



# Independent Review of Adult Social Care in Scotland



# Foreword

**I am grateful to the Cabinet Secretary for Health and Sport for the opportunity to chair this independent review of adult social care support in Scotland. I also want to thank the panel of advisers who guided this work so expertly, our excellent team in the Scottish Government, and most of all the many people, carers and staff who have contributed their experience and insight so generously in the most difficult of times.**

A good deal of public attention to social care support has been recently focused on care homes. We make a number of recommendations specific to the care home sector and, at the same time, it is important to recognise that most social care support is delivered in local communities and in people's homes. We want that pattern to continue, and wherever possible, to intensify. The Covid-19 pandemic has tended to focus attention still further on a small part of the system. Of course, there is learning to be had from people's experience during the last year. However, the vast majority of the challenges we are addressing in this review pre-dated Covid-19 and will outlive the pandemic unless we tackle them now. And we know that social care support touches upon the lives of a very wide range of people and settings, so we have taken as inclusive an approach as we can to understanding both the diversity and similarity of their experiences.

The core remit of the review was to "recommend improvements to adult social care in Scotland". The more work we did, the more it seemed like that was the right framing for the review. While we have not undertaken a review of social work, we have considered the key role of social workers, particularly in relation to assessment. I want to be absolutely clear from the outset that there is much about adult social care support in Scotland that is ground-breaking and worthy of celebration. The introduction of self-directed support, the integration of health and social care, and the promise of the Carers Act form the scaffolding upon which to build. When we add to those foundations the commitment and compassion we saw in the workforce, the immense contribution of unpaid carers and the will to improve that we saw across the sector, many of the ingredients for improvement are in place. And of course adult social care support does not stand alone: it has deep, historical and important links to social work, with children's services and the wider public sector.

And yet, the story of adult social care support in Scotland is one of unrealised potential. There is a gap, sometimes a chasm, between the intent of that ground-breaking legislation and the lived experience of people who need support. In the improvement world, there is a maxim which reads something like "every system is perfectly designed to get the results it gets". That is the basic challenge for us. We have inherited a system that gets unwarranted local variation, crisis intervention, a focus on inputs, a reliance on the market, and an undervalued workforce. If we want a different set of results, we need a different system.



I want to be absolutely clear from the outset that there is much about adult social care support in Scotland that is ground-breaking and worthy of celebration. The introduction of self-directed support, the integration of health and social care, and the promise of the Carers Act form the scaffolding upon which to build."

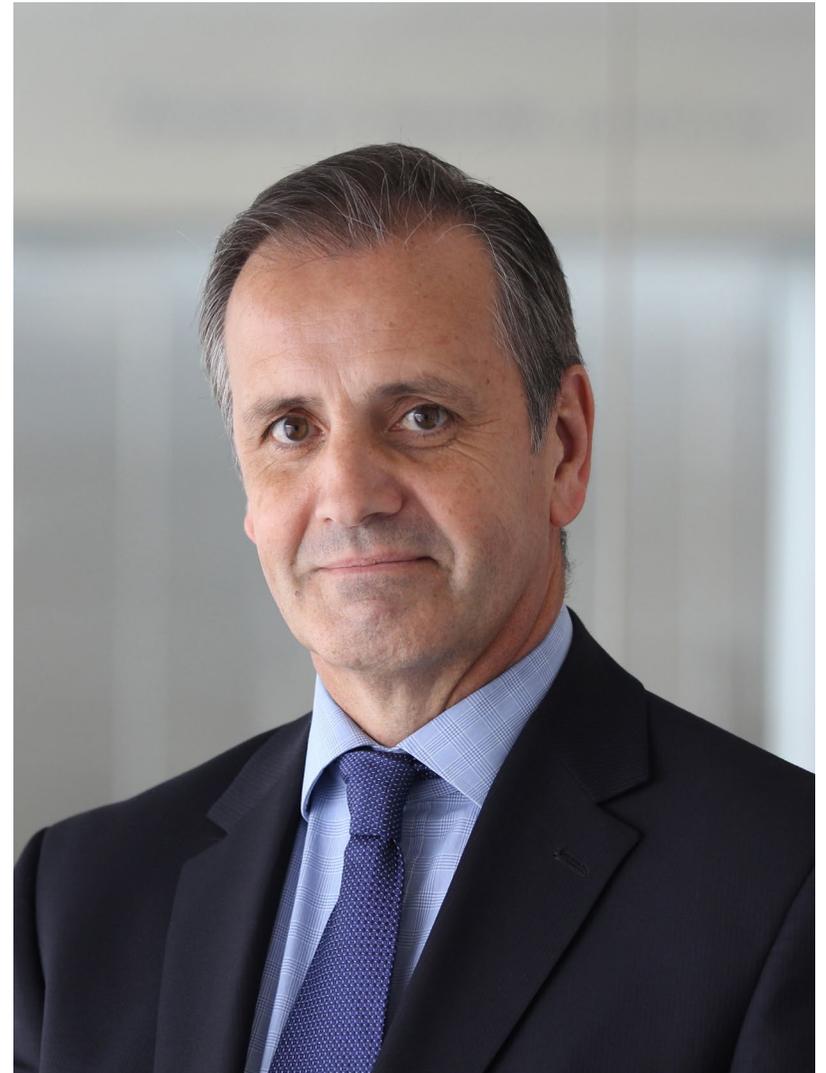
# Foreword

We also need to have an eye to the future. For example, the projected increase in the number of people living with dementia means that we need to start planning now for a future in which people can live well, in their homes wherever possible. The answer to tomorrow's challenges in social care support is not more of the same.

In the chapters that follow, we set out our vision for that new system. We describe how a National Care Service can drive consistent, high quality social care support in partnership with people who have a right to receive that support, unpaid carers and the workforce. We also look carefully at funding and make some recommendations about investing in social care support and ending all non-residential charging for services. To achieve that new system, we need the structural change and the new accountabilities that a National Care Service will bring and we need more. We need a new narrative for adult social care support that replaces crisis with prevention and wellbeing, burden with investment, competition with collaboration and variation with fairness and equity. We need a culture shift that values human rights, lived experience, co-production, mutuality and the common good.

In her Programme for Government speech that launched this review, the First Minister said "this is a time to be bold". The good news is that everyone we spoke to agrees with her. What follows is a plan for how. It will take time. It has taken over 50 years for our current system to form. It will take investment. It will take partnership. But we have an opportunity to create a system of social care support where everyone in Scotland has the opportunity to flourish. If not now, when?

**Derek Feeley**  
February 2021



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# Executive summary

At the centre of the remit for this review was a request to recommend improvements to adult social care support in Scotland, primarily in terms of the outcomes achieved by and with people who use services. Having listened carefully, over the last several months, to the voices and the stories of many people with lived experience of social care support, unpaid carers and staff working in the sector we believe that there are three things we must change in order to secure better outcomes. These can be summarised as follows:

1. Shift the paradigm
2. Strengthen the foundations
3. Redesign the system

## Shifting the paradigm

We need to start by challenging some of the prevailing narrative about social care support. It has its fair share of challenges, as this report will recognise and tackle, but it need not be unsustainable, or in crisis, or confined to the margins of society. Strong and effective social care support is foundational to the flourishing of everyone in Scotland. It is a good investment in our economy and in our citizens. In order to maximise the potential of social care support we have to change our perspective of what is social care support. We need to shift the paradigm of social care support to one underpinned by a human rights based approach. The table below summarises the changes required which are explored in greater detail throughout our report:

| Old Thinking                               | New Thinking                                |
|--|---|
| Social care support is a burden on society | Social care support is an investment        |
| Managing need                              | Enabling rights and capabilities            |
| Available in a crisis                      | Preventative and anticipatory               |
| Competition and markets                    | Collaboration                               |
| Transactions                               | Relationships                               |
| A place for services (e.g. a care home)    | A vehicle for supporting independent living |
| Variable                                   | Consistent and fair                         |

# Executive summary

## Strengthening the Foundations

As we will rehearse in various sections of this report, there are many strengths in the Scottish system of social care support. We need to build on those foundations. We need self-directed support and the Independent Living Fund, and we need integration of health and social care. The challenge here is implementation. How do we bridge the gap between promise and reality? That will require a step change in the capability of the system across the whole country, in the adoption of science based improvement methods, and in the ability of the National Care Service to learn from success and failure – to solve problems when they are identified and to scale-up and spread promising practice much more effectively.

A second foundation that needs nurturing and strengthening is the social care workforce. For us to achieve the improvements we seek, they need to feel engaged, valued and rewarded for the vitally important work that they do. We have not made recommendations about the social work workforce in proposed new arrangements as we believe these will require careful consideration alongside implementation of The Promise the review of children's services, and any changes planned for criminal justice social work.

Third, we need to support and enable unpaid carers to continue to be a cornerstone of social care support. The contribution they make is invaluable. Their commitment and compassion is humbling. We need to provide them with a stronger voice and with the networks, support and respite they need to continue in their vital role.

## Redesigning the System

We won't achieve the potential of social care support in Scotland without a new delivery system. We need a National Care Service to achieve the consistency that people deserve, to drive national improvements where they are required, to ensure strategic integration with the National Health Service, to set national standards, terms and conditions, and to bring national oversight and accountability to a vital part of Scotland's social fabric. The National Care Service will bring together everyone with a role to play in planning and providing social care support to achieve a common purpose.

We also need a transformation of the way in which we plan, commission and procure social care support. We need an approach that builds trusting relationships rather than competition. We need to build partnerships not market-places.

Finally, it is vital that we amplify the voice of lived experience at every level in our redesign. We have a duty to co-produce our new system with the people who it is designed to support, both individually and collectively.

# Chapter 1

## What we heard



## What we heard



... it should feel nurturing and supportive, rather than a battlefield.”



This review is about people’s experiences of social care support, whether you use social care services and supports, care for someone who uses them, or work in them. It has been our priority to hear from as many people as possible, to listen to your experiences and to learn from your ideas. To make that happen, we have carried out an engagement programme focused on three kinds of activity:

- ▶ **Open enquiry** – From September to November 2020, individuals and organisations could submit views, papers and evidence to the review.
- ▶ **Stakeholder engagement events** – From September to November 2020, stakeholder engagement events were held with the support of the Health and Social Care Alliance Scotland (The ALLIANCE<sup>1</sup>). Each event had a particular focus such as learning disabilities, physical disabilities, mental health and dementia, addictions and the experience of carers.
- ▶ **Meetings with key stakeholder groups and organisations** – From September 2020 to January 2021, the Chair of the review, members of the advisory panel and members of the review Secretariat attended meetings to hear from key stakeholder groups and organisations, and from people who work in social care support services.

The quotes you will find at the start of each chapter in this report are from individuals and organisations who participated in our programme of engagement, and who have lived experience of either using social care supports, or working in social care services.

Our programme of engagement, most of which took place online, resulted in:



1 [Home Page – Health and Social Care Alliance Scotland \(alliance-scotland.org.uk\)](https://alliance-scotland.org.uk)

## What we heard

In total, we met over a thousand people in just a few months, and we are grateful to you all for your time, insights and wisdom.

This review was commissioned by Scottish Ministers in response to the experience so far of Covid-19, and we of course heard about people's experience of care during the pandemic.

We heard some positive experiences of the sector's response to Covid-19, including how quickly providers adapted to new and very difficult circumstances and a heightened public awareness, in time, of the vital work of the sector. Some people who work in social care support mentioned to us that during the pandemic they have been able to make decisions more quickly, to good effect. Inevitably, we heard of many negative experiences too: people who had been affected by the impact of the pandemic on care home residents and staff, people whose community-based supports had been reduced or entirely stopped, pressures on carers and providers and the impact on people's physical and mental wellbeing.

However, this is not "just" a review of social care during Covid-19 and all that we have learned from it. It takes into account all the different types of support and care that are provided in a range of settings, including residential settings such as care homes and in people's own homes, and it covers care and support for a broad range of people with long-term conditions, older people, people with physical disabilities, people with learning disabilities, people with mental health problems, people with addictions, and people with experience of the criminal justice system. This review covers all of these life circumstances, and takes account of people's experiences over many years.

Because our remit is so broad, it was vitally important that we listened to people's experience of the full spectrum of adult social care services and supports. We have summarised the key themes we heard below. You can read a full report on the engagement events here: [Independent Review of Adult Social Care – Engagement report](#).

“Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room.”

# What we heard

## Key Themes

### Access, eligibility and assessment

People told us about the transformative impact that “good” social care services and supports can have – and in many cases have had – on their lives and the lives of people they love. We heard about the dedication and responsiveness of people in the workforce; about self-directed support enabling people to “live a real life”; about integrated health and social care support services that work together well, jointly focusing on the wellbeing of the person using care; and about carers being supported to carry on caring for loved ones.

But we also heard a lot of frustration about the existing structure and design of social care. People feel that the term itself – social care – is too often used negatively, to mean services that are for people only when in crisis, that just prevent or delay a deteriorating situation, or are a buffer to absorb pressure that would otherwise fall upon the NHS. People told us that social care support should instead be understood as an asset that provides constructive, optimistic support to help people achieve their goals and desired outcomes: to live their best lives and maximise their wellbeing, as equal citizens.

We heard that our current system too often does not feel like a system at all: it feels like a guddle, and that causes people worry and anxiety. For people with care and support needs and their families the challenges of accessing support, only to find they are unavailable or unaffordable, or those seeking support are ineligible, causes unnecessary suffering and hardship. This is not a humane response to people living with disability or ill health, or who are simply getting older and are no longer able to live their lives without some support. For family members it means having to take on heavy responsibilities for caring. Some try to juggle this alongside work, but many give up, putting themselves into a precarious financial position. For staff it can lead to burnout, with the constant stress of having to respond to crises, and the feeling that whatever you do it is not enough.

People described the process of accessing social care as ‘notoriously difficult’, ‘over-complicated’ and ‘bureaucratic’. When experiences had been negative, people told us that they had to ‘fight for’ and ‘justify’ their right for support. We heard that accessing social care is sometimes too difficult right from the start, with an inadequate referral process and not enough information available about supports, including peer support.



