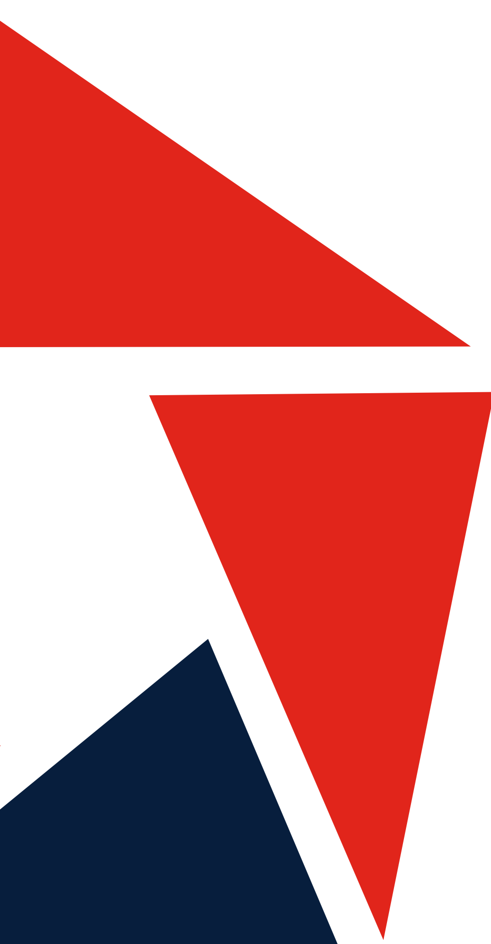
University of Strathclyde Business School

Annex A

Summary of Scottish Government research and analysis of the NCS

August 2022



A series of contextual evidence papers have been produced, setting out key sources of information about social care and related areas in Scotland, linking to the National Care Service Consultation proposals published in August 2021. All documents are available here.

Social Care Support Service Provision Scotland

This document gives an overview of the national data on the main social care services in Scotland. The key findings show that in 2020/21 approximately 1 in 25 people in Scotland received social care support and services and 84.4% of these people were provided with Self-directed Support (SDS), an increase from 77.1% in 2017/18. Consistently, the most frequent choice of SDS has been to allow the health and social care partnership to arrange their services. In 2020/21, 88% of all people choosing an SDS option chose this. Care at home hours have increased year-on-year from 2010- 2021 and the average hours of care at home per person per week has increased from around 9.5 hours in 2010 to 12.2 hours in 2021. The number of people in receipt of community alarm and/or telecare packages increased year-on-year from 2015/16-2018/19 but has declined in recent years. In 2020/21, around 130,130 people were in receipt of a community alarm and/or telecare package. As of 31 March 2021, there were 1,069 care homes for adults and 40,632 registered places. This is a 20% and 5% reduction, respectively, since 2011. In 2020/21, there were 28,120 long-stay residents aged 65+ in care homes in Scotland, with 10,420 self-funding care home residents aged 65+ receiving Free Personal Care payments. Proportionally, more people are having their support needs met at home rather than in a care home. However, care homes have been seeing an increase in short stay admissions over time, reflecting a change in the types of services some care homes are providing. Several factors which influence social care service type/ provision are identified including demographics, policies, commissioning and procurement, workforce, and financial resources.

Experiences of Social Care in Scotland

This document provides an overview of experiences of social care and unpaid caring in Scotland. Survey returns data from the 2021/22 Health and Care Experience Survey (HACE) is analysed, focusing specifically on the experiences of people receiving care and support and those providing unpaid care. The key findings show that in 2021-22 62% of respondents reported that their care and support services were either ‘good’ or ‘excellent’, a decrease from 69% in 2019-20. The proportion of people considering their care and support services ‘poor’ or ‘very poor’ increased from 12% to 17%. Respondents reporting funding for help and support with everyday living decreased between 2019-20 and 2021-22, across all sources of funding, with the NHS experiencing the biggest drop (-4.8 percentage points). At the same time there has been an increase of almost 10 percentage points in the proportion of people for whom unpaid care forms at least part of their support. People reporting a choice in arranging their care fell from 42% to 36% between 2019-20 and 2021-22, while those saying they did not have a choice increased from 17% to 24%. Respondents not receiving support but felt they needed it were proportionally more likely to be non-white,

