

### Part 3. Social Care: relationship to ICSs

One implication of *Integrating Care* is that social care – which is currently managed by local authorities - might be brought into the ICS, under direct management of the NHS. This threat to local authority control implies a major loss of public accountability for these services. **Part 2** of KONP's response suggested an alternative model for democratically accountable NHS management involving Strategic and Local Integrated Health Boards, that would give local authorities a genuine partnership with the NHS and bring local accountability to the NHS. This Part of KONP's response concentrates on the implications for social care.

### Unequal Partnership Proposed

Joint strategic needs assessments and health and wellbeing strategies are developed by local councillors working with CCGs, Directors of Public Health and of Adults and Children's Services at local authority level. *Integrating Care* recognises that '*Vulnerable people need support that is joined up across councils, NHS, care and voluntary organisations; all based on a common understanding of the risks different people face*' (1.5). It highlights the importance of links to '*other public or voluntary services that have a big impact on residents' day-to-day health, such as by improving local skills and employment or by ensuring high-quality housing*' (1.16).

It stresses that '*The aim is a progressively deepening relationship between the NHS and local authorities, including on health improvement and wellbeing*'. In discussing options for legislative change, the NHSEI preferred Option 2 '*also provides a clearer statutory vehicle for deepening integration across health and local government over time*'.

However, despite implying that ICS would mean positive partnerships between the NHS and local authorities, it would not be an equal partnership. The intention looks like a power grab to bring social care resources under NHS control. For instance:

*From April 2021 this will require all parts of our health and care system to work together as Integrated Care Systems, involving:*

- *Stronger partnerships in local places between the NHS, local government and others with a more central role for primary care in providing joined-up care;*
- *Provider organisations being asked to step forward in formal collaborative arrangements that allow them to operate at scale; and*
- *Developing strategic commissioning through systems with a focus on population health outcomes;*
- *The use of digital and data to drive system working, connect health and care providers, improve outcomes and put the citizen at the heart of their own care.*

ICSs are NHS bodies, not subject to democratic control or accountability. Local authority boundaries are generally synonymous with ICS 'place level', within which funding of services will be determined

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<sup>1</sup> <https://www.england.nhs.uk/integratedcare/integrated-care-systems/>

by the ICS Board. Where there are place level budget shortfalls, the place leader will look to their local partners for assistance.

This is also significant because current CCG funding is based on numbers patients enrolled on GP lists, while the CCG is also responsible for healthcare of people living in the area who are not registered on GP lists – with a disproportionate impact on deprived areas.

At ‘place’ level, *Integrating Care* states that ‘*the place leader **on behalf of the NHS** .... will work with partners such as the local authority and voluntary sector in an inclusive, transparent and collaborative way*’ (2.18). One of the four main roles of this NHS place leader is stated as: ‘*to simplify, modernise and **join up health and care.***’

This will also involve a data strategy. *Integrating Care* proposes ‘*legislative change that clarifies that sharing data for the benefit of the whole health and care system is a key duty and responsibility of all health and adult social care organisations. This will require a more flexible legislative framework than currently exists*’. With no hint of the major issues this raises, *Integrating Care* appears to propose shredding current notions of both client and patient confidentiality.

As well as suggesting the transfer of social care from local authority to ICS control and loosening of data requirements, *Integrating Care* also has sights on local authority capital assets: ICS capital investment strategies should ‘*not only [be] coordinated between different NHS providers, but also aligned with local authorities’ management of their estates and wider assets*’. (2.47).

## Reform of Social Care

KONP has pointed to the widely acknowledged crisis in social care and argued for root and branch reform through the development of a publicly provided National Care and Support Service that is available to everyone living in the country and is free at the point of use.

### Summary of KONP demands on social care

- A national care and support service, fully funded to meet the needs of a modern advanced democracy through investment in the social infrastructure and progressive taxation, with a national framework setting out entitlements and standards, delivered under local authority management.
- Care and support services to be publicly provided and managed by local authorities with support from not-for-profit organisations, funded through grants, not contracts.
- Community ownership of social care through involvement of service users, family carers, staff and community groups.
- Care and support must be regarded as skilled work, with the need for a professional workforce and a wide range of skills, including some that are highly specialised. Pay and conditions should reflect this and match those of staff with comparable responsibilities in the NHS.
- Family and friends should not be expected to provide more care and support than they are willing and able to give, and child carers should not miss out on education and other experiences because of the care needs of others.
- Care and support should be provided free at the point of delivery to those in need, with entitlement for everyone living in this country. Support provided should be in line with the wellbeing principles set out in the Care Act 2014.