# What we heard

Eligibility criteria were described as one of the main barriers to accessing social care.

People also told us that the threshold for accessing support is too high, and too often meaningful support is only available when people are acutely unwell or in crisis<sup>2,3</sup>. We heard about the negative impact this has on the mental and physical wellbeing of people using social care support, their carers and the workforce.

We heard that the assessment process is too often based on a medical model focused on deficits – the things people cannot do – with little or no account taken of holistic and social needs; that it is too complex and takes too long; and once it is completed it takes too long before support is available. Some people with complex needs, including neurological conditions and sensory impairments, told us that their experience of assessment was that not all social workers had enough training in their functional difficulties.

In order to improve, people told us that social care needs to focus on holistic wellbeing and personal outcomes, rather than outputs and money. It should be flexible so that it can adapt to changing needs and wishes. It should take account of wider supports in a person's life, such as the support of carers and local services offered by community organisations to enable people to fulfil their potential, goals and outcomes, without reducing appropriate formal supports and shifting a burden of care onto families and informal networks. Assessment should be simplified and based upon collaborative engagement with the person's needs, rights and preferences at the centre.

## Structure and design of services

We heard that recent changes across health and social care have produced improvements, especially in some parts of the country, but there is much more to be done. People told us that Integration Joint Boards have had benefits in terms of health and social care support services working together better locally, but in many instances people need to be much more directly involved in planning their own care, and in decisions about local priorities.

We heard that national and local services need to work together better, that transitions between children's and adult's services must improve, and so should joint working with other services such as transport, housing, education and employment.

People told us how frustrating they found it to be asked to repeat the same information to several different professionals when better data sharing arrangements would remove the need.

We were told consistently that Scotland needs to shift its attitude towards technology and data sharing to improve people's experience of social care. Technological solutions should of course never be "forced" on people as a substitute for other kinds of care, but experience during the pandemic has highlighted that, for some people, technology can really help people to live independently in their own communities and to feel less lonely.

2 <https://www.centreforwelfarereform.org/uploads/attachment/655/an-emancipatory-welfare-state.pdf>

3 [https://discovery.dundee.ac.uk/ws/portalfiles/portal/34825382/insights\\_49.pdf](https://discovery.dundee.ac.uk/ws/portalfiles/portal/34825382/insights_49.pdf)

## What we heard

Technology is not a replacement for support provided by another person but it can play a much bigger role in improving the lives of people who use social care services and supports. It can also help with people's ownership of their care and support, particularly when people "own" their own data or information that is about them and share it with the people who support them.

### Planning, commissioning and procurement

Many people told us that Scotland has 'good strategies but poor implementation'. This 'implementation gap' was often referred to in terms of the differences between what is set out in legislation and guidance and what actually happens on the ground. We were also told about places and local teams that are good at follow-through from intention to service delivery, but with a sense that where that was people's experience it was partly because they were 'lucky'. More generally, people described current planning, commissioning and procurement processes as 'discredited', with poor outcomes for people who use services and for the workforce. Some people felt that Integration Joint Boards had made some improvements on this but a significant number of people we spoke to had serious concerns. Currently, Integration Joint Boards do not have responsibility for procurement or contracts.

We heard that the market approach to commissioning and procurement produces 'competition, not collaboration', which, in turn, leads to too much focus on costs rather than high quality, person-centred care and support. We were repeatedly told that this focus on costs causes poor terms and conditions, including pay, for the workforce.

People spoke to us about 'short-termism' resulting in providers spending significant time and resources applying and reapplying for contracts. This results in uncertainty for providers and the workforce, which makes it difficult to attract and retain staff. Providers cannot afford to have staff 'waiting in the wings for contracts to come along'. We also heard that commissioning using generic frameworks based on hourly rates does not work well for people with fluctuating needs for support, particularly where those relate to mental health.

Just as with individual care planning, people told us that local communities and third sector organisations should be more involved in collaborative approaches to planning, commissioning and procuring social care support services. Where people felt that they had had a good experience of using self-directed support they often also described good collaboration between organisations, communities and individuals in the design and delivery of care and support.

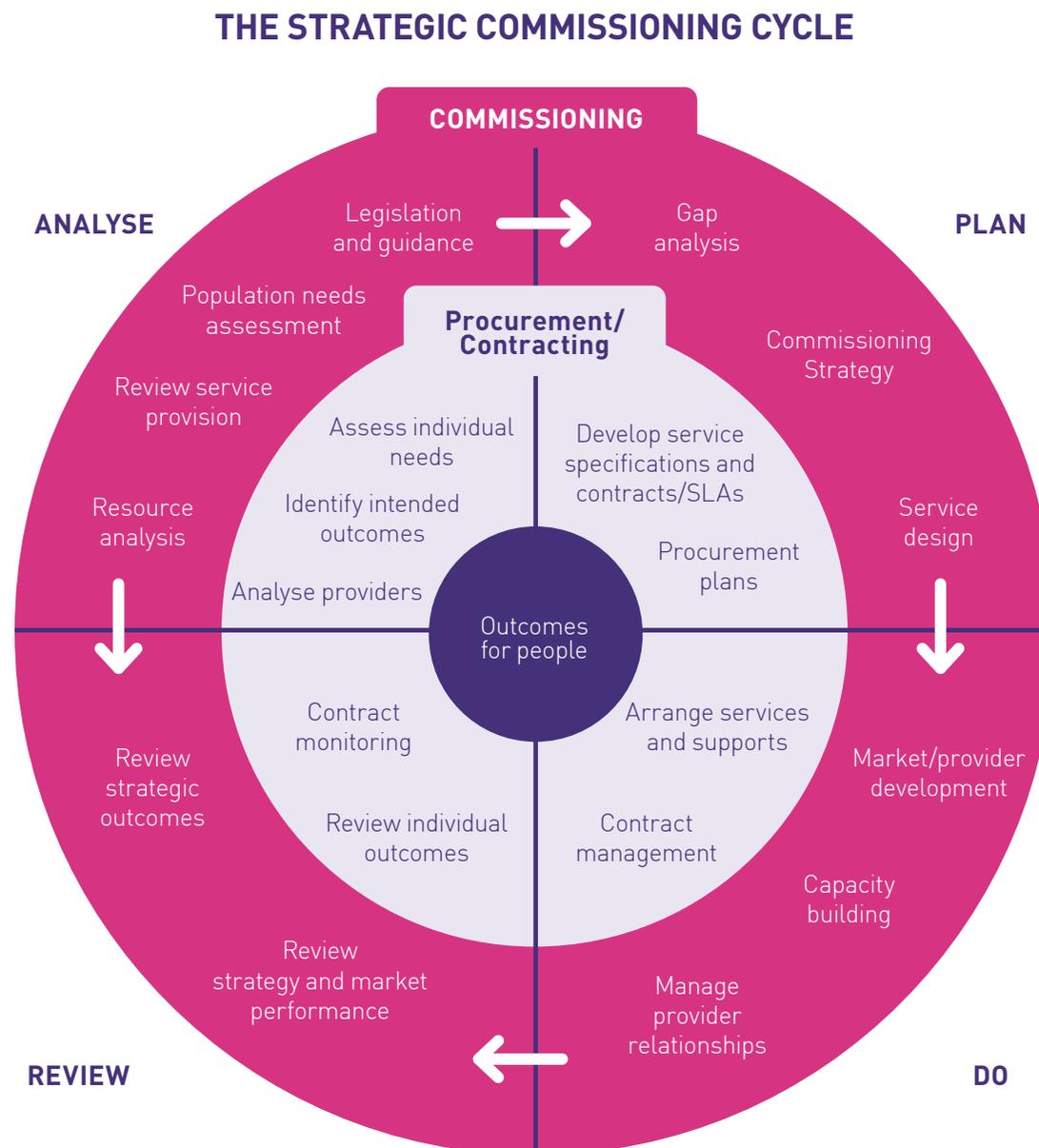
And we heard repeatedly that simpler and more accessible arrangements to challenge decisions – without recourse to the Courts – need to be established.

We refer to commissioning and procurement practices throughout this report, and Chapter 9 is dedicated to the subject. These are fairly technical terms and it may be helpful to explain what we are referring to at the start. Commissioning is the process by which public bodies strategically plan ahead for the services they will provide, either directly or by procurement, to meet their populations' needs, using the budgets at their disposal. Procurement is the process of contracting for (purchasing) specific services on the basis of that commissioning activity. It is important to note that not all commissioning activity results in procurement and that commissioning decisions and priorities should form the basis of any procurement process – never the other way around.

## What we heard

Most models of commissioning emphasise its cyclical nature, with strategic commissioning providing the context for procurement and contracting. The cycle is sequential and each part is of equal importance. A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an on-going dialogue with people who use services, unpaid carers and providers. Outcomes for people are at the centre of the model, which is commonly illustrated in the diagram shown here (originally developed by the Institute of Public Care at Oxford Brookes University).

This diagram of course does not take account of our proposals for ethical and collaborative commissioning. It could usefully be updated to reflect those as work progresses.



# What we heard

## Workforce

Despite challenging circumstances, we heard repeatedly that the social care workforce are 'motivated', 'resilient', 'adaptable' and 'proud of their work'. However, a range of serious concerns were raised.

People told us they are worried about 'casualisation' of the largely female social care support workforce, which is both undervalued and underpaid as a result, despite their essential work to improve people's lives and wellbeing, and support their independence, every day.

We frequently heard that people 'could earn more working in a supermarket', and people also spoke to us about a lack of support and training opportunities with sometimes serious consequences for people who use services. This need to improve the skillset of the workforce was reported to us in various ways. People with complex needs or sensory impairments told us they could not get appropriate support. We heard about assessments being inadequate because assessors do not have sufficient training to understand people's circumstances. People told us that sometimes the full range of options available under self-directed support are not adequately explained. And employers told us that the lack of training and career development opportunities makes it difficult to attract and retain staff, which makes it difficult to establish rapport and trust between people who use social care support and their carers. At the same time, it was brought home to us many times that social care support is highly skilled and that many people in the workforce are very experienced. The fact that people who work in social care are undervalued and underpaid in no way correlates either with their skillset or importance to society.

Some people had specific ideas for how to improve the experience of the workforce, such as a national campaign to promote the value of social care support and help make it a more attractive career choice; a minimum wage for social care workers, with some suggesting £15 per hour; implementation of the Fair Work principles to improve workers' working conditions; peer support and supervision; and a more consistent approach to providing high quality training for staff.

## Unpaid Carers

Unpaid carers were very clear with us that they want to care, and care well. But like the workforce, they told us that they are simultaneously undervalued by society and given 'all the responsibility without the support, resources or recognition'. We heard that carers are often unaware of their rights and the support available to them. Accessing support, whether for respite services or advice, was often described as 'complex', 'time consuming' and 'frustrating'.

Carers told us that respite is not always recognised as essential support. Without respite, some carers are 'on the job' 24 hours a day, which is unsustainable, unfair and limits their own life opportunities. Sometimes, we were told, inappropriate respite is offered, such as taking cared-for people into unsuitable care homes.

We also heard many carers reflect on the gender issue that also applies to the paid workforce. Many unpaid carers are women, and they told us they are often overlooked and disregarded.

# What we heard

## Registration, regulation and inspection

We heard mixed views on current arrangements for regulation and inspection of social care support services. Some good examples were described to us of meaningful dialogue and engagement with the Care Inspectorate, illustrated with observations like inspections being based on dialogue and improvement. On the other hand, we heard that too much attention is paid to procedural and process issues and not enough to individuals' experience of care and how social care connects people with their communities.

People told us that there is a clear accountability gap between national and local levels, and that there is not meaningful joint inspection of health and social care support services. We also heard that there is significant duplication in the information requested from services by the Care Inspectorate and local commissioners, which wastes time that could be better used to improve quality. Many people emphasised the need for much more support for locally driven improvement work to raise standards of care. Where members of the workforce had taken part in local improvement work, they expressed pride and satisfaction in the progress made, and they wanted to do more of it.

On registration, regulation and support for the workforce, we heard that the Scottish Social Services Council is not equipped or resourced to support effective training and development of staff. We listened to general observations that the workforce too often feel policed rather than supported as a consequence of current registration arrangements. We also heard particular concerns about the absence of support for, and regulation of, personal assistants, and failure to extend training opportunities for the paid workforce to unpaid carers.

## Equality

Equality – and inequality – were raised with us again and again.

Some people who use social care services and supports told us that they are expected to pay to access their human rights: to carry out normal day-to-day activities such as washing and getting dressed, and going to work.

We heard about gender unfairness, as before; that the needs, rights and preferences of people from minority ethnic communities are often overlooked; that communication support for people with sensory impairments and learning disabilities is often inadequate; and that the stigma sometimes attached to accessing supports for mental health problems, addictions and criminal justice issues should be addressed.

We also heard that advocacy arrangements need to be improved, so that people with incapacity and others who are accessing supports and services have their needs, rights and preferences properly represented.

# What we heard

## National Care Service

Many people asked what would be meant by a National Care Service, which the First Minister mentioned when she announced this review in the Programme for Government<sup>4</sup>. In response we asked the people we were talking to what they thought such an idea should and should not mean.

There was a wide variety of views about what a National Care Service should represent. Points mentioned frequently included: social care services should not be run for profit as a matter of principle – different rules should not apply to social care support compared with the NHS; charges, if any, should be fairer and the same in different Local Authority areas; assessments and care packages should be portable between Local Authority areas; and the workforce should be better supported with effective planning, training and support arrangements consistently managed at national level. We asked what would worry people about a National Care Service, and the most frequently mentioned concern was that it would bring loss of local knowledge and expertise. Many people said they thought a better mix of national and local responsibilities and activities was needed.

Having listened carefully to the experiences, views and ideas so generously shared with us, we have set out our proposals for reforming adult social care in Scotland in the remainder of this report.

4 [Programme for Government – gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/programme-for-government-2018-2021/pages/100-109.aspx)

## What we heard



Those who need support to live fully and to navigate the real-world barriers they face should be able to ask for that support without guilt or the endless need to justify themselves.”