disabled, living in deprived areas, LGBO (lesbian, gay, bisexual, other) and unpaid carers. 60% of unpaid carer respondents reported receiving no support or help with their caring roles. 5.5% of respondents reported that they were providing 35 or more hours of care a week in 2021-22, an increase from 5% in 2019-20. Unpaid carers were proportionally most likely to be supporting parents/grandparents (48%) or spouses/partners (24%). Young people (aged 17-24) reported the highest rates of feeling supported to continue caring. However, 51% of these young respondents reported that caring has had a negative impact on their health and wellbeing.

People who Access Social Care and Unpaid Carers Scotland

This document provides an overview of people who access social care and unpaid carers in Scotland. The key findings highlight that approximately 1 in 25 people in Scotland (231,925 people) received social care support and services at some point during 2020/2, of which 77% were aged 65 and over and 61% were female. An estimated 93,280 people received home care and an estimated 130,130 people had an active community alarm and/or telecare service in 2020/21. There were an estimated 33,353 residents in care homes as of 31st March 2021, 11% lower than in 2011. Over 90% of residents in 2021 were in older people care homes. The number of carers living in Scotland was estimated to be around 700,000 to 800,000 before the pandemic. In 2020, it was estimated that there were around 839,000 adult carers living in Scotland. Unpaid care is more likely to be provided by older, working age females and people in the most deprived areas are more likely to provide 50 or more hours of unpaid care a week compared to people living in the least deprived areas. During the Covid-19 pandemic some people had their care at home service packages reduced or stopped as partnerships focused on providing support to those with critical needs. Many people also chose to reduce the support they received. Care homes were impacted significantly by the pandemic and more than a quarter of deaths where Covid-19 was mentioned on the certificate between the start of the pandemic and February 2022 were in care homes.

Scotland’s Health Demographic Profile

This document provides an overview of Scotland’s health and demographic profile, drawing on evidence about life expectancy, healthy life expectancy, the burden of disease and multimorbidity and population projections. The key findings show that Scotland has the lowest life expectancy and widest socioeconomic inequalities in health in Western Europe. Life expectancy at birth in Scotland was 76.8 years (males) and 81.0 years (females) in 2018-20. The gap between the most and least deprived SIMD deciles was 13.5 years for males and 10.2 years for females. For a child born in Scotland in 2018-20 the estimated healthy life expectancy was 60.9 (± 0.5) years (males) and 61.8 (± 0.5) years (females). Socio-economic inequalities in healthy life expectancy are wider than socio-economic inequalities in life expectancy. The estimated gap in healthy life expectancy between males and females across the most and least deprived deciles was 24.4 and 24.2 years, respectively in 2018-20. National Records of Scotland project that Scotland’s population will age across the coming decades, with a substantial increase in the proportion of the population over the age

of 65. The increasing number of single adult households is also set to continue. The proportion of individuals who have two or more medical conditions simultaneously (‘multimorbidity’) has risen and a recent study found that 93% of people aged over 65 who received social care had multimorbidity.

Adult Social Care Scotland Equality Evidence Review

This document gives an overview of evidence related to equality in adult social care in Scotland, focusing on groups with protected characteristics under the Equality Act 2010, and those who experience socio-economic disadvantage. The key findings highlight that it is diverse groups with a broad range of needs and experiences who access social care, unpaid carers, and social care workers. In 2020/21 77% of people receiving social care support and services in Scotland were aged 65 and older, and 61% were female. However, there has been an overall increase in the number of people receiving adult social care in Scotland across all age groups in recent years. Women are more likely than men to report that they provide regular unpaid care and caring prevalence varies by age, at 12% of those aged 16-44, 28% of those aged 45-64 and 14%-18% among those aged 65 and over. The social care workforce is older than the general workforce and in 2020, 80% of adult social care staff were female. There is little data and evidence on the scope and experiences of some protected characteristic groups most notably, gender reassignment and religion or belief. Certain groups have been particularly disadvantaged by the Coronavirus pandemic, including older people; disabled people and people who had been advised to shield. Substantially higher proportions of people in the most deprived areas in Scotland receive home care support; 26% in the most deprived areas compared to 13.9% in the least deprived.

