**REFORM OF HEALTH AND SOCIAL CARE**

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In the daily update on Friday 15th May 2020 Matt Hancock said that the current crisis had demonstrated how closely health and social care need to work together and had acted as a catalyst to reform, referring to “integration”.

Care homes are not, and were never intended to be, hospitals. The residents are just as entitled to hospital care, if that is what is needed, as are the rest of us. That so many have been left to die in Care Homes, rather than being admitted to hospital, and thereby denied the benefit of oxygen, ventilators and intensive care which might have saved their lives is the real concern. The minute a resident exhibited symptoms they should have been tested and if positive admitted to hospital. The discharge of older people from hospital to care homes, without testing, in order to free up beds for coronavirus patients may also have spread the virus. Admissions to care homes should have been stopped from the time relatives were stopped from visiting. Instead instructions were issued, as late as March, to discharge older people to care homes in-order to free up hospital beds. The latter situation might well have been worse had Care Homes been the responsibility of the NHS as that would have removed the checks and balances, And that not all older people have an "assessment of need" and "verification of wishes" by a social worker prior to admission to a care home whether or not they are self-funders, as envisaged by the 1990 National Health Services and Community Care Act, is a real concern. All staff in Care Homes and those working in Home Care should have worn masks from day one of the pandemic. These are real concerns as is the under funding of the care sector.

However, that Baroness Ros Altmann also referred to “integration” on “Good Morning Britain” and Matt Hancock reiterated it on the 21st May would suggest the matter is under consideration. But what is to be integrated with what and how?

Most Care Homes and Home Care Providers are now in the private sector.

Countless enquiries into “child abuse” and “adult abuse and neglect” have criticised agencies for not working together. And successive Governments have tried to get Health and Social Services, in particular, to work more closely together from “joint funding” in the 1970s to the “pooling of budgets”. But no Government has grasped the nettle of the lack of common geographical boundaries, different funding streams and different lines of accountability which have been the real impediments. This does not mean a merger of health and social services as that would further marginalise Social Work and different combination of agencies are required depending upon the problem and desired outcome. For example: Child Protection requires children’s services, health, education, the police and foster care to work together. Older People require Adult Services, Health, Housing, Leisure Services and Income Support to work together. But not all of them all the time. It is quite a complex multi-dimensional organisational issue across countless scenarios.

Repeated re-organisations of health and social services over the past thirty years have added to the fragmentation and cost. In my days as a Director of Social Services my counterpart in health managed nine hospitals, five of which were regional, community services and the family practitioners committee (GPs) all with a management team smaller than is now found in each hospital trust.

Since the late 80s, health, and the early nineties, social services, have been required to separate out the management of in-house provision from that of purchasing and commissioning. This doubled the management and administrative costs. The intention being that it would encourage a mixed economy of care and force quality up and prices down. Clearly this has not been the case and that social workers were employed on the “purchasing”, rather than the “providing”, side, led to a “minding” rather than a “mending” service with an ever-growing case load of dependent people. It led to over prescription with providers unable to respond in situ to changing need or priorities and further fragmentation and lack of continuity as different component parts of a “package of care” could be purchased from different providers.

Wales, which had common boundaries for health and social services with several All Wales Strategies, went from 8 County Councils and 37 District Councils to 22 Unitary Authorities at considerable cost. Had Government opted for the County Councils, as their unitary authorities, there would have been immediate savings on the cost of democracy and year on year savings as District Council Departments were merged and some into County Departments through natural wastage.

 The splitting of Adult and Children’s Services in England added to the management costs as did the creation of unitary authorities.

Therefore, as a first step, the answer might be to bring all services together in either the old County Council or Police Authority boundaries, returning the NHS and Police to local democratic scrutiny within central government legislation, in order to achieve common geographical boundaries, common funding streams, common lines of accountability and economies of scale. Whilst abolishing the costly and ineffective purchaser / provider split. And replacing it with a new Statutory, Voluntary, Private Sector partnership.