### ▶ Susan McKinstery

I think the public don't realise, that when you depend on care services for your most fundamental rights and needs, that can put you in a very precarious position. The fact that services can be taken away by someone who often doesn't know you or understand the complexity of your situation is such a violation.

You are made to feel guilty for asking for help and you have it driven home to you that resources are limited and there are people with greater needs than yours. The result of this is that you are given the sense that by accepting support, you are taking resources away from someone more deserving. Nobody should be made to feel like that. We need a system based on rights and aspirations of individuals and one which is adequately funded and structured in a way which allows these to be upheld. Those who need support to live fully and to navigate the real-world barriers they face should be able to ask for that support without guilt or the endless need to justify themselves. Care itself shouldn't be yet another barrier.

Ultimately, I believe we need more people with lived experience of social care in positions of power and influence. Those of us who have experience of the system from this perspective know the importance of not only involving people in decisions which affect their lives but, importantly, believing them as experts in their own needs. As the saying goes, nothing about us without us.



# Chapter 2

## The purpose of social care

## The purpose of social care

“Social Care should be a springboard not a safety net.”

Looking back at the history of failed adult social care reforms, the debate has all too often started and ended with funding. We have tried not to make the same mistakes. We will talk about funding in this report but only once we have described our statement of purpose for social care support in Scotland, our design of a system to deliver on that vision, and the values and relationships that will be required to make improvement happen.

There have been multiple helpful attempts to articulate a shared vision or ambition for social care.<sup>5 6 7 8</sup>

We suggest the following as a definition:

**Everyone in Scotland will get the social care support they need to live their lives as they choose and to be active citizens. We will all work together to promote and ensure human rights, wellbeing, independent living and equity.**

We have been absolutely determined to describe the purpose from the point of view of people who receive or may benefit from social care support. That is why we have drawn heavily from previous articulations of vision and ambition. And, of course, the incredible input that we received as we conducted our engagement meetings has also been vital here. We have also used the term social care support throughout the report to reinforce that the person directs the system to support them – not the other way around.

Why start with purpose? To improve social care support, we must change systems and processes, but first we must change hearts and minds. A common purpose unites and helps to ensure that the right things are done well. It is the basis of continuous improvement in any system. It is difficult to conceive of a successful national scale improvement effort that did not have a unifying purpose.

5 [Social care – gov.scot \(www.gov.scot\)](http://www.gov.scot)

6 [Social care: Reforming adult social care support – gov.scot \(www.gov.scot\)](http://www.gov.scot)

7 [Health and Social Care Standards: my support, my life – gov.scot \(www.gov.scot\)](http://www.gov.scot)

8 [Health and Social Care Standards: my support, my life – gov.scot \(www.gov.scot\)](http://www.gov.scot)

# The purpose of social care

In addition, the purpose needs to drive a set of changes that will lead to people being able to live their lives to their full potential. We might see those changes as follows:

- ▶ **A new narrative for social care support;**
- ▶ **A redesign of the system of social care support (including the creation of a National Care Service);**
- ▶ **Redefining quality and closing the gap between intent and lived experience (the implementation gap);**
- ▶ **Protecting, promoting and ensuring human rights and equality;**
- ▶ **Greater empowerment of people who need support and unpaid carers at the level of the individual and the collective; and**
- ▶ **Valuing of the social care support workforce.**

Giving effect to any stated purpose of social care support requires us to create the right conditions for change. When we examine successful improvement efforts at large scale, the purpose is 'hard-wired' into the design of the delivery system. The purpose needs to provide a direction for the securing of long-term results. It needs to guide our shared understanding of rights and needs. It needs to inform the planning and stewardship of resources in the system, and it needs to influence culture, behaviours and values.

## A new narrative for social care support

Frederick Seebohm, in his landmark 1968 report<sup>9</sup>, said that social care should enable 'the greatest possible number of individuals to act reciprocally, giving and receiving service for the well-being of the whole community'. Social care support is the means to an end, not an end in itself. The end is human rights, wellbeing, independent living and equity, as well as people in communities and society who care for each other. However, more recently the default narrative about social care support is too often one of crisis, unsustainability, providing for the vulnerable, staff shortages and underfunding and occasionally even harm. It's time to change that.

In our engagement sessions, there was a debate about independent living as an outcome. Independent living means people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means having rights to practical assistance and support to participate in society and live a full life. This is the definition of independent living adopted over many years in the strategic approach to independent living, by the Scottish Government, COSLA, the NHS and the Disabled People's Independent Living Movement.

9 Report of the Committee on Local Authority and Allied Personal Social Services The Seebohm Report HMSO(1968)

## The purpose of social care

Giving effect to the narrative requires some shifts in mindset. First, we need to shift from seeing the funding of social care support as a burden to be borne to seeing it as an investment in society and the economy. Second, we need a shift away from crisis being the entry point to the system of social care support to a system that values prevention and early intervention. Third, we need to see people who need some support for their assets, their experience, and their potential rather than as passive recipients of a service.

We will set out elsewhere in this report the strong economic case for investing in social care support. It is a good investment of public funds. It is also the right thing to do. In setting out Scotland's purpose in the National Performance Framework<sup>10</sup>, the Scottish Government sets out five tests, to:

- ▶ **Create a more successful country;**
- ▶ **Give opportunities to all people living in Scotland;**
- ▶ **Increase the wellbeing of people living in Scotland;**
- ▶ **Create sustainable and inclusive growth; and**
- ▶ **Reduce inequalities and give equal importance to economic, environmental and social progress.**

Investing in social care support helps us to achieve every one of these.

### Redesigning the system

There is a maxim in improvement science that 'every system is perfectly designed to get the results it gets'. The real point being made is that if you want different results, you need a different system. There are some good things upon which to build the new system. For example, if we did not have self-directed support, we would need to introduce it. If we did not have integration of health and social care, we would need to create it. However, to fully meet the needs, rights and preferences of people, we need some re-design too.

Further details about the proposed new system are in Chapter 6. In summary, the key design principles that have guided our thinking are not dissimilar to those first set out in the work of the Christie Commission back in 2011<sup>11</sup>. The Commission set out four pillars of public service reform that should be kept in mind when developing plans for public services:

- ▶ **A decisive shift towards prevention;**
- ▶ **Greater integration of public services at a local level driven by better partnerships, collaboration and effective local delivery;**
- ▶ **Greater investment in the people who deliver services through enhanced workforce development and effective leadership; and**
- ▶ **A sharp focus on improving performance through greater transparency, innovation and use of digital technology.**

<sup>10</sup> [National Performance Framework | National Performance Framework](#)

<sup>11</sup> [Christie Commission on the future delivery of public services – gov.scot \(www.gov.scot\)](#)

## The purpose of social care

To the Christie principles, we would add:

- ▶ **A stronger voice for the person requiring support and their advocates;**
- ▶ **A means to learn and improve across the country;**
- ▶ **A sharp focus on equity, equalities and human rights;**
- ▶ **Fairness and consistency in relation to access, eligibility and outcomes; and**
- ▶ **Transparency and accountability.**

In order to ensure that prevention, investment in people, learning, fairness and accountability are driven by national strategy and national partnership, we need a National Care Service. To get different results, we need a different system.

### Quality and the Implementation Gap

This is one of the immediate priorities for any National Care Service. At present we have no national infrastructure and no national approach for delivering on the good intent of world leading policies such as those relating to self-directed support. In this report, we have identified three areas where we can begin to create the capacity and capability required for social care support in Scotland to make breakthroughs in performance.

In order to make progress, we will need to be clear about our improvement aims, we will need to build the collective will to improve, and we will need to engage people with lived experience in generating ideas for change.

### Empowering people

Throughout the report, we stress the importance of partnership and collaboration, and of amplifying the voice of staff and of people who need social care support. That is true at every level and in every part of the system.

At the individual level, self-directed support must be scaled-up to achieve its full potential across social care support, including at transition points from children's services.

At the population level, Integration Joint Boards and locality planners need to do a better job of building the user voice into their considerations. People with lived experience must be partners in the commissioning process and integral to decision-making and prioritisation, monitoring progress and making improvements; nothing about me, without me, as the saying goes.

And at the system level, we strongly recommend the involvement of people with lived experience in the governance of the National Care Service, including positions on the Board (see Chapter 6). We also recommend that unpaid carers should be similarly recognised. They already have a non-voting seat around the Integration Joint Board table, but they should be full partners and also involved at the Board level of the National Care Service.

## The purpose of social care

“Understanding of the role of social care starts from its visibility within an integrated health and social care landscape, including ensuring the social care voice is present and heard within IJBs.”

### Valuing the workforce

A welcome thread throughout our work has been unanimous support for the idea that a top priority for investment is the social care workforce. People who access social care support, advocacy groups, disabled persons organisations, and trade unions have all put forward compelling arguments for a national approach to workforce issues and for social care staff to be fully (and more generously) recognised and rewarded for the vital work they do. We make some recommendations in Chapter 10 about how this might be done, building on the strong foundations of the Fair Work Convention<sup>12</sup>.

### A Human Rights based approach

We believe we cannot improve social care support and people’s health and wellbeing if we do not ensure their human rights are upheld. A human rights based approach has been central to the creation of the report and we believe that it needs to be central to its implementation. We set out proposals for strengthening the ability of individuals to vocalise and secure their rights in Chapter 3. We outline areas where duty bearers – organisations and professionals – need to enhance their capability to recognise and enable the fulfilment of human rights.

Human rights are described extensively in international law. Important examples for this review include freedom from torture and inhumane or degrading treatment, the right to liberty and security, and respect for your private and family life. We recognise that not all rights are absolute, that they can be overruled in certain circumstances, and that practitioners are frequently required to balance competing rights.

We are aware of work underway to consider the incorporation of human rights conventions within Scots law. Whilst we do not wish to anticipate the outcome of that expert analysis, everything we have heard during our discussions suggests that there would be a warm welcome for any approach that brought clarity and certainty to the importance of human rights, not just for social care support but across civic life. We have no doubt that the incorporation of human rights conventions would aid the direction of travel set out in this report.

12 [The Fair Work Convention](#)

# The purpose of social care

We also recognise that the Taskforce for Human Rights Leadership is considering options for resolution and redress where required. Without anticipating the specific recommendations of the Taskforce on this, we welcome the attention being paid to this critical topic and agree that progress is a key priority.

## A new social covenant

One key factor in the realisation of the above is the need for mutual commitment by citizens, representative bodies, providers, civic Scotland, and national government to set aside self-interest and each work together for the common good. Trust is not currently in plentiful supply in social care support and so we believe that there is a need for an explicit social covenant to which all parties would sign up. This will be particularly important if we want to achieve our aspiration for everyone in Scotland to get the social care support they need to live their lives as they choose and to be active citizens.

In their 2014 report, the World Economic Forum describes a social covenant as a vehicle for giving effect to a common set of values and beliefs:

- ▶ **The dignity of the human person, whatever their race, gender, background or beliefs;**
- ▶ **The importance of a common good that transcends individual interests; and**
- ▶ **The need for stewardship – a concern not just for ourselves but for posterity.**

Together, these offer a powerful, unifying ideal: valued individuals, committed to one another, and respectful of future generations. Fostering these values, which we believe would serve Scotland well as guiding principles for improving social care support, is both a personal and a collective challenge. We must do more than just talk about them; we must bring them into public life and use them to guide decision-making.



# Chapter 3

## A human rights based approach

## A human rights based approach



It shouldn't be a fight to get the support I need, nor a fight to keep the support I have.”

Respect for the fundamental dignity of each and every person lies at the heart of human rights, as do the principles of equality and individual autonomy. The Covid-19 pandemic has intensified pre-existing inequalities and a lack of focus on rights, especially for older people, disabled people, people from minority ethnic communities and people from disadvantaged communities. This underlines our belief that more attention must be paid not only to recognising but to realising human rights, equality and participation for people using social care support.

In summer 2020, the Scottish Human Rights Commission (SHRC) carried out monitoring research into the impact of the Covid-19 pandemic, and how it has been managed, on people's rights in the context of care at home and support in the community. SHRC published its report in October 2020<sup>13</sup>. It details how legislative, policy and practice decisions taken by public authorities have affected the rights of people who access, or wish to access social care support, unpaid carers, and people who work in social care support. The report makes 24 recommendations, some of which call for urgent action to resolve immediate human rights concerns.

Similarly, the Equality and Human Rights Commission (EHRC) published a report in December 2020<sup>14</sup> about its findings on the impact of the pandemic on equality and highlighted the diminution that many people using social care support have experienced. In addition, the Glasgow Disability Alliance<sup>15</sup> and Inclusion Scotland<sup>16</sup> undertook surveys of disabled people to understand and put on record their experiences of the pandemic.

13 [COVID-19, Social Care and Human Rights Monitoring Report \(scottishhumanrights.com\)](https://scottishhumanrights.com)

14 [Equality in residential care in Scotland during coronavirus \(COVID-19\) | Equality and Human Rights Commission \(equalityhumanrights.com\)](https://equalityhumanrights.com)

15 <https://gda.scot/what-we-do-at-gda/resources/publications/supercharged-a-human-catastrophe-inequalities-participation-and-human-rights-before-during-and-beyond-covid19>

16 <https://inclusionScotland.org/covid-19-evidence-survey/>

# A human rights based approach

## Strengthening the rights of citizens

We asked people about respect for their rights when using social care services and supports in recent years as well as during the pandemic. People told us about their experiences over a much longer timeframe, and in many cases over very many years.

We heard a few examples of where human rights had been put at the core of services and supports and where staff and supported people alike felt valued and their rights upheld. We also listened to positive experiences where people were managing their own budget and had put in place the support they wanted, and that was helping them to lead fulfilling lives in their local communities. However, we heard from many people that their human rights were not being upheld and that equality was not at all obvious, nor was there a focus on supporting and ensuring individual autonomy and participation in decision making.

Access to social care services and supports presented particular challenges for many people and there was not clear understanding about what their rights to social care and support were. These rights must be made more transparent by “duty bearers”. Where rights are not upheld people must understand the means by which they can complain or seek redress and this must not be so cumbersome as to make that an impossible process for people to embark upon. They must also be provided with appropriate support in this process.

