverage of issues. • Current attitudes and behaviour within care are damaging and have deteriorated in the face of pressures in the sector.
Concerns about progress towards ethical commissioning.	• It's important that developing ethical commissioning arrangements themselves embody ethical commissioning principles in the programme of work. • There is variation in approaches across the country. • Some authorities are doing some good work with commissioning approaches for example Fife and Aberdeen City • In general, we still a long way to go to put ethical commissioning into practice – lots of different components to it.

Improvement culture	
We don't have the right culture or processes in place to encourage and nurture innovation. Some innovative practices and approaches are being carried out, but this is in 'despite of' rather than by design and is not always shared.	• We don't have a good culture around innovation and good practice. – A focus on criticising IJBs comes at the expense of overlooking the good work happening. – There is a reluctance to share and to seek out and learn from good practice elsewhere – inwards focus, arrogance or fear of implying to colleagues and elected members that things are done better elsewhere. – Leaders lack the bravery/resource to implement some of the good work on roles in social care for example, care technologists. – We need to understand and address what's stopping the spread of good practice and improvement.
We lack the capacity and funding needed for innovation	• It's difficult to have the space to think about transformation when you're firefighting – can't do everything. • We keep adding more to the existing system and never take things away. • Lack opportunities to invest and do tests of change for example we've lost investment funds for transformation, and it can be difficult to get funding needed to get ideas off the ground – this may rely on match funding from academic institutions. • Rolling out successful pilots involves deciding on what to de-fund. Not enough money to do everything. • Staff aren't sufficiently empowered to make changes. • Improvement needs to be owned by people who need to make the change. • There isn't funding available for flexible, innovative spending. • Ring-fenced money can stifle innovation. • Too much focus on delayed discharges all the time at expense of other things. Can only do interesting initiatives if delayed discharges are under control.
Lack national strategic drive and oversight of improvement.	• Need to be bolder that things need to change rather than just improve. • Some good practice at operational level but not at a strategic level. • Lack an evidence-based understanding of initiatives and what works. • Improvement work is not being driven by improvement agencies. • Don't want more frameworks and standards – too cluttered as it is. • There is an appetite to change, but this can only be done with wider shifts in the system, including leadership, accountability, etc. that need a radical rethink.

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Improvement culture	
Examples of good practice mentioned.	• Improvements in care at home with district nurse/GP input. These approaches prevent readmissions. • Community care homes decrease hospital admissions. • Some good work on roles for example care technologists but not implemented. • Fife and Aberdeen City doing good collaborative work with independent sector around commissioning and procurement. • Glasgow City Council – has been good work on mental health and commissioning done jointly with services and communities. • Link worker programme – showed impact. • Canada reduced commissioning and procurement process from six months to six weeks.

Attendees

Angela Leitch	Accounts Commission
Malcolm Bell	Accounts Commission
Joe Chapman	Policy Manager, Accounts Commission
Iona Colvin	Chief Social Work Advisor, Scottish Government
Angie Wood	Co-Director for Social Care & National Care Service Development Directorate, Scottish Government
Jackie Irvine	Chief Executive, Care Inspectorate
Ralph Roberts	Chief Executive, NHS Borders
Alison White	Chief Officer, West Lothian IJB
Dave Berry	Chief Finance Officer, Dundee IJB
David Robertson	Chief Executive, Scottish Borders Council
Robert Emmot	Director of Finance, Dundee City Council
Ben Farrugia	Director, Social Work Scotland
Maree Alison	Director of Regulation, Scottish Social Services Council
Dee Fraser	Chief Executive, Institute for research and innovation in social services
Karen Hedge	Deputy CEO, Scottish Care
Diana Hekerem	Associate Director of Transformational Redesign, Healthcare Improvement Scotland
Justine Duncan	Director of Communications and Engagement, The Alliance
Dorry McLaughlin	Chief Executive, Scottish Autism
Jill Laspa	Policy Manager, COSLA
Antony Clark	Executive Director PABV, Audit Scotland
Kathrine Sibbald	Senior Manager Social care portfolio, Audit Scotland
Leigh Johnston	Senior Manager Health portfolio, Audit Scotland
Tricia Meldrum	Senior Manager Education and children's services portfolio, Audit Scotland
Jillian Matthew	Senior Manager Equalities and human rights portfolio, Audit Scotland
IJB finance and performance report audit team members	

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