**A whole systems review**

The NHS and social care are in crisis. Nearly two million older people are living in poverty and more and more older people are having to sell their houses to pay for their care in this the fifth largest economy in the world. Many of these people were forced into retirement and condemned to spending the rest of their lives in poverty.

However, it cannot be solved by pouring more and more resources into the first aid camp at the bottom of the cliff, rather than building a fence at the top. There needs to be a whole systems approach designed to reduce demand, increase efficiency and effectiveness and find sufficient money to make health and social care (not living costs) free at the point of delivery of service.

Britain’s state pension is 29% of national average earnings compared with 100.6% in Holland, 94.9% in Portugal, 93.9% in Italy, 91.8% in Austria and 81.8% in Spain. The official definition of poverty is anything less than 60% of the median household income.

Given the correlation between income and demand upon the NHS it is hardly surprising that older people account for 4/5th of the expenditure. An estimated 1.3million older people suffer from malnutrition costing the NHS £19.6billion per year. There are five main causes of malnutrition: lack of money; lack of motivation; incapacity; lack of support and social isolation.

Holland, with the highest pension in Europe spends 60% of its health budget on older people compared to 80% in Great Britain.

A starting point may be to raise the state pension from 29% of national average earnings to 60% at a cost of £100.26billion. This could be offset, in part by people who go on working, beyond the age of eligibility for the state pension, continuing to pay National Insurance (raising £4.1billion) and not drawing their state pension until they retire (saving £8.24billion) with phased arrangements.

There would be a saving of £37.05billion on other benefits and £14.47billion would be clawed back through income tax from those with other pension income.

If this increased income were to reduce malnutrition by 90% it would save a further £17.85billion. A reduction of 15% in demand upon the health service, which would still be higher than Holland, a further £21billion.

These figures are for illustrative purposes, and do not take into account a number of other variables such as population increase which would be constants but would produce a credit of £2.45billion

The statutory agencies need to work with housing associations to develop “extra care sheltered housing”. It is possible to put just as much nursing and social care into such developments as it is the more traditional residential care. The owner or tenant has their own front door, defended space and retains control over the essentials of daily living. This alleviates many of the harmful effects of traditional residential care and reduces the risk of abuse which is greater when the victim is subservient.

The average cost of a care home is £30,000 People would hand over their income up to the cost of the home, less their personal allowance of £24.90p per week, as now. With an increased pension of £17,802 the minimum residents could contribute would be £16,507 leaving a maximum of £13,493 for the local authority to find. (Currently people are deemed to have £1 per week income for every £250 of capital they have, including their house, between the disregard and full cost thresholds and this would no longer apply). There are currently 416,000 older people in Care Homes and it is anticipated this number would reduce, possibly by 20% as a result of this whole systems review. The cost of providing free social care (nursing care is already paid for) would be 332,800 X £13,493 or £4.5billion – less the contributions from those with occupational pensions.

The total cost of raising the state pension to lift older people out of poverty and no longer take savings into account in the financial assessment for long term care would be £2billion which would be more than recovered by the changes proposed above and below.

**Align resources behind outcome**

There is just as much empirical evidence in respect of organisation, management and leadership as there is medicine, social policy and social work and yet this is rarely applied in practice. For many years, until the late 1980s, Brunel University received Department of Health funding to apply organisational analysis to health and social care. The Tom Peters Group has studied cultural change, customer care and leadership. And applying his unique whole systems methodology to a hospital in Holland, Christian Schumacher (the son of the author of Small Is Beautiful) was able to achieve a 30% increase in output with higher morale and lower sickness levels.

Social Service and Health Service Managers are extremely lucky in that the majority of their staff are working in their chosen vocation, it is what they want to do. It should therefore be possible to arrive at a situation whereby they can say, as many sports people do, aren’t I lucky I am doing what I want to do and being paid for it. Why then is morale reported to be so low? It often appears that staff are doing excellent work despite the system, instead of the system helping and supporting them in their work.