- Disability and welfare benefits are needed to meet the additional costs which disabled people face in daily living and must not be reduced to pay for social care.
- Care home costs should be disaggregated, distinguishing between costs of accommodation, care costs and costs of everyday living. Disaggregation is also an essential part of deinstitutionalisation of residential care, allowing for more transparency and autonomy for users.

## **KONP's Objections to NHS management of Social Care**

*Integrating Care* suggests that social care should be delivered as part of an extended National Health and Care Service under ICS management. KONP objects strongly to this proposal for several reasons:

1. The issue of charges for social care versus free NHS care
2. Disruption of existing good collaboration and effective working between local authorities and the NHS
3. The remit of social care extends far beyond a mere extension of NHS services
4. Consequent concern about NHS capacity to understand and manage social care
5. Social care funding has suffered massive cuts during years of austerity; ICS would be likely to accelerate new models of social care to cut state expenditure further
6. Lack of democratic accountability currently in the NHS – covered in Part 2 of KONP's response

### **1. Charges for services**

NHS care is provided free (although this principle has been significantly eroded in recent years, not least through punitive charges imposed on migrants who live in the UK), while charges are made for social care services and these can be considerable even for people relying wholly on state benefits. If ICSs take on social care, they will need to develop comprehensive charging mechanisms. The development of charging mechanisms for one service makes it relatively easy to extend charges to other services, and facilitates development of private payment and insurance payments for procedures.

### **2. Collaboration between NHS and social care services**

Over two decades, hospital stays and rehabilitation have consistently diminished, and community nursing reduced. Many functions that were formerly regarded as nursing care (and hence provided free) are no longer offered, or are provided as part of charged social care. This shift lies behind much of the overlap between health and social care services, with social care staff expected to take on responsibilities for skin care, nutrition and more with inadequate skills and training.

In these areas of overlap between health and social care services effective collaborative and joint working is essential – and has often been in place for years. Many local authorities have worked closely with NHS bodies since the 1990's operating pooled budgets and managing joint teams. Social services have shared responsibility with the NHS for public health, rehabilitation, occupational therapy and community equipment, children's and adult mental health and drug and alcohol services. Other joint teams support children and families, people with mental health or addiction needs, people with learning disabilities, disabled people and older people, and young people in

transition from children's services and education to adult services. There are no existing legal barriers to these partnerships and in many areas they work very effectively. This joint work needs to continue.

### 3. Remit of Social Care

Virtually all media discussion of social care focuses on elderly people and on *personal care* (ie, broadly, hands-on support with bodily functions). However social care and support extends way beyond this.

The **Care Act 2014** (which is currently suspended as part of the Covid-19 regulations – and may risk being dropped completely if vital definitions are not strongly defended), establishes a far wider remit for social care than 'personal care'. Under the Act, local authorities have many responsibilities for social care that have little or nothing to do with NHS services, including a *duty to promote wellbeing* and they must consider a wide range of areas as part of their statutory community care assessments. Statutory guidance to the Act states:

1.5 'Wellbeing' is a broad concept, and it is described as relating to the following areas in particular:

- personal dignity (including treatment of the individual with respect)
- physical and mental health and emotional wellbeing
- protection from abuse and neglect
- control by the individual over day-to-day life (including over care and support provided and the way it is provided)
- participation in work, education, training or recreation
- social and economic wellbeing
- domestic, family and personal
- suitability of living accommodation
- the individual's contribution to society

These cover the same areas set out in S19 of the UN Declaration of the rights of disabled people.

The same Guidance continues:

1.6 The individual aspects of wellbeing or outcomes above are those which are set out in the Care Act, and are most relevant to people with care and support needs and carers. **There is no hierarchy, and all should be considered of equal importance when considering 'wellbeing' in the round.** [*emphasis added*].