Adult Social Care Workforce Scotland

This document outlines the available evidence on the adult social care workforce in Scotland. The keys findings highlight that in 2020, 134,640 people were employed in adult social care in Scotland, 5.7% higher than in 2011. This increase was driven mainly by increases in the housing support/care at home sub- sector. In 2020 80% of adult social care staff in Scotland were female, and 44% of workers were aged 45 and over. On average adult social care staff worked for 31 hours per week and 86% were employed on permanent contracts. Brexit and Covid-19 have impacted the adult social care workforce. In 2020 the social care sector had a very high vacancy rate (43%), compared to 11% across all sectors. In particular, care at home, housing support, and care homes for older people reported that vacancies were hard to fill. There is also a qualifications gap in the sector, as only 52% of staff reported holding qualifications suited to their role in 2020. The private sector employed 44% of the adult social care workforce in 2020 and was the largest employer. The largest sub-sectors in adult social care were housing support/care at home (employing 56% of the workforce) and care homes for adults (employing 39% of the workforce). Scotland is projected to have more older people and fewer younger people in mid-2045 than in mid-2020, which will impact the supply of, and demand for, adult social care in the future.

Rapid review of learning and evidence on national systems of social care in Nordic and Scandinavian countries

This document outlines the findings of a rapid scoping review of national systems of integrated health and social care from the Nordic and Scandinavian countries, to identify the key learning, barriers, and facilitators. Due to the rapid nature of the review, the research studies included are not critically appraised. The key findings show that there was not any specific national "model" of integrated social care and social care tended to be delivered in a country-specific context in which services varied by how they were governed and funded and the welfare regime and political views at a given time. The importance of relationships between users of care services, professionals and unpaid carers was highlighted to ensure users' needs are met, their preferences are considered, and different parts of the system are aligned.

The evidence reviewed suggests the importance of incorporating the following principles into governance systems: a clear vision for integrated care and underpinning legislation that is supportive and consistent; only enshrine critical elements in law to leave room for local flexibility; the balance of centralisation and decentralisation is less important than being clear about roles and responsibilities and level of funding; and that monitoring systems should include user and process outcomes.

Evidence on the effect on cost, health and service use outcomes is mixed and approaches to achieve integrated funding vary across countries. The key facilitators of financial integration identified include a shared vision among stakeholders, unified structures, coordinated funding and consideration of local circumstances. Difficulties in implementing financial integration were common, with a specific challenge around different payment structures or separate budgets and the transfer of funds between different parts of the system. Marketisation in the provision of health and social care is increasingly common and approaches varied across countries.

Collaboration with users is shown to be key for service delivery. However, there are issues around practicalities, time, service provision and administrative processes in developing individual care plans. The importance of safeguarding systems across all levels of staff and service providers is also emphasised alongside the need for cooperation and trust between different parts of the system and service providers. In providing efficient social care services there also needs to be a commitment to provide continuous professional development, training, and good work conditions with a degree of autonomy across the social care workforce.

The document does not provide a quality-assessed synthesis of evidence. Rather than providing a comprehensive analysis of what works, it provides learning on national social care systems from Nordic and Scandinavian countries. The report also does not include any detailed analysis of the current health and social care system structures in the included countries. Overall, no single national "model" of social care was identified, and no consensus was found on optimal governance or funding arrangements. However, general key principles that can act as enablers or barriers to the creation of a national social care service are highlighted.

Justice Social Work Scotland

This document gives an overview of social work services provided in the justice system in Scotland. JSW services include assessments and reports to assist decisions on sentencing, court services to assist those attending court, bail information and supervision services as an alternative to custodial remand, supervising people on social work orders to tackle offending behaviour and its causes, supervising people who are required to perform unpaid work for the benefit of the community, prison-based justice social work services to those serving custodial sentences that involve statutory supervision upon release, preparing reports for the Parole Board to assist decisions about release from prison and throughcare services including parole, supervised release and other prison aftercare orders to ensure public safety.

