ARK Feature

What now for Social Care?

Ann Marie Gray, *Ulster University*

Across the UK and in many countries social care has been in the spotlight as a result of the COVID 19 Pandemic and the high number of care home deaths as a proportion of overall COVID 19 deaths. Of course, the impact on social care extends beyond care homes with many users of domiciliary and day care services and unpaid carers left very vulnerable. The BBC has reported that 4,000 domiciliary care packages were suspended in Northern Ireland during the pandemic as users or families were concerned about the spread of the Coronavirus. A clear picture has emerged of social care systems under significant pressure and a workforce struggling to cope. But, many of the now highly visible problems relating to social care are not new; the pandemic has just brought to public attention serious problems resulting from years of under funding and political neglect. Even in Northern Ireland where health and social care provision has been structurally integrated since 1973, a clear fault line exists between universal health services and means tested social care.

While health services benefit from strong public support people generally know little about social care, how it is organised or that they have to pay for it (Gray and Devine, 2017). The British Social Attitudes Survey reports a consistently low satisfaction rating for social care (29%) (Robertson et al, 2019) – significantly below that of any of the NHS services. This lack of public understanding and the low profile of social care has also contributed to a problem of low expectations with social care rarely subject to the same scrutiny as health services. An example of these low expectations is the way in which the 15 minute visit for domiciliary care has become 'acceptable' and the perception of four short visits a day as maximum entitlement regardless of whether this is sufficient to meet needs. Within the UK health and social is a devolved responsibility and while this has resulted in some divergence between jurisdictions there are common challenges. There are inequities driven by how services are funded, how needs are assessed, how individual contributions are assessed, the fragmentation of the provider market and variation in care standards and quality.

Fragmented provision and variable standards

Across the UK funding has not kept pace with demand for services or the increasing cost of care resulting in unmet need - much of it undocumented. There is variance in quality and standards and the outsourcing of care based almost exclusively on price has resulted in a fragmented and fragile care provider market. The collapse of care home provider Southern Cross Healthcare in 2011 and the withdrawal from the publicly funded home care market of several major suppliers has given rise to questions about the appropriateness and ability of the private market to deliver the bulk of social care provision. Of the 483 registered care homes in Northern Ireland all but 49 are in the independent sector and most are owned by private companies.

Fragility in the home care market creates substantial risk for users and ultimately for the state which is required to ensure that people's needs are met. A Competition and Market Authorities report (2017) raised concerns about sustainable capacity. It was also concerned that people had difficulty accessing the information which would allow them to make good care home choices and by the infringement of consumer law by some providers. A 2016 OECD report recommended a set of social care standards and better public reporting of the quality of service provision to increase transparency. Public confidence has also been shaken by a number of high-profile scandals involving abuse or neglect in the care of those with learning disabilities and older people (for eg, COPNI, 2018; BHSCT, 2019; DoH, 212) highlighting deficiencies in regulation and inspection systems, workforce training and governance.

The Social Care workforce

The COVID crisis has highlighted the critical role of social care workers. While the evidence is clear that high quality care and high quality working conditions are linked this is a workforce characterised by a high degree of precarity and where many workers struggle even to be paid the minimum wage. That pay and conditions of care workers do not reflect the commitment and skill required from them means there have been long term problems with recruitment and retention. In Northern Ireland seventy-five per cent (of 31,000) of care workers are employed by the private sector; 12,000 of these work in domiciliary care. There are significant differences between pay and conditions in the statutory and independent sectors, whileinvestment in learning and improvement is more limited in the independent sector (Dept of Health, 2018; Dept of Health, 2017). Questions have also been raised about how the government support for social care during the pandemic was much slower than for health care increasing the risk to workers and those they care for. This included delays in ensuring adequate PPE provision and issues regarding sick pay. Some private sector homes did not pay sick pay to staff self isolating because they may have contacted the virus. It wasn't until the 2th June that the Minister of Health announced that the Department would provide funding for care homes to pay staff 80 per cent of their salary when on sick leave for reasons related to COVID as part of an £11.7 mill package of support for care homes (Swann, 2020).

Health and social care is a growth area within the economy. Investment in care as social infrastructure, which provides

for higher level training and qualifications and career progression, would have distinct economic benefits as well as professionalising the workforce and improving the quality of care.

What about the integration of health and social care in Northern Ireland?

While there is consensus about the need for better integration between health and social care services, the structural integration which has existed in NI since 1973 has not delivered the benefits that might have been expected. Silos operate with regard to funding and delivery and there are distinct cultural differences between the two services (OECD, 2016). Successive reviews under the devolved administration – from the Developing Better Services report (DHSSPS, 2002) to the Bengoa Review (Dept of Health, 2016) - barely addressed social care issues except to acknowledge that better integration is a key requirement for the delivery of a seamless service. The Bengoa report acknowledged that "the benefits of integration have not been fully exploited" and that more "depth" in the integration of health and social care called for more work on how the system plans, funds and purchases care across the various health and social care areas and sectors. The only review to look specifically at adult social care (Dept of Health, 2017) contained 16 proposals including creating a "valued" and "professional" workforce by paying employees the living wage but it was not within the remit of the panel to address the fundamental issues of funding and structures.

A question being asked across the UK is whether this is a watershed moment for social care? Alyson Pollock (2020) has argued that the current emergency has exposed the need for a universal fully integrated health and social care service where all services and staff are brought back under government control in a national and publicly accountable system, adding to growing calls over the past 20 years for a service free at the point of use. The experience of NI has shown clearly that structural integration does not in itself lead to parity between health and social services. That can only be a achieved by reform of the funding and delivery of social care. There is a fundamental conflict between free at the point of use NHS and a residual and means tested system of social care. The scale of reform required is not possible within any of the social care systems currently operating on these islands. There is evidence of public support for such a move and that they would be willing to pay for it. Understanding public attitudes and securing public support is important given the significant cost to the public purse. Surveys, polls and Citizens' Assemblies have shown that, across all sections of the population, there is a preference for a collective rather than an individualistic approach to raising funding for social care (Health and Social Care and Housing and Local Government committee, 2019; Citizens' Assembly NI, 2019; Gray and Devine, 2017). Given the financial implications of social care reform, and that tax and national insurance are largely powers reserved by the Westminster government, this needs to be progressed on a UK wide basis.

Across the UK social care has been a political failure. Government after government has talked about improving quality in care without linking this directly to substantial improvement in funding and the pay and conditions of workers. It does not now seem logical that planned transformation of services in NI can continue without a radical rethink about reforming the system of social care.

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Author: **Ann Marie Gray** is Professor of Social Policy in the School of Applied Social and Health Sciences, Ulster University and Co-director of ARK