People in Health and Social Care are working in some very stressful situations but which can be very rewarding if they see the outcome of their work and the improvement they have brought about in people’s lives. Many hospitals are still organised on the discredited production line model with, for example, some nurses just taking blood, not knowing why, the results or outcome for the patient.

The use of Agency Staff also distracts from the continuity of care. Agency Staff are very expensive, with money going on travel, board and agency fees, and it should not be beyond the wit of managers and trades unions to manage without them until there is no work and they have to apply for permanent positions and the savings shared in higher salaries.

Much of what underpins current management thinking is that people are motivated by, and can be controlled by, money when there is little evidence to substantiate this. People are motivated by job satisfaction and recognition of a job well done. Health and Social Services need to move away from the traditional management model of getting people to do what needs to be done by reward and sanction (the carrot and the stick) to a Leadership Model whereby people want to do that which needs to be done and the role of the manager is to train and enable.

Staff, including their managers, need the capacity (intellect X knowledge X experience) to match the complexity of work. They need the “generic skills” of their profession, specialist knowledge of their area of work, and to be employed on the work which interests and motivates them. It is little point employing someone who wishes to work with young offenders on the care of older people. They also need the confidence to take decisions up to the extent of their discretion in the knowledge that they will be supported should things go wrong without losing sight of their accountability to elected representatives on central or local government or a board of trustees or directors, or that they work with some of the most vulnerable and least powerful members of society.

Social Workers need to be freed from “care management” and the “gate keeping” role of assessing the eligibility for specific services thereby enabling them to practice their skills in using relationship to bring about change in motivation, behaviour, inter-personal relationships and community support by various therapeutic techniques and counselling – thus reverting to a “mending” rather than the current “minding” model.

There is a need to:

i)                   take out functional divisions along patient pathways;

ii)                  create “whole task, right sized, multidisciplinary, inter-agency teams” aligned behind outcome with access to all the expertise and resources required to complete the task;

iii)                ensure these teams can “plan, do and evaluate” their own work, which completes the learning cycle of constant improvement.

These teams can be quite local as are many “community support teams for people with learning difficulties” and co-ordinated by an employee of the lead agency with a “key worker” appointed to co-ordinate work at an individual level.

This approach was implemented successfully by South Glamorgan County Council across all areas of work in the 1980s and 90s with individual plans, local planning groups and joint management boards. It was done at a time of severe financial constraints with an outcome of within 0.1% of cash limit year on year. It did not have the benefit of common funding streams and lines of accountability.

The number of tiers of management should be kept to a minimum to avoid the party game “messages” and appropriate levels of delegation can reduce the amount of time spent in meetings.

This article is intended to stimulate discussion in order to avoid the imposition of yet further top down re-organisation.

**FOOTNOTE**

Prior to 1980 private residential and nursing homes were only available to those who could afford to pay. Means Tested residential care was provided by Local Authorities under Part III of the 1948 National Assistance Act and State Nursing Homes provided by the NHS. In 1980 Margaret Thatcher extended choice by enabling people to have their fees in private and voluntary homes paid for by the then Benefits Agency subject only to the availability of a place and a means test. The cost escalated to billions which Sir Roy Griffiths termed the “perverse incentive” as the money was not available for home care and it was thought there were people in residential care who neither wanted nor needed to be. The money was transferred to Local Authority Social Service Departments, by the 1990 National Health Service and Community Care Act, which had to carry out an “assessment of need” and “verification of wishes”. For some reason Sir Roy included Nursing Homes in this, which had always been a health responsibility, so that for the first time they became means tested. And what had been an “open-ended entitlement” became a “cash limited allocation” with Social Service Departments charged with “managing the market”. The majority fixed their “contract price” below the cost of their in-house provision (so much for the level playing field) which meant that private and voluntary homes have struggled financially and have had to subsidise local authority placements from the fees of private residents.