The key findings show that in 2020 there were 937 main grade or senior justice social workers, an increase from 898 in 2011. In 2019-20, 1,990 cases were commenced for diversion from prosecution, covering 1,930 individuals. 28,500 criminal justice social work reports were submitted in 2019-20, 8% less than in 2014-15. Total community payback orders imposed fell between 2015-16 and 2018-19, then rose by 2% in 2019-20 to 16,800. The number of drug treatment and testing orders fell by 14% between 2018-19 and 2019-20, to 520, around the same as in 2015-16. 1,900 statutory throughcare cases commenced in 2019-20 and 2,000 voluntary throughcare cases commenced during 2019-20. 1,800 individuals received assistance during this year.

Children's Social Services Scotland

This document provides an overview of social services provided to children and families in Scotland. Children receiving social services can be aged from 0-18 but a social work or social worker-led service may continue up to the age of 26 for some young people. The need for social work involvement may vary, but usually the parents, children and/or whole family will be experiencing a combination of practical, emotional, and relationship difficulties. While children and parents in all income groups and with a wide range of disabilities, and emotional and relationship difficulties may be assessed as in need of a social work service, families from areas of higher deprivation are more likely to receive statutory social work services. In 2021, 570 Child Protection Orders were granted in emergency/high risk situations, with more orders granted for very young children. 4,397 initial and pre-birth Case Conferences were held, of which 76% resulted in registration to the Child Protection Register. As of 31 July 2021, 2,104 children were on the Child Protection Register (the lowest figure since 2002) and 13,255 children were looked after (the lowest figure since 2006). The most common types of placements for looked after children were at home with parents, kinship care, and with foster carers. In 2020, the overall headcount for children's social services was 15,830, an increase of 5% since 2015. Residential childcare (55%) and fieldwork services (37%) were the two largest subsectors in children's social services.

Integrated Care Studies: The SCFNuka (Alaska) and Canterbury (New Zealand) Models

This document outlines the key findings and learning from two case studies of integrated care models: the SCFNuka model from Alaska and the Canterbury model from New Zealand. The SCFNuka model is predominantly a primary care model with little or no social care interventions. However, the Canterbury model in New Zealand is an example of an integrated care model between health and social care. This review pulls together the peer-reviewed and grey literature to identify evidence relating to the SCFNuka and Canterbury models in which the findings can be used to design the Scottish NCS model.

Key aspects of integration in the SCFNuka system include structural integration across all services, care staff and specialist care in hospitals, horizontal integration with hierarchies removed and team members regarded as peers, a patient-focused approach, and all decision-making regarding how care is provided include community members in each step of the process. Change under the SCFNuka system was focused on two areas: engaging and listening to customer-owners and adapting healthcare staff and team's roles and ways of working to meet customer-owner needs. One of the key priorities in the redesign was to improve ways of data management and information sharing. SCFNuka pilots that have been identified in Scotland include Isle of Eigg and Forfar. The only evaluation of a Scottish pilot identified was the Fife "Tayriver" pilot. However, this 6-month pilot ended early after it was considered unsuccessful at a six-week internal evaluation. The findings suggested that different models of community-led health care cannot easily be transferred to a different setting with different cultures.

The Canterbury model began integrating health and social care in the mid-2000s, and rapidly gained momentum in 2010/2011 following the earthquakes in New Zealand. New Zealand (NZ) has around 20 District Health Boards (DHB), in which each DHB is responsible for planning, organising, purchasing, and providing health and care services. Canterbury's success has been attributed to developing three key approaches: a clear vision of a "one system, one budget" approach, investing in staff through training, skills development, and innovation, and developing new models of service contracting and integrated working. Effective areas within the Canterbury model include the Acute Demand Management Systems (ADMS), electronic shared care records, Community Rehabilitation Enablement and Support Team (CREST) and alliance contracting. Following the implementation of the Canterbury model, the demand for acute care has slowed but not reversed, harm from falls in the older adult population has reduced due to integrated falls prevention strategies, clients who have been through the Community Rehabilitation programme have reported that the service worked well with other health services in the home, demand for acute hospital beds has fallen and Canterbury has reported lower spending on emergency hospital care than the rest of New Zealand, but higher spending on community-based services.

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