Local authority social care services involve a vast remit and £billions of annual funding with more spent on people aged 18-64 than on people over 65. A Health Foundation summary of local authority-funded social care services<sup>2</sup> illustrates this:

In 2018/19 some 842,000 people were receiving long term social care support from their local authority. 548,000, (65%) of these are older adults. 293,000 (35%) are aged 18-64.

Of those aged 18-64: 134,000 (46%) have learning disabilities as their primary disability; 94,000 (33%) have physical or sensory impairments; 59,000 (20%) have mental health needs, and 7,000 (2%) have other social support needs.

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<sup>2</sup>[https://www.health.org.uk/sites/default/files/upload/publications/2020/Social%20care%20for%20adults%20aged%2018-64\\_Analysis.pdf](https://www.health.org.uk/sites/default/files/upload/publications/2020/Social%20care%20for%20adults%20aged%2018-64_Analysis.pdf)

Only 10% of those with physical or sensory impairments, 18% of those with mental health issues and 19% of those with learning disabilities are supported in nursing or residential care homes, the rest receive their local authority support in the community.

In contrast, 61% of older people who are funded by local authorities live in residential or nursing homes.

In 2018/19 local authorities spent £12.46bn on social care support: £1.43bn supporting people aged 18-64 with physical and sensory impairments; £5.24bn supporting people aged 18-64 with learning disabilities, and £5.79bn on services for older people (older people are far more likely to be self-funding because of tight financial eligibility criteria).

In line with their legal requirements to determine the extent and range of local need, local authorities plan integrated social care support to meet the diverse needs of all their local communities and to address the wider determinants of health. Their teams of professional social work staff have vital skills and sound understanding of the local area to conduct individual assessments to plan and provide support for people with a wide range of needs and to respond to the diverse needs of Black and minority ethnic communities, migrants and asylum seekers, LGBT communities and more. This includes supported accommodation, home care, residential care and day services; safeguarding, advocacy, and services for family carers; support to access employment, education, housing and transport, mainstream and specialised community sports, leisure, arts; support with digital services, to access and maximise benefits and advice on all aspects of living; counselling, support for refugees and asylum seekers and communities with specific needs; support to access both public and private community provision.

Local authorities also have important responsibilities for shaping and supporting development of local communities. They can make support contingent on services providing the widest access and support for people with additional needs – for instance by ensuring both directly delivered and grant-aided services provide good access and support for disabled and vulnerable people and providing incentives for other service providers to do the same. If responsibility for social care is removed from local authorities, there will be little incentive to address these wider issues.

As well as shared responsibilities with the NHS, social service teams have shared responsibility with education and children's services, for managing transition to adulthood for young disabled people, with housing for arranging adaptations to homes, community alarms and key holding, supported and sheltered housing schemes, and for supported leisure facilities and assisted transport. These shared responsibilities don't mean social care can or should be merged with Education or with Housing – services just need to be well co-ordinated, with shared objectives and performance indicators.

The importance of these links to the wider determinants of health, to local planning and services, also illustrates starkly why social care must not be separated off as a separate, independently managed service.

#### **4. Concern about NHS capacity to manage social care**

The NHS with its mainly individual and clinical approaches cannot begin to mesh social care and support into wider community structures and services as outlined above. The necessary co-ordination between social care and the NHS should be achieved through structures that involve some shared objectives and promote and share pathways, not through NHS management.

The NHS's main interest in social care has been mainly concerned with older people, as the means through which NHS beds can be emptied more rapidly. This was reflected dramatically in the way

older people occupying NHS beds were discharged to care homes without being tested for coronavirus, resulting in thousands of care home deaths. Most social care accommodation is now managed by the private sector, but in the past NHS learning disability hospitals – *Assessment and Treatment Units* - (along with far more private sector counterparts) have ~~also~~ been the subject of investigation over poor care. Yet this is an area of social care where there is significant overlap with NHS services, so offers a poor example of how the NHS might address wider aspects of social care.

## 5. New models for social care

Increasingly there has been a push towards ~~both~~ direct payments to individuals (who then purchase their own support from an open market of providers – which may or may not function locally), and a determined move towards new models of social care based on what is known as ‘asset-based commissioning’.