The assessment process was difficult for many and was variously described as intrusive, not focused on rights or equality, not focused on assets or potential but on deficits, reduced to identifying care tasks, and always overly focused on eligibility, which was frequently set at “critical needs”, and costs. Most damningly, one person summed up her experience of the assessment process as “brutal”.

Charging for services and supports that had been assessed as needed also presented major issues for many people, as this reduced their income and had a real impact on their choices, limiting their options and control about what they wanted to do with support in place. Charging is considered in more detail in Chapter 11 on finances.

## Decision making, participation and self-directed support

Many people did not feel they had the opportunity to be a partner in the decision making process about their care and support, and nor did their unpaid carers or families. Some people felt totally unprepared for the assessment process and had not had all of the options for self-directed support set out, explained or offered. A network of support and brokerage services is in place in parts of Scotland that can help people prepare for assessment, including identifying what goals or outcomes people want to achieve with support. This has been crucial in highlighting the choices and possibilities people have across the self-directed support options but it is not available to everyone and not everyone who would benefit from this support knows about it.

There is also not enough local independent advocacy (either individual or collective) available to people to support them in this process, nor to ensure that support plans are a co-produced effort involving other people whom the supported person wishes to involve, including families and carers. A recent ALLIANCE and Self-Directed Support Scotland report<sup>17</sup> identified that around 50% of people had not had access to all of the self-directed support options. Independent advocacy should also be available assist people when things do not go well and they wish to complain or to seek redress.

17 [My Support My Choice: People’s Experiences of Self-directed Support and Social Care in Scotland- National Report, October 2020 \(alliance-scotland.org.uk\)](https://alliance-scotland.org.uk)

## The purpose of social care



Start listening to disabled people. We are the solution, we're not the problem."

### ► Kiana Kalantar-Hormozi

I've had a traumatic experience trying to get the support hours I need to live independently, stay healthy and have a full life like everyone else.

I can't live fully independently because of the piecemeal support package I have. My arm movement is limited, I'm at risk of choking and need support to shower, turn in my bed at night and do all my breathing and other exercises that I have to do to keep healthy. So, the support I don't have impacts directly on my health, social, work and family life.

To move my arms and legs, go to the bathroom, take a shower and exercise when I choose; those things are fundamental rights for me to be able to live independently.

I want everything in the system to change. The funding allocated to facilitate someone's human rights and independence is an extension of healthcare.

Start listening to disabled people. We are the solution, we're not the problem. If you give people what they need to have a full and healthy life, that in turn has benefits to society as a whole. I think we need to stop thinking that disabled people are supposed to be patronised or locked up in their homes.

## A human rights based approach

Some supported people had taken part in “good conversations” about their assets and strengths, together with the assets of their local communities, and what would help them to lead a fulfilling life, rather than being assessed for all that was wrong, and had been part of joint decision making about their support plan. However, this could then be hampered by having to go through a bureaucratic process of approval, that they were not part of, leading to changes in the plan because it could not be delivered within costs or provided in the way planned.

People told us how important it was to them to be involved in decisions about their life and to be supported to do so, when required. We were pleased to hear about the work underway on developing supported decision making for people who lack capacity, who beyond most have experienced all decision making being made by others on their behalf, based on their past wishes and preferences but ultimately with a proxy making those decisions for them. People want to be regarded and treated as experts on their own needs and preferences, and the extent to which they wish to be active citizens, participating in life and in their local communities in the way they want.

Many people told us that they do not want to be treated as passive recipients of services that are provided. They want social work professionals to work with them to help plan how support will assist them in achieving their own goals, aspirations and personal outcomes, not to limit possibilities from the outset because of budgets or to plan without them the services and support that can be made available. An effective relationship, based on trust and mutual regard between the social worker and the supported person, and whoever they wish to involve in the assessment, is absolutely key to planning support.

The lack of portability of support packages and plans between different local authority areas is a further issue that serves to diminish people’s rights and self-determinism. The whole process of assessment and decision making has to be repeated if a supported person moves home or residence from one local authority area to another. While everyone understands that the range of services and supports available in the larger conurbations in the central belt cannot be replicated in full in more rural or remote communities, it is unnecessary and unfair for previous assessment and support plans to be stopped and entirely new ones developed, often after much delay and at great distress to individuals. The result is wasteful with much unnecessary duplication of effort by professional staff.

### Prevention and extending eligibility

As a result of access to social care support being based on eligibility, where the starting point means that you have to be in critical need and at crisis point in your life, it is little wonder that there is a lack of focus on prevention and early intervention, and few resources targeted at providing a little support to prevent the crises from occurring in the first place. This needs urgent attention and priority, and is picked up later in the report.

Social workers and their representative organisations told us about their frustrations with this process, which put social workers in the position of gatekeeping budgets on behalf of cash-strapped Local Authorities, and prioritising cost and eligibility considerations above working with people to plan their support and to ensure access to high quality support. As one social worker put it to us: It’s the equivalent of NHS staff having to make a case for funding every time someone needs a blood test.



It’s the equivalent of NHS staff having to make a case for funding every time someone needs a blood test.”

## A human rights based approach

### Taskforce for Human Rights Leadership

Taking a human rights approach is about using the comprehensive set of international human rights established and adopted worldwide. The Scottish Government has established a Taskforce for Human Rights Leadership<sup>18</sup>, jointly chaired by the Cabinet Secretary for Social Security and Older People, and Professor Alan Miller. Professor Miller was previously the Chair of the First Minister's Advisory Group on Human Rights Leadership and we have ensured that close links have been forged between these key pieces of work.

The Taskforce, which is due to report in March 2021, is considering the incorporation of international treaties and conventions on human rights into Scots law, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Convention on the Rights of Persons with Disabilities (CRPD), and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). As well as this, the Taskforce is considering how to better support delivery of these rights and is looking at a range of additional support that would be required to underpin incorporation of these rights into Scots law, with which we have a great deal of agreement:

- ▶ **Practical steps to build the capacity of those delivering public services, including workforce development and training.**
- ▶ **Accountability, including regulations, standards, audit measuring and ensuring capacity to take a human rights based approach towards their work.**
- ▶ **Rapid access to justice and redress and in the instance of systemic failure with potential for particular bodies to undertake this on behalf of individuals.**
- ▶ **Strengthening the role of rights holders through public education and the provision of support through independent advocacy, more status to third sector agencies who can articulate the rights of rights holders, allocation of resources, equality impact assessments etc., and based on international law and remedies.**

“We no longer have a life outside full time work and our family home resembles a care home. Our bills have trebled and quality of life decreased – disappeared in fact.”

18 [National Taskforce for Human Rights Leadership – gov.scot \(www.gov.scot\)](http://www.gov.scot)

# A human rights based approach

## Recommendations

Our recommendations for establishing a human rights and equality approach to social care services and support are rooted in the work to consider incorporation of international treaties into domestic legislation, and the recent experiences during the pandemic that exposed structural inequalities and pre-existing inadequacies in the current social care support system:

1. Human rights, equity and equality must be placed at the very heart of social care and be mainstreamed and embedded. This could be further enabled by the incorporation of human rights conventions.
2. Delivering a rights based system in practice must become consistent, intentional and evident in the everyday experience of everyone using social care support, unpaid carers and families, and people working in the social care support and social work sector.
3. People must be able to access support at the point they feel they need it, including for advice and signposting to local community-based resources and help, and for barriers to this, such as the current eligibility criteria and charging regime, to be fundamentally reformed and removed, to allow a greater emphasis on prevention and early intervention.
4. People should understand better what their rights are to social care and supports, and “duty bearers”, primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.
5. Where not all needs can be met that have been identified as part of a co-production process of developing a support plan, these must be recorded as unmet needs and fed into the strategic commissioning process.
6. Informal, community based services and supports must be encouraged, supported and funded to respond appropriately to the needs of local citizens, including for preventative and low level support.
7. A co-production and supportive process involving good conversations with people needing support should replace assessment processes that make decisions over people’s heads and must enable a full exploration of all self-directed support options that does not start from the basis of available funding. Giving people as much choice and control over their support and care is critical.
8. More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.
9. When things do not work well for people and their rights have not been upheld, they must have rapid recourse to an effective complaints system and to redress.
10. Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.



# Chapter 4

## Unpaid Carers

# Unpaid Carers

“ We are preventing a tsunami of need from overwhelming public services. That comes with costs to us, to our families.”

Caring is normal. 60% of us will be carers at some point in our lives, supporting family members, friends or neighbours who are affected by disability, physical or mental ill-health or who may just need some support. A carer does not need to be living with the person they care for and can be any age: very young, very old and anything in between. Around 4% of the population aged 4-18, i.e. 29,000 children and young people, are carers. Around 15% of the adult population, i.e. 661,000 people aged over 18, are carers.

The Scotland’s Carers research report<sup>19</sup> estimates that the number of carers in Scotland fluctuates, with about 700,000 people currently providing unpaid care<sup>20</sup>. The value of unpaid care in Scotland is estimated at over £36 billion a year. For comparison, in 2019 the NHS Scotland budget was £13.4 billion.

Unpaid carers in Scotland represent a larger workforce than the paid health and social care support workforces combined. The people we spoke to acknowledged that Scotland recognises the contribution of unpaid carers in a number of ways<sup>21</sup>.

Nevertheless, a survey carried out by the Coalition of Carers in Scotland in 2019 reported that only 16% of carers knew what the Carers (Scotland) Act 2016 was and the rights it provides; 33% had heard of it but didn’t know what it was about; 51% had never heard of it. We heard from many carers during the review that much needs to be done to better support and sustain carers in their caring roles.

We heard that unpaid carers are often best placed to understand the needs, rights and preferences of the person they support. It is also important that we record what we heard about the toll unpaid care, however willingly given, can have on its giver. Deciding to provide care should be a positive decision on the part of the giver. When someone is being assessed for social care support, the role of the carer should be determined by them and not assumed by the assessor. Carers and carers organisations told us about personal sacrifices made by thousands of carers, and the impact caring without decent breaks can have on their physical, psychological and mental wellbeing.

19 [Scotland’s Carers – gov.scot \(www.gov.scot\)](http://www.gov.scot)

20 <https://www2.gov.scot/Resource/0054/00548776.pdf>

21 <https://www.gov.scot/policies/social-care/unpaid-carers/>

## Unpaid Carers

Unpaid carers are integral to good care, so it is important that we recognise the value they bring and ensure they are included as equal partners in the team of people who together plan and provide support and care. The phrase ‘nothing about me without me’ should apply equally to people who use services and their unpaid carers.

Over half of the respondents to the Coalition of Carers survey were not aware of any of their rights, including their right to a carer’s assessment<sup>22</sup>, and advised that pre March 2020 they had still not had an assessment. The subsequent introduction of Covid-19 emergency legislation has meant that many Local Authorities have suspended carer’s assessments. In the same timeframe, a recent survey by Carers Scotland showed that most respondents have taken on more care since March, and that 77% are exhausted and worn out.

Carers need more support. Many asked for the same things that people who use social care services and supports asked for as discussed in Chapter 3: greater consistency between Local Authority areas in terms of provision; clarity on the application of eligibility criteria; better involvement in, and transparency about, decisions regarding support; better data on support provided to carers and unmet need.

Many carers give up work to care, and it was also suggested that consideration of the carer’s access to employment should be a routine part of assessment for support. Carers should not be prevented from working, or indeed studying or having social connections of their own, because of their caring role. Yet we heard that many people are prevented from working because of their caring responsibilities, and about the impact this can have on household income that is not addressed by the Carer’s Allowance. We reflect further on this in Chapter 11 on finance. Some carers told us about their need for support to get back into employment and education – and indeed into social activities – after a period of caring, which can be difficult and daunting.

“Carers feel invisible, that they are just left to “get on with it” and that no one cares or appreciates them.... now is the time to act and make carers count, treated as equal partners in care with professionals.”

“Loneliness is such an integral part of caring. I no longer have a husband. I care for him.”

22 <https://www.carersnet.org/wp-content/uploads/2019/01/Awareness-of-the-Carers-Act-January-2019.pdf>

## Unpaid Carers

Access to respite came up repeatedly as a priority. Carers need to be able to take a break and respite should be viewed as integral to carer support. However, a greater range and more imaginative options should be developed for both the supported person and unpaid carers to better meet needs and preferences.

When carers are unable to access their rights, including their right through the Carers Act to have their eligible needs met, they are unable to challenge effectively. We heard that the complaints system is inadequate and legal recourse is not a viable option for most people. As well as an improved complaints process, and greater transparency about decision making processes, we were frequently told that more, easily accessible information is needed for carers.

In appropriate circumstances, there is also a need for the carer's assessment to be undertaken alongside that of the supported person, to ensure that the support provided helps to support their relationship, is jointly agreed and helps to deliver choice and control, especially in family relationships.

# Unpaid Carers



There is also very little accountability in the current system and this inevitably results in unpaid carers and the people that they care for, feeling powerless.”

## ► Shubhanna Hussain-Ahmed

In Scotland we are fortunate to have some really great pieces of legislation such as the Carers Act and the Social Care (Self-Directed Support) Act. This has given unpaid carers in Scotland some key rights to access support, as well as greater choice and control over how care and support for themselves and the people that they are caring for should be met. However, many of these great policy intentions are very rarely implemented in the way that they were intended or in the ‘spirit of the Act’. There is also very little accountability in the current system and this inevitably results in unpaid carers and the people that they care for, feeling powerless about decisions made about their lives, and less likely to seek support for themselves or their families. It feels pointless introducing new legislation or policies, if we are going to continually fail to implement them.

The current social care system also prides itself on being person-centred. However, once again, we see very little evidence of this in practice. A person-centred approach would acknowledge that unpaid carers are not a homogenous group; we come from all ages, from different cultural and ethnic backgrounds, and with very different caring experiences. Each of us have our own needs, desires, and aspirations, and these cannot be addressed by a one-size-fits-all service.

When we think about what the future of social care should look like, we need to begin by viewing social care as a right, and not as a service or industry. Social care shouldn’t be limited to only those who can afford it or to those who are in crisis; it should be available to anyone who has support needs to be able to reach their full potential and to ultimately have the same life opportunities as anyone else.

# Unpaid Carers

## Recommendations

Our recommendations for creating a National Care Service provide a mechanism for better representation of carers in local planning, commissioning and procurement of services. To ensure the contribution of carers is properly recognised and supported, we recommend:

11. Carers need better, more consistent support to carry out their caring role well and to take a break from caring with regular access to quality respite provision. Carers should be given a right to respite with an amendment to the Carers Act as required, and a range of options for respite and short breaks should be developed.
12. A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights based approach to the support of carers.
13. Local assessment of carers' needs must, in common with assessment of the needs of people using social care support services and supports, better involve the person themselves in planning support.
14. Carers must be represented as full partners on the Integration Joint Boards and on the Board of the National Care Service.



# Chapter 5

## The case for a national care service (NCS)

## The case for a National Care Service (NCS)

“ We need a system that is controlled nationally, that delivers locally, has the person at the centre, that does not cost the earth”

The Terms of Reference for this review make no reference to a National Care Service, although the First Minister in her Programme for Government announcement set out her ambitions to build out of the Covid-19 pandemic a social care legacy equal in stature and impact to the creation of the National Health Service after World War 2:

“ . . . the pandemic has reminded us of the vital importance of social care services, and of the extraordinary professionalism, dedication and compassion of those who work in that sector. However, it has also underlined the need for improvement and reform. I can therefore announce today the immediate establishment of a comprehensive independent review of adult social care. The review will seek the views of those with direct experience of adult social care, and make recommendations for immediate improvements. However, more fundamentally, it will examine and set out options for the creation of a National Care Service. . . The quality of adult social care is something that matters deeply to us all. This is a moment to be bold and to build a service fit for the future. The National Health Service was born out of the tragedy of World War 2. Let us resolve that we will build out of this COVID crisis, the lasting and positive legacy of a high quality, National Care Service for all who need it.”

Nicola Sturgeon MSP, First Minister  
1 September 2020<sup>23</sup>

During the engagement phase of our review many people asked what a National Care Service would consist of, how it would be organised and who would pay for it. When we asked people for their suggestions, many different ideas were shared. Some people were strongly in favour, others strongly opposed, and others were not sure without more details.

The pandemic has demonstrated clearly that the Scottish public *expect* national accountability for adult social care support and look to Scottish Ministers to provide that accountability. Statutory responsibility for care homes sits with Local Authorities and individual providers. However, it was clear during the pandemic there was an expectation that Scottish Ministers should be held to account, which makes sense from a public health perspective. We therefore recommend the establishment of a National Care Service – that brings together all adult social care support delivered in Scotland.

23 [Programme for Government 2020-2021: First Minister’s speech 1 September 2020 – gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/programme-for-government-2020-2021/pages/first-minister-s-speech-1-september-2020.aspx)

## The case for a National Care Service (NCS)

We recognise that Ministers do not currently hold the levers that would enable them to manage the social care support services for which they are held to account. We nevertheless think the expectation of Ministerial accountability is reasonable, in light of adult social care support's impact on people's wellbeing, its deep links to and mutual dependency with the National Health Service, and the scale of public funding for it.

We also recognise that Local Authorities have a key statutory role to play in supporting public wellbeing that is wider than provision of social care support, extending to for instance housing, transport and, leisure and recreation. We believe that, by establishing national accountability for adult social care, the Scottish Government can work with local systems to address systemic problems evident in our current arrangements while at the same time developing, maintaining and enriching key links to other Local Authority services. We envisage an important and continuing role for Local Authorities as public providers of social work and social care services, and as partners in Integration Joint Boards, where they will continue to work with their NHS partners and others to meet local needs and steward health and social care resources.

A National Care Service must ensure that people have equity of access to social care supports, and experience a similarly high quality of care, wherever they live in Scotland. Where there is variation in the kinds of care provided in different parts of the country, that should be a positive response to differences in geography, local assets and local priorities. There should not be inexplicable or un-evidenced variation in care that diminishes or harms people's life experiences. There should be a consistent, national focus on preventative, early intervention and anticipatory forms of support that shift the emphasis, and experience of care, away from crisis intervention and towards better quality of life. Lower level needs should not be left unattended until they become a bigger problem, they should be addressed to avoid the bigger problem occurring.

As identified in Chapter 3, care and support should be portable. When someone has been assessed for care in one part of the country they should be able to move to another area and take their entitlement to social care support with them. The current situation, which requires people to be re-assessed for support in their new home, impinges directly on their rights to lead a socially engaged, full and active life, and is wasteful and bureaucratic.

“The changes which are required are national, we should therefore deal with the social care service in a national way just like our NHS”

## The case for a National Care Service (NCS)

Some aspects of adult social care support need new and modified arrangements at national level to support the progress required.

New provision should be made for learning and improvement programmes for social work and social care, to support quality, improvement, consistency, professionalism and to work directly with equivalent provision in the NHS. There is a pressing need for a national infrastructure to scale-up and spread promising local practice as well as to deal consistently with common challenges. These arrangements must focus on the skillsets specific to social work and social care support and links to equivalent developments of the health workforce. The Scottish Social Services Council (SSSC) and NHS National Education Services Scotland (NHS NES) linking effectively to Scottish Universities and Colleges, should be part of the new arrangements and must work much more closely together to build upon each other's strengths. Neither organisation is currently fully equipped to provide the scale and range of support required to improve the quality of social care support or deliver effective integration.

Provision should also be made at national level for support for people whose needs are very complex or highly specialist. This will provide people with greater levels of support and allow for the cost to be absorbed nationally. The Independent Living Fund Scotland should form part of the suite of services supported at national rather than local level and become part of the National Care Service. We consider in Chapter 11 whether the Independent Living Fund should be reopened with additional investment.

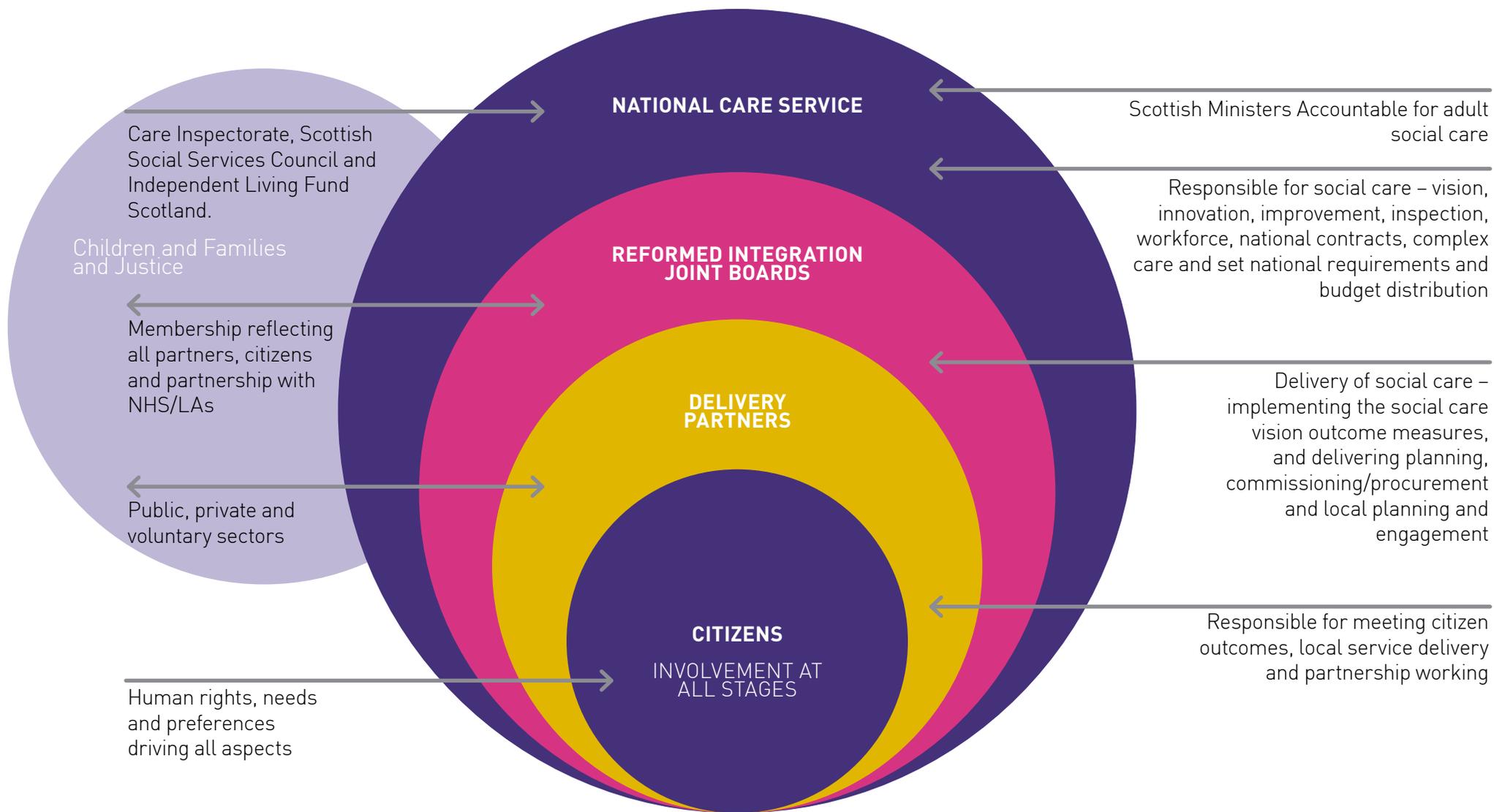
Consideration should also be given to supporting social care in prisons and other custodial settings as part of the national service rather than through local arrangements.

We believe that the problems outlined above can only be dealt with by a National Care Service that drives forward improvement and requires certain common standards and rights based approaches across Scotland. We therefore recommend that the accountability of Scottish Ministers for adult social care support should be legally established to put beyond doubt that overall responsibility sits with the Scottish Government. This will mean that Local Authorities are no longer legally accountable for adult social care support. Of course, as key partners in Integration Joint Boards, they will continue to influence and direct resources to meet identified local needs and they will provide social care support and professional social work services.

We also recommend that, recognising this shift in responsibility, a Minister for Social Care should be appointed.

Statutory responsibility for adult social care support should be set out in law along similar lines to those already established for health services, to establish parity of esteem and clarify mutual dependencies between health and social care support, and to establish equity in terms of reporting arrangements. We recommend the creation of a National Care Service via which Ministers are empowered to discharge their responsibilities for adult social care support, to oversee delivery in local areas as set out in further detail below. In simple terms, we envisage a National Care Service that operates along these lines:

# The case for a National Care Service (NCS)



## The case for a National Care Service (NCS)

To ensure parity and clarity with the NHS we recommend that the Scottish Government should at the same time establish NHS Scotland in law on an equal footing to a National Care Service, to oversee delivery by individual NHS Boards.

### Why not nationalisation?

We have considered whether nationalisation – taking all of adult social care into public ownership and management – is desirable.

The evidence suggests that nationalisation would not in and of itself improve outcomes for people using care. Care Inspectorate data<sup>24</sup> indicates that, when it comes to community based services, quality is generally highest among third sector providers. In terms of residential care for older people, evidence from the pandemic<sup>25</sup> indicates a correlation between size of care home and quality of care, with smaller facilities faring better than larger ones, but no evident link between type of ownership (public, private or third sector) and quality. We therefore think that the evidence does not support nationalisation into public ownership on the basis of improving the quality of care.

Notwithstanding quality, if nationalisation is supported by some people they need to explain how it would be paid for. We have considered public value and how much it would cost to take the social care sector into public ownership. Examples such as the purchase of Home Farm care home in Skye at a cost to the public purse of £900K during the Covid-19 pandemic suggest that nationalising the sector would require an unaffordable level of public outlay, particularly in terms of investment in capital. It would also be hugely time-consuming: time that could be better spent working with providers and people who use services to improve care. We have also considered more fundamental financial questions, like responding to unmet need for social care supports, which in our view should be the priority for financial solutions; we provide further detail in Chapter 11.

Different arguments and different solutions apply to the social care workforce. Material inconsistencies in terms and conditions, low pay, high turnover, lack of training and development, low esteem and long-standing gender-based unfairness need to be tackled consistently and fairly without undermining the arrangements that underpin good quality existing provision as above. A national approach – without nationalisation itself – is needed to resolve these unacceptable features of current employment arrangements, without removing the unquestionable value added by the diversity and specialism of the third sector in particular, and without dismantling organisations that are already doing a good job. We set out our recommendations for achieving fair work in social care support in Chapter 10.

24 [Datastore \(careinspectorate.com\)](https://careinspectorate.com)

25 [Discharges from NHSScotland hospitals to care homes 28 October 2020 – Data & intelligence from PHS \(isdscotland.org\)](https://www.isdscotland.org/News/2020/10/28-discharges-from-nhsscotland-hospitals-to-care-homes)

# The case for a National Care Service (NCS)

## Local responsibilities

Local planning for, and delivery of, adult social care support should continue and should build upon the progress made to date with integrating health and social care support. That progress has not, the evidence is clear<sup>26 27</sup>, been sufficient so far to meet the Scottish Government's ambitions for integration, which are necessary and urgent to improve public wellbeing.

Currently, the onus to integrate health and social care support sits locally, with responsibility devolved to Health Boards, Local Authorities and Integration Authorities. Lack of integration at national level is contributing to unacceptable variation in local progress.

Integration Authorities are new organisations, created only a few years ago under the Public Bodies (Joint Working) (Scotland) Act 2014. They should be reformed to take full responsibility for the commissioning and procurement of adult social care support locally, accountable directly to the Scottish Government as part of the National Care Service. Local Authorities should no longer be responsible for commissioning and procuring adult social care support but can continue to provide social care services procured by reformed Integration Joint Boards. One model of integration, the Integration Joint Board, should be used throughout the country. There is no evidence that lead agency arrangements have delivered better results than Integration Joint Boards and consistency will be important in the new system to simplify governance arrangements and improve public understanding of who is responsible for what.