Lot 7 (Patient empowerment and activation) of NHSE’s Health Service Support Framework makes clear their intention to increase the scope of personal budgets whereby people are allocated a fixed sum and left to find and manage their own care, often in the form of a direct payment in cash. While this approach is popular in social care amongst some, especially younger physically impaired people, it is rife with difficulties. In many localities it can be difficult or impossible to find support and most people who need social care are not able or don’t want to take on responsibility for arranging and managing their own services.

The asset-based approach is set out in a 2010 Local Government Association report ‘A Glass Half Full’<sup>3</sup>.

*“The asset-based approach sees citizens and communities as co-producers of health and wellbeing; promotes community networks, relationships and friendships as a way of providing mutual help and support; and, most importantly, empowers communities to control their futures and create tangible resources for themselves.”*

The 2010 report signalled a resurgence of a community development approach to building community resilience that was common in the 1970s alongside more traditional social care. Many local authorities have gone some way to developing their services in line with these models which may also offer a way to address the swingeing cuts to social care budgets.

10 years on, a review of progress on *A Glass Half Full*<sup>4</sup> paints a very mixed picture. An asset-based approach was not meant to be an excuse for cutting direct service provision: they were meant to be complementary. But in a period of austerity basic community services have been dramatically reduced. The authors of the original report themselves state that:

*“The idea that we can do without public services... that communities, families, neighbours will step in is not one we advocate. We didn’t imagine that when the report was published the social infrastructure that supports people’s lives... community life... the libraries... access to the park and public space... the leisure centre, would be so reduced...”*

Although the report cites examples of successful community initiatives, Chapter 3 provides a major critique: that an asset-based approach fails to address issues of power and that, particularly in a time of austerity, it could exacerbate growing economic and social inequalities. They point to the

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<sup>3</sup> <https://www.local.gov.uk/sites/default/files/documents/glass-half-full-how-asset-3db.pdf>

<sup>4</sup> <https://www.local.gov.uk/glass-half-full-10-years-review>

*‘prevailing narrative of people living in poverty and experiencing inequality frames them as shirkers, scroungers or ‘troubled’: a general drain on resources and burden on ‘the taxpayer’ that supports this view.*

The report cites a Scottish study<sup>5</sup> where *‘local practitioners admitted that asset-based approaches were often not experienced as empowering by the communities involved and did not contribute to greater social and health equity’.*

They point out that *‘programmes of austerity in Europe and the UK have impacted most on those already vulnerable, such as those with precarious employment or housing, or with existing health problems [and is] associated with worsening mental health and, as a consequence, increasing suicides’.* ***‘In this context the government has co-opted the asset-based way of working as a way to reduce ‘unaffordable demand’ on services, linked to public spending cuts’, and so ‘at their worst strength-based approaches could help to create a new world of ‘DIY welfare’ at the community level where provision of publicly funded and provided health, social and welfare services recede into the background’.***

The past decade has witnessed a very sharp rise in child poverty, loss of services and the use of food banks, with no Government inclination to address any of these issues. If social care were placed under the responsibility of ICSs there is every chance that the push towards both direct payments and asset-based commissioning would greatly accelerate, forcing vulnerable people to rely on family and community volunteers who would all but replace traditional social care services. Local authorities may have proved an ineffective opposition, but without their input who can say where we might have been.

## **Conclusion**

**For all these reasons, we argue it is essential that social care should not be included within the management remit of ICSs. We need a National Care, Support and Independent Living Service that operates alongside but independently from the NHS, is funded at national level and managed at local level by local authorities.**

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<sup>5</sup> Tackling health inequalities through asset-based approaches, co-production and empowerment [https://www.research.ed.ac.uk/portal/en/publications/tackling-health-inequalities-through-assetbased-approaches-coproduction-and-empowerment\(84a4a1b5-7357-4743-ad6b-88db3e64cdd2\).html](https://www.research.ed.ac.uk/portal/en/publications/tackling-health-inequalities-through-assetbased-approaches-coproduction-and-empowerment(84a4a1b5-7357-4743-ad6b-88db3e64cdd2).html)