We heard evidence that those Integration Joint Boards, which have gone beyond the statutory delegation minimum of all adult social care, and that have all children's services and criminal justice social work also delegated, have performed well in relation to these services. It will be important in the implementation of this report to have regard to implementation plans for the review of children's services (The Promise) and of the work being done to consider the future of criminal justice social work. Social workers and their representative organisations expressed concerns about further fragmentation of the social work workforce, across different arrangements for those working in adult care, children's services and criminal justice. We fully recognise and value the role of social workers in respect of assessment and care management, and in changing the way self-directed support currently operates, as well as their critical role in adult support and protection.

Social workers were also concerned about the impact possible fragmentation would have on children, families and adults needing support and who do not lead their lives according to administrative boundaries or arrangements. Careful consideration should be given to these concerns as changes are taken forward and close joint working forged between the implementation of The Promise and the recommendations in this report.

As the local delivery agencies of a new National Care Service, Integration Joint Boards will need considerable support from the Scottish Government, Local Authorities, the NHS, and delivery partners, to make consistent progress. Contributing wholeheartedly to that support must be a priority for all partners in health and social care support in Scotland. There will be a continuing need for partners at a local level to work collegiately to share intelligence and understanding about local needs and to explore joint solutions. This will only be achieved by prioritising it and working together to achieve the best outcomes for local communities. The importance of clear, committed leadership at all levels and in every organisation to making a reformed system work cannot be overstated. We recommend the creation of a National Integration Joint Board where the senior leadership of the National Care Service and NHS meet regularly to agree strategy and priorities.

26 [Health and social care integration: update on progress | Audit Scotland \(audit-scotland.gov.uk\)](#)

27 [Health and Social Care integration: progress review – gov.scot \(www.gov.scot\)](#)

## The case for a National Care Service (NCS)



The amount of paperwork support staff now need to complete has got out of control and takes away precious support time.”

### ► Richard Toner

I was transitioned to adult care providers at the age of 16. The care provider I was initially given, wasn't able to work with people who have physical disabilities, therefore was totally unsuited to meet my needs.

The British Red Cross stepped in and gave me a new outlook on life and the opportunity to have the independence I desired and I stayed with them for almost a decade. I am now in the process dividing my care package between Quarriers and Ayrshire Independent Living Network to better suit my requirements.

Transitioning from children services to adult services is a daunting experience. The communication between social worker and care provider could be improved to allow a steady transition, and in my situation there could have been better research into care services to ensure they met my requirements. The amount of paperwork support staff now need to complete has got out of control and takes away precious support time. This bothers me as I have to allow staff time away from caring for me to write reports. Support from team leaders and management to the service user is much less forthcoming since I transitioned to adult services and this should be improved to allow issues to be dealt with more effectively and positive relationships to be formed between management and the service users.

Overall, I've found my experience of transitioning between children services to adult services and between care providers steady and carefully considered over the years.

## The case for a National Care Service (NCS)

Budgets for integrated health and social care support services should be determined nationally and distributed directly by the Scottish Government to Integration Joint Boards, as they are to Local Authorities and NHS Boards. This will mean that budgets that are currently distributed to Integration Joint Boards via Local Authorities and Health Boards will now be allocated directly by the Scottish Government. Too much time and effort is currently spent agreeing budgets for integrated health and social care support services at local level. We heard that budgets are often not agreed until well into the financial year in question. A new distribution formula for Integration Joint Board budgets is needed to ensure equity and transparency, rather than relying on a blend of the existing NHS and Local Authority formulae as at present. Such a formula will need careful development with partners to ensure a fair outcome for Integration Joint Boards, Local Authorities and Health Boards. Consideration will need to be given to VAT in relation to the National Care Service.

We set out our recommendations for how a new National Care Service should work in Chapter 6.

### Recommendations

#### We recommend that a National Care Service should be established:

15. Accountability for social care support should move from local government to Scottish Ministers, and a Minister should be appointed with specific responsibility for Social Care.
16. A National Care Service for Scotland should be established in statute along with, on an equal footing, NHS Scotland, with both bodies reporting to Scottish Ministers.
17. The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers. Integration Joint Boards should manage GPs' contractual arrangements, whether independent contractors or directly employed, to ensure integration of community care and support provision, to respect and support professional interdependencies, and to remove the current confusion about where responsibility for primary care sits.
18. The National Care Service should lead on the aspects of social care improvement and support that are best managed once for Scotland, such as workforce development and improvement programmes to raise standards of care and support.
19. The National Care Service should oversee social care provision at national level for people whose needs are very complex or highly specialist and for services such as prison social care that could be better managed on a once-for-Scotland basis.
20. The National Care Service's driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce.



# Chapter 6

## A National Care Service for Scotland – how it should work

## A National Care Service for Scotland – how it should work

“ We must shift beyond the mindset of existing systems and services to embrace individual and community capacities, and collaborative opportunities to enable innovative support mechanisms.”

The importance of integrating health and social care is as important today as it was in 2012 when the Scottish Government consulted on proposals that were given effect by the Scottish Parliament through the Public Bodies (Joint Working) (Scotland) Act 2014.

Progress has been patchy. In particular it is evident that the ambition quoted above – that whether money for support and services is from an “NHS budget” or a “Local Authority budget” should be of no importance to the person using services – has not been achieved. This is not merely an accounting problem. It is a significant impediment to the wellbeing of people who use health and social care support services, because it gets in the way of early intervention and preventative approaches, and it is a significant barrier to innovation for people working in health and social care support.

This chapter builds on the principles set out in Chapter 5. We have included quite a lot of detail about structures in this chapter, to help people who currently work in health and social care organisations understand the changes we are suggesting.

We are concerned that, by setting out this detail, we may give the unintended impression that we believe structural change is what matters most. We do not. In some ways we would prefer not to have to recommend any structural change at all. All structural change involves effort, and money, which some people will argue would be better used in supporting people. We do not disagree. But structural change is necessary if the structures themselves are impeding good care and support for people, which we believe is currently the case.

The changes we propose here would likely not be necessary if more progress had been made by the Scottish Government, Health Boards, Local Authorities and Integration Joint Boards with integrating health and social care. Wishing it were so does not make it true, however. We therefore encourage everyone involved to embrace these proposals as they are intended to be received: as a means through which to achieve consistent, Scotland-wide improvements in social care supports focused entirely on improving outcomes for people using and working in social care, and to the potentially enormous benefit of civic life and local communities. We have been asked for clarity on responsibilities; for obstacles to be removed to good, rapid decision making; for arrangements to be made to enable good ideas to be shared, spread and deployed easily; and for changes that will enable money to flow easily to where it can be used to best effect. We have framed the recommendations that follow around these basic, reasonable, requests. It should not be beyond our collective means in Scotland to achieve them.

# A National Care Service for Scotland – how it should work

## Statutory basis for a National Care Service

To address the problems we have already outlined, and for the reasons we set out in Chapter 5, we recommend that new legislation should empower Scottish Ministers to:

- ▶ **Discharge responsibility for the local planning, commissioning and procurement of social care support via Integration Joint Boards; and**
- ▶ **Create national bodies to service and support social care support and social work at local and national level.**

Ministers should be able to change the number and configuration of Integration Joint Boards and national care bodies without changing primary legislation. This approach mirrors the existing powers of Ministers to establish NHS territorial and special boards.

Some existing agencies should become national care bodies under the National Care Service: the Care Inspectorate and Scottish Social Services Council. We recognise that the remit of each of these agencies extends beyond adult social care but believe their inclusion will be vital in establishing a coherent context for the National Care Service. We also consider that this will provide additional impetus for close working between adults, children's and criminal justice social work services, whatever the conclusion made about overall structures.

Within the National Care Service, provision will also be needed to oversee priorities that currently have no home in the national infrastructure, such as workforce planning and development, data and research, IT and, as appropriate, national and regional service planning, and to manage services that are better organised on a once-for-Scotland basis, such as support for people with complex and specialist needs, provision in custodial settings including prisons, and so on.

The remit of this review is only to consider adult social care. As part of our work we have engaged closely with colleagues leading on The Promise, which is responsible for driving the work of change demanded by the findings of the Independent Care Review for children's care<sup>28</sup>. The recommendation of our review is that social work and social care support should be made more cohesive across age and professional groupings, should enable transitions between children's services and adult services, and that further work should be done to ensure that implementation of the two reports is mutually reinforcing. This will need close attention during implementation.

## A National Care Service for Scotland – how it should work



I am living a full life, but there are still too many other people who aren't getting the support I'm getting and are suffering as a result."



Sophie self-manages very well. She knows the strategies she needs to cope, and she knows physical health is good for her mental health."

### ► Sophie Hogg

I am 74 years old and was diagnosed with vascular dementia a couple of years ago. I thought I'd been asked to go to the clinic to get help with my diabetes when I was given the news. The doctor told me I had dementia, handed me a DVD and a book and opened the door for me to leave. Within the space of a few minutes I had been told I wouldn't be able to drive again and I'd need to get a power of attorney. It was a dreadful way to be given a diagnosis. I thought my life was nearing an end, I even started to clear out my house and give my jewellery away to my family. However, since then I have been very lucky with the support I've had. I was referred to Alzheimer Scotland and given a great link worker. I am able to live a great life because I have support and have been put in touch with other people in the same position. My husband Robert and I regularly volunteer, helping people with special needs. I am living a full life, but there are still too many other people who aren't getting the support I'm getting and are suffering as a result.

### ► Marian Garcia

Link Worker

Sophie is a fine example of someone who has learned how to live well with dementia. Her confidence has grown exponentially, having gone from not attending groups to now contributing, supporting her peers, campaigning and helping others with a recent diagnosis. Sophie self-manages very well. She knows the strategies she needs to cope, and she knows physical health is good for her mental health. Before COVID, Sophie had a regular gym and swimming routine. She lost a lot of weight and reported feeling empowered and confident. Without Post Diagnostic Support, I believe we'd be seeing a very different Sophie today. She is an inspiration.

# A National Care Service for Scotland – how it should work

## Governance of a National Care Service

The National Care Service should have a board of governance with a Chair appointed by, and accountable to, Ministers. Its other members must include representation of the workforce, people experiencing social care support, unpaid carers and providers.

The National Care Service should have a Chief Executive who is the accountable officer to the National Care Service national board of governance and is also a member of the Scottish Government Health and Social Care Management Board, as the Chief Executive of NHS Scotland is now. The Chief Executive of NHS Scotland should be a member of the board of the National Care Service. If there is a similar board for NHS Scotland then the Chief Executive of the National Care Service should be a member of it.

## Functions of a National Care Service

The National Care Service should:

- ▶ **Provide assurance to Ministers and to the public about the quality of social care support in Scotland and ensure that opportunities for continuous improvement are identified and implemented.**
- ▶ **Oversee the work of reformed Integration Joint Boards and national care bodies and ensure effective engagement is taking place at all levels.**
- ▶ **Establish, maintain and oversee national requirements for ethical and collaborative local commissioning and procurement of social care (see Chapter 9). These requirements will cover standards of care and outcomes to be achieved, and fair work.**
- ▶ **Develop and maintain the distribution formula for direct allocation of budgets by the Scottish Government to Integration Joint Boards and national care bodies.**
- ▶ **Be responsible for social care support functions that currently have no home in the national infrastructure, such as workforce planning and development, data and research, IT and, as appropriate, national and regional service planning, and to manage services that are better organised on a once-for-Scotland basis, such as support for people with complex and specialist needs, provision in custodial settings including prisons, and so on.**
- ▶ **Ensure effective working with NHS Scotland, establishing a joint approach where beneficial to people accessing care. This priority could be enabled by the creation of a similar board of governance for NHS Scotland and the creation of a National Integration Joint Board where the senior leadership of the National Care Service and NHS meet regularly to agree strategy and priorities.**
- ▶ **Ensure effective local and national working with other public services including transport, housing and education, all of which are key to public health and wellbeing. People's environments can be disabling if not properly planned for accessibility, and people's needs for care and support vary depending on their context. More broadly than social care and health, it is important that the public sector as a whole designs different environments – home, workplace, local services and infrastructure (e.g. transport, amenities), community networks – to support people's independence and enable everyone to participate as full citizens in society.**

# A National Care Service for Scotland – how it should work

## Monitoring progress

As part of its oversight of local and national progress the National Care Service will need to develop and maintain outcome measures for the Integration Joint Boards and national care bodies, and monitor their performance.

Previous attempts to establish a single set of outcome measures across adult health and social care have been hampered by complexity and duplication. These obstacles need to be overcome to ensure clarity of purpose and transparency of the evidence base for progress. We recommend that a single, clear set of outcomes, process measures and balancing measures should be developed for the whole health and social care system. This should involve people using social care support, patients, unpaid carers, providers, clinicians and professionals, to ensure the right balance of measures is identified. This should be developed as a priority and should simplify, reduce in number and improve the current range of measures. It should acknowledge this report and ensure a focus on outcomes for people using social care supports and healthcare services and should reflect the ethical and collaborative approach to commissioning that we recommend here.

## Reforming Integration Joint Boards

The law should be changed so that Integration Joint Boards are reconfigured to employ staff, hold assets and contracts, including the GMS contract and employment of directly employed independent contractors in health, as described in Chapter 5.

Integration Joint Boards should contract directly with public sector providers, and with the third and independent sectors. This means that the National Care Service, through Integration Joint Boards, will hold contracts with providers of social care support services, which is an arrangement not unlike the contractual arrangements between NHS Boards and primary care contractors such as GPs and pharmacists. Consideration should be given to whether any contractual arrangement is needed with Local Authorities for the provision of professional social work services and how this would work.

The post of Integration Joint Board Chief Officer should be retained though the skillset for the job should be updated, clarified and sharpened to reflect the new responsibilities of Integration Joint Boards. Currently Chief Officers perform a dual role as accountable officer for the strategic commissioning plan and use of the integrated budget to the Integration Joint Board, and as director of integrated delivery within the Health Board and the Local Authority. Under the new model Chief Officers, and the staff who plan, commission and procure care and support, as well consideration given to other key staff such as Chief Finance Officers, should be employed by the Integration Joint Board itself, rather than by the Local Authority or Health Board as is the case now. They will no longer be jointly accountable to Chief Executives of Local Authorities and Health Boards.

## A National Care Service for Scotland – how it should work

We heard and saw compelling evidence of where current integrated arrangements were working well under Integration Joint Boards and their delivery arm, Health and Social Care Partnerships. This was especially the case where all social care, social work and community based healthcare were delegated to its greatest extent. We strongly believe that there is scope to be more consistent in these arrangements and embed the effective working we saw throughout the country. We are also keen to ensure a further narrowing of the gap between purchaser and provider, an unwelcome split introduced to social care and social work some 30 years ago. We intend this as a means by which the best possible outcomes are planned for and achieved, and high quality integrated services are delivered across Scotland.

Integration Joint Boards should continue to develop strategic commissioning plans, and should be given direct responsibility for procurement, holding contracts and contract monitoring. Strategic commissioning plans must be better linked to planning for other types of service, including particularly housing plans and plans for acute hospital care.

The Integration Joint Board (equal numbers of elected members and NHS non executives) and Integration Joint Board Strategic Planning Group (a broad range of representative user and professional interests) should be combined to form the membership of the reformed Integration Joint Board.

Every member of the Integration Joint Board should have a vote. Membership should include but not be limited to representation of the workforce, people who use services, carers, providers, professionals, localities and local communities. Careful thought will need to be given to the workable size of Integration Joint Board and appropriate support will need to be provided to enable participants to fulfil their responsibilities. We know from experience with integration that very large Boards are unwieldy, but that at the same time narrow membership seems to inhibit innovation and a local sense of ownership, and the clear sense of involvement that gets things done. This combined with active community engagement and involvement will provide a powerful basis for planning and delivering change and improvements at a local level. Additional support and training for members and Chairs of reformed Integration Joint Boards would help them to fulfil their functions more effectively without resorting to simplistic solutions to these challenges.

The Integration Joint Board budget should continue to include a sum for unplanned adult hospital care to help incentivise preventative interventions. Integration Joint Boards should bear responsibility for unplanned and potentially avoidable hospital care.

Integration Joint Boards' budgets should be allocated directly by the Scottish Government, rather than via Health Boards and Local Authorities as at present, as set out in Chapter 5. See Chapter 11 for financial recommendations.

# A National Care Service for Scotland – how it should work

## Recommendations

We recommend the following arrangements should underpin a National Care Service:

21. The National Care Service in close co-operation with the National Health Service should establish a simplified set of outcome measures to measure progress in health and social care support, through which to oversee delivery of social care in local systems via reformed Integration Joint Boards and national care bodies.
22. A Chief Executive should be appointed to the National Care Service, equivalent to the Chief Executive of the National Health Service and accountable to Ministers.
23. Integration Joint Boards should be reformed to take responsibility for planning, commissioning and procurement and should employ Chief Officers and relevant other staff. They should be funded directly by the Scottish Government.
24. The role of existing national care and support bodies – such as the Care Inspectorate and Scottish Social Services Council – should be revisited to ensure they are fit for purpose in a new system.
25. The National Care Service should address gaps in national provision for social care and social work in relation to workforce planning and development, data and research, IT and, as appropriate, national and regional service planning.
26. The National Care Service should manage provision of care for people whose care needs are particularly complex and specialist, and should be responsible for planning and delivery of care in custodial settings, including prisons.



# Chapter 7

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

“Self-directed support is absolutely the right policy but there has been a failure of implementation.”

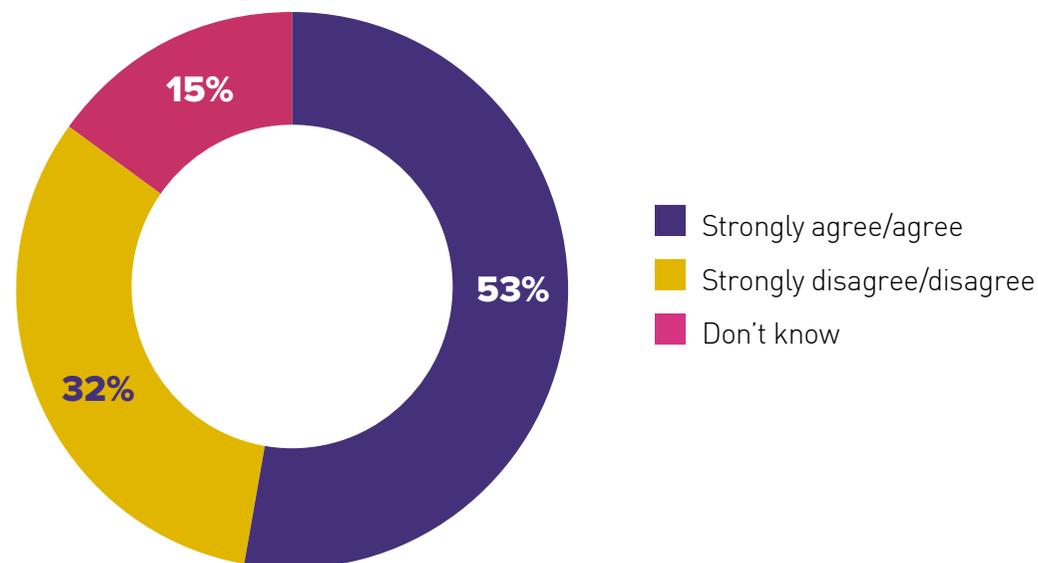
Elements of an ideal model of social care would include suitable housing, investment in training, technology enabled care, capacity building in communities, funding for community rehabilitation, and a shift away from crisis intervention to a much earlier more enabling, person centred, model of care.”

### What is high quality social care support and where do we find it?

The quote about self-directed support from one of the participants became a recurring theme in our engagement process. People recognised the ground-breaking legislation to introduce initiatives like self-directed support but were frustrated by both the pace and the variability of implementation. The recent report by Self-Directed Support Scotland (SDSS) and the ALLIANCE<sup>29</sup> provides evidence to back up the assertion. As the charts below show, only 53% of people felt prepared for their needs assessment and only 42% felt that they had all self-directed support options discussed with them:

### “I felt prepared for my needs assessment”

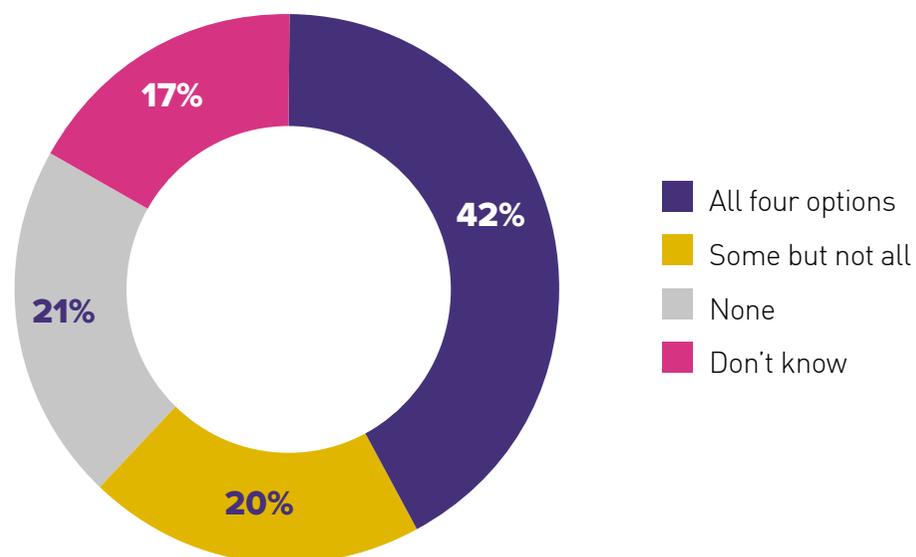
(My Support My Choice (Health and Social Care Alliance Scotland and Self-Directed Support Scotland, Chart 11)



## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

### “Discussing SDS Support with Professionals”

My Support My Choice (Health and Social Care Alliance Scotland, Chart 12)



We heard similar perspectives shared with us on the impact of the Carers Act. Furthermore, the Audit Scotland Report on progress with implementation of health and social care integration<sup>30</sup> explores a consistent set of themes, describing progress in some areas but a good deal of variability.

The underlying reason for these challenges lies in the fact that we have no systematic approach to implementation and improvement in social care support. One widely used system of improvement is built on five components, all of which we'll cover in the report (adapted from Langley et al, The Improvement Guide, 2009):

- ▶ **Establishing constancy of purpose;**
- ▶ **Gathering intelligence for improvement (establishing whether and how people's right and needs are being met);**
- ▶ **Taking a systems approach (seeing the interdependencies between the various parties);**
- ▶ **Planning for improvement (commissioning and investing in the right activities); and**
- ▶ **Learning from a portfolio of improvement programmes (a way to share learning across the country).**

<sup>30</sup> [Health and social care integration: update on progress | Audit Scotland \(audit-scotland.gov.uk\)](#)

## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

In chapter 2 of the report, we described what we believe to be the purpose of social care support in Scotland. Simply stating the purpose is not enough, however, to secure constancy in pursuit of the purpose. That needs an environment and culture that enable everyone in the system to contribute every day to the achievement of the purpose. We explored with people what might be the key elements of that supportive culture. Amongst the issues that were identified were: a focus on long term outcomes, an environment of co-operation and trust, valuing lived experience, replacing judgement with learning, and backing that up with a proper stewardship of our resources.

In the remainder of this chapter, we will set out recommendations for a system of improvement. We will propose how to close the implementation gap in a way that is rights based, systematic, planned, prioritised and continuous. But before we get to how we are going to improve, it is useful to spend some time on the question of what. Our remit specifies that we are to “recommend improvements to adult social care support in Scotland, primarily in terms of the outcomes achieved by and with people who use services . . .” In short, we are invited to improve quality. Don Berwick, former Administrator of the Centres for Medicare and Medicaid in the Obama Administration, describes quality as the degree to which the results of the work you do match the needs you intend to meet. What people have been describing to us as they talk about SDS etc., is a quality gap. This is how we go about closing the quality gap.

First, we need a workable definition of quality in social care support. A statement of its essential dimensions. There is already a lot to build from here. Principally (but not exclusively), we currently describe high quality social care support through 5 Health and Social Care Standards, 146 Standard Statements, 9 Health and Wellbeing Outcomes, and 23 Integration Indicators. Through a process of well-intentioned accretion, we have a situation now where we could not find a single shared definition of social care support. On the basis of our feedback from people receiving support and those providing it, we have created the following distillation of high quality social care which we recommend is deployed across the system to help understand people’s experience of social care supports, alongside measures of the kind recommended in Chapter 6, whether the person is receiving support to live at home or is in a care home:

### 6 Quality Dimensions

- ▶ **Accessible** – I get the support I have a right to receive when and how I need it.
- ▶ **Personalised** – I am able to direct my support and I am a full partner in its planning.
- ▶ **Integrated** – if I need care, it is joined up. I get the help I need to navigate.
- ▶ **Preventative** – my needs are understood and addressed at lower levels, they are anticipated and I have a plan for the future.
- ▶ **Respectful** – I can live with dignity and my voice is heard.
- ▶ **Safe** – I feel safe in my environment and free from harm.

# A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

## Creating the conditions for improvement – infrastructure and culture

There is an old Palestinian saying which goes something like “you can’t fatten a cow by weighing it”. It has shades of the recommendations made by W Edwards Deming<sup>31</sup>. As Deming points out, inspection is too late. The quality, good or bad, is already in the product or service. You cannot inspect quality into a product; instead you have to reduce the need for inspection on a mass basis by building quality into the product in the first place.

It is important to note Deming’s use of the term “inspection on a mass basis.” He doesn’t call for the elimination of inspection altogether, but rather for its reduction to the optimal level. Some inspection is always necessary, and is an important tool for gathering intelligence about what and how you are doing, as well as what needs to be prioritised for improvement. We also recognise and value the regulation role at individual practitioner and service levels. But wholesale reliance on inspection is seldom appropriate, and is costly in both time and money. And most important, inspection cannot always catch problems that are inherent in the system itself.

And yet, that is pretty much all we have in social care support a total reliance on external verification as a vehicle for improvement. It won’t work. It distorts our sense of who is the ‘customer’ away from the person in need of care and support towards the inspector and it inhibits the sharing of learning and innovation.

Our social care support system is crying out for the kind of step change that the Scottish Government made with the National Health Service back in 2007 when they introduced the Scottish Patient Safety Programme as a means to secure large scale national improvement in outcomes for patients. The programme has become a world leader, replicated across the world, and achieved a significant breakthrough in the quality and safety of the NHS in Scotland.

We recommend that creating a similar approach to national improvement in social care should be a key responsibility of the National Care Service. The National Care Service should utilize the intelligence generated from the Care Inspectorate’s work to identify a number of areas where national performance is currently falling short of our expectations. It should set aims for the improvement required then commission the Care Inspectorate and Healthcare Improvement Scotland to design and develop a collaborative improvement effort to generate the level of performance required. Those two organisations should engage with providers, people with lived experience and unpaid carers to agree a set of changes and build the necessary local improvement capacity and capability.

We recommend that just as Healthcare Improvement Scotland sits within NHS Scotland, so too should the Care Inspectorate be part of the National Care Service. We further recommend that it should work in partnership with Healthcare Improvement Scotland and the two organisations should create complementary functionality rather than compete or duplicate. In social care national improvement programmes, the Care Inspectorate can bring subject matter expertise and the quality improvement input can be provided by Healthcare Improvement Scotland.

31 W. Edwards Deming, *Out of the Crisis*, 1982

## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

Their role in the development of quality improvement activities will require a rebalancing of the Care Inspectorate's role, building on the current strategy, energy and direction of travel. It will be a key contributor to the quality planning that will be carried out in the National Care Service. Elsewhere in this report, we propose an important new role for the Care Inspectorate in relation to market oversight. In order to create space for these new functions, we recommend that the Care Inspectorate shifts some of its quality assurance activities to the Integration Joint Boards and to providers, involving people using services and carers in improvement and quality assurance work. The Care Inspectorate and Healthcare Improvement Scotland should be held jointly accountable for the planning and delivery of improvement programmes.

### Building capacity and capability

These new approaches and quality improvement methods will require a significant building of improvement capability at the point of social care support. Staff in care homes, for example, will need basic improvement knowledge. In addition, we will have to create some kind of quality improvement infrastructure for this work.

In order to manage the impact of the Covid-19 pandemic, the Chief Nursing Officer for Scotland and her team have led work to develop what they call a 'safety huddle tool' in care homes. This has generated daily intelligence on the current situation in all care homes across Scotland and has potential as an important building block for the kind of quality improvement infrastructure we might require.

In the United States, The Agency for Healthcare Research and Quality (AHRQ) is partnering with the University of New Mexico's ECHO Institute and the Institute for Healthcare Improvement (IHI) to establish a National Nursing Home Action Network. The network aims to provide training and mentorship to 15,000 nursing homes across the country via over 100 geographic hubs to increase the implementation of evidence-based infection prevention and safety practices to protect residents and staff. A similar model could be used to build on the success of the 'daily huddle'.

## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality



“We’re dying out there, my pals are dying out there and we are trying to get treatment but it’s hard to get treatment.”

### ▶ Robert Faulds

I had addiction issues and was on methadone for 18 years and I was a heroin addict for a couple of decades. It stole a good part of my life. Now I volunteer at the treatment centre, which helped me get clean and I also work a 12 step programme with a sponsor which has changed my way of thinking.

Having to go to the chemist *for methadone*, is brutal. Going through the door at the chemist made me feel like less of a person, a second class citizen. I had a terrible self-hatred, there was no exit strategy. I thought I would die in addiction and although I would have accepted that, I couldn’t accept it for my daughter, she never chose this situation.

We’re dying out there, my pals are dying out there and we are trying to get treatment but it’s hard to get treatment. I just needed some guidance, and the structure that Rainbow House, *a recovery service in Glasgow*, gave me.

I needed time to breathe and process the things that had gone on in my life. My life transformed in seven months. If I wasn’t for that service, I would likely be dead.

I now volunteer at Rainbow House and I plan to work in addictions, in the future. I’ve got a beautiful daughter and a lovely family and I believe my life is going to be good. A big part of recovery is hope. Most people don’t know what recovery is, we need to make it visible, we need to give it direction.

# A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

## Recommendations

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We make the following recommendations:

27. A National Improvement Programme for social care, along the lines of the NHS Patient Safety Programme, should be introduced by the National Care Service, and should address the three following key areas:
  - ▶ The experience and implementation of self-directed support must be improved, placing people using services' needs, rights and preferences at the heart of the decision making process.
  - ▶ The safety and quality of care provided in care homes must be improved to guarantee consistent, appropriate standards of care.
  - ▶ Commissioning and procurement processes must be improved in order to provide a vehicle for raising the quality of social care support and for enhancing the conditions and experience of the social care workforce.



# Chapter 8

## Models of care

## Models of care



A person-centred approach to social care support must be premised on ensuring citizens are able to fully exercise autonomy and choice in the supports available to them, which includes clear and defined resources directly available to citizens and a strong, healthy and diverse suite of support options tailored around the needs of local communities.”

We heard about some excellent examples of innovative work that is improving people’s experience of care and support while local systems maintain core supports and services. However, innovation seems usually to be the result of a combination of enthusiastic local leadership, availability of additional funding and willingness locally to change. We heard little to suggest consistent efforts to share learning, scale-up or spread approaches that work well. The current system seems to support local innovation rather than widespread improvement, which is why we have made specific recommendations about prioritising improvement programmes for self-directed support, and commissioning and procurement.

Examples of the kind of improvements that people are trying to make include:

- ▶ **Reducing use of institutional/residential care**
- ▶ **Making better use of adaptations and technology**
- ▶ **Involving people and their families more in decisions**
- ▶ **Including wider community supports in care**
- ▶ **Professionals working together better across traditional boundaries of health, social care support and other services such as housing.**

We have not called this chapter “new” models of care because Scotland has been committed to these approaches for the last 30 years. The problem is not that we do not have good ideas; it is that we have not acted on them at scale and with genuine commitment. We seem to rely too much on bottom-up developments that we expect to flourish without systemic support. We have summarised a few of the good ideas and good practice examples we have heard about over the last few months, below. This is by no means a comprehensive description of “what good looks like”. It is just an illustration that Scotland does not seem to be short of inspiration, and can learn from other places – but we have not bridged the gap between these good ideas and consistent access to the best quality social care supports for everyone.

## Models of care

### Reducing use of institutional/residential care

Given the demographic trends, including the projected growth in diagnoses of dementia, this needs urgent attention. We do not believe that the answer to those demographic challenges lies in building additional care homes. Most people say they would like to live in their own homes for as long as possible. Nonetheless, people told us that there is still an almost automatic default to care home care in some areas, particularly for frail older people. This observation is especially striking in light of our human-rights based approach: moving into a care home must always be the informed choice of the person requiring care and support. We are concerned that at times the emphasis on residential care for older people is counter to that fundamental right to choose and is sometimes suggested because care at home can be more expensive. Alternatives exist beyond the traditional choice of care home/care at home, a few of which we outline here.

We heard about extra care housing from Moray, Scottish Borders and South Lanarkshire. These combine private housing space with communal facilities, on-site care and dedicated nursing support. Fewer people with learning disabilities live in care homes, with most using Supported Living arrangements. Although designed for different needs, this model is not so different from extra care housing for older people: it enables the person with learning disabilities to live alone or with other people of their choosing, in their own home with an onsite team providing 24 hour support.

The Shared Lives model takes a different starting point, with approved carers welcoming adults who need day support or longer term care into their own home. This model is currently used, most extensively in Scotland in Fife, to support a range of people, particularly people with learning disabilities, but it could be extended to offer respite to unpaid carers of frail older people and utilised more extensively across Scotland.

For older people, there is also potential in a Home Share model, in which someone facing a housing challenge – for instance a younger adult or student – provides companionship and practical help with tasks like shopping and cleaning in exchange for low-cost accommodation. Arrangements like this are overseen by a management company for the protection and assurance of everyone involved.

As we find new ways of providing care at home for more people, there is likely to still be a need for facilities, where care at home is no longer suitable, that can provide extra care but are alternatives to hospital and residential nursing facilities. Innovative approaches are emerging for those adults and older people who have more complex needs, enabling them to remain in a more homely setting where extra care is provided. Close working between social care, health and housing services is needed to develop such services and there are good examples in Scottish Borders and Midlothian.

### Early intervention

We heard from Alzheimer Scotland that a more preventative and early intervention approach to dementia can sustain people in their own homes and communities for a longer period of time and result in a high quality of life for people who might otherwise have been institutionalised. The success of the post diagnostic support service that is provided for one year by professional and highly trained staff is undisputed and helps people recently diagnosed with dementia, along with unpaid carers and families, understand the illness, access supports and services, and to plan for their future – yet this is not implemented across universally across Scotland. Dementia friendly communities have been developed in a number of towns and cities but this too needs to be the norm rather than exception. The efficacy of this strategic approach has been clearly demonstrated through detailed evaluations, including powerful testimony from people with dementia, and their carers and families.

## Models of care

### Making better use of adaptations and technology

If our aim, as so often stated in Scotland, is to emphasise supporting people to stay in their own homes and communities for as long as possible, we must do more to improve and adapt those homes to support a better quality of life. Even minor adaptations can deliver significant improvements, particularly when combined with necessary repairs and home improvements, yet we heard that for some people the process of getting adaptations and improvements done is so complex that even professionals struggle to navigate it.

In this context, housing adaptations are often an investment rather than a cost, and we heard that it is helpful if clear arrangements are in place setting out where responsibility sits for paying for and arranging work. Similarly, Technology Enabled Care (TEC) in people's own homes can support greater freedom while also providing greater assurance. However, we know some people are concerned that the introduction of such technology may be used to reduce costs, particularly of overnight support and that reducing face to face support may increase loneliness. It is therefore suggested that the introduction of technology should be explored and discussed thoroughly as part of support planning, where the person's needs, rights and preferences should be paramount.

### Involving people and families more in decisions

The need to involve people who use services, their families and carers better and earlier in discussions about social care supports is one of the most consistent themes of this review and we discuss this particularly in Chapter 3 in relation to human rights. In policy terms, much has been written in recent years about the benefits of co-production and some people report a really positive experience. We heard about a couple of approaches that help support an inclusive approach.

In Falkirk, community-based Living Well centres offer appointments or access to a web portal where people can come in and have a conversation about their wellbeing, and health and social care supports, and access holistic supports, community-based supports and advice to help manage their own health and wellbeing. In Edinburgh, a Three Conversations model is being tried, which focuses on: a) really listening to what matters, so that connections can be made to resources already available in the community; b) understanding what needs to change immediately so that arrangements and a plan are put in place; and c) establishes what support or connections are needed for the person to continue to live their chosen life. This is early work, which is showing positive results at this stage.<sup>32</sup>

The "Esther" approach from Jönköping County Council<sup>33</sup>, in Sweden, is well known internationally, with its focus on delivering the best possible outcomes for a fictional older resident. Creating Esther helped professionals to map a range of care pathways and explore how these could be improved to best meet Esther's needs. A number of areas of Scotland have in recent years tried to take a similar approach, and a National Care Service should build on those examples to ensure a consistent focus in local systems on improvement through the eyes – and experiences – of people using services, their families and carers.

32 [Case study: Assessment and care planning – 3 conversations – SCIE](#)

33 [Case study 1: Jönköping County Council | The King's Fund](#)

## Models of care

### Prevention and community support

The role communities play in supporting adults to remain active in their community simply cannot be overstated. There are many community-led initiatives across the country that provide vital advice and support to adults and unpaid carers, for example through practical peer support, activities and outings. These community supports are often not recognised as part of a care package, but we heard that they can make a tremendous difference to people's quality of life and provide a clear sense of choice and control, including deciding how they spend their time to follow their passions and interests.

Again, there is positive work already underway upon which a National Care Service can build, working in close partnership with Integration Joint Boards, Local Authorities, NHS Boards and other Community Planning partners at a local level. Community supports should not be regarded as an optional add on. Experience during the pandemic has demonstrated just how crucially important community and social connections are to people of all ages and across civic society, and we saw the heroic effort of communities to support people who needed essentials such as food, pharmacy deliveries and socially distanced company. To be sustained, community supports do however need some form of infrastructure and funding – often fairly modest to develop and flourish. There is a network of third sector interfaces that provide a good starting point for this. Community supports are discussed further in Chapter 9.

Social connections are intrinsic to everyone's wellbeing – people who access social care as much as people who do not – and befriending networks can play a significant role in reducing isolation, improving quality of life and providing a gateway to other types of activity. Transport is an important matter for many people as it can inhibit or enable accessibility to a range of support - it was suggested to us that transport should be integrated into the care pathway. Peer support can have a very positive impact, especially for people with mental health problems and people with addictions. The Links Worker Programme<sup>34</sup>, which makes links between people and their communities through their GP practice aims particularly to mitigate the impact of the social determinants of health in people living in areas of high socioeconomic deprivation. There are opportunities, with leadership, investment and focus from a National Care Service, to develop approaches like these more and to support connections that make them more than the sum of their parts.

34 [Links Worker Programme – In the Community \[alliance-scotland.org.uk\]](https://alliance-scotland.org.uk)

“Digital advancements must be embedded in adult social care, however care must be taken to ensure that services remain person-centred.”

## Models of care



“What a buzz Laura gets when she realises that she has actually controlled a situation by vocalising what she wants!”

### ► Marion McArdle and daughter

My eldest daughter Laura is 37 years old and she has profound and multiple learning disabilities and complex health needs which means she needs maximum support with every aspect of her life.

Having a personalised budget has made huge positive changes in Laura's life. She is happier and healthier and she's able to communicate with us much more than she ever did before.

Previously Laura could have up to 42 different people in her life in one week. There was no way these people could get to know her well and so often Laura's limited communication was lost.

Now with Self Directed Support (SDS) Laura employs a small staff team of six people who know her so well and have time to understand what she is trying to communicate.

What a buzz Laura gets when she realises that she has actually controlled a situation by vocalising what she wants!

Before SDS Laura's days were regimented and timetabled to fit in with staff shift times and transport availability. Each morning Laura was washed, dressed and strapped in her wheelchair by 8.30 am regardless of what kind of night she'd had. I could see little chance of her ever reaching her full potential with these limitations.

Now every day is about what suits Laura and she has choice and control over her life and the opportunity to reach her potential.

Despite Laura's significant health problems we hardly ever need to see a doctor or social worker. This must have a huge cost saving. It seems like a win /win situation!

The SDS care package has worked so well, because whilst Laura's needs were being assessed the cost wasn't mentioned. I didn't want to think of Laura's life in terms of money. We got it right for Laura because the focus was always kept on Laura- not the budget!

## Models of care

In some parts of Scotland, such as Glasgow and East Ayrshire, community connectors provide a free confidential service to help people access activities, advocacy services, community transport; buddy support and volunteering opportunities. Sometimes these arrangements are embedded within GP practices.

On a similar theme, community brokers across Ayrshire provide information and support to help identify personal outcomes, develop and set up a funded package of support, connecting people to community activities and services. This service is free to the person accessing support: brokers are self-employed, local people who have some personal experience of directing their own support or that of a relative or family member, and now use that experience to help other people. They receive specific training including a new SVQ qualification.

### Professionals working together better across traditional boundaries of health, social care support and other services such as housing

We reflect elsewhere in this report on the need for better, faster, more consistent progress with integration of health and social care support. Again, there are areas where progress is really good. The Scottish House of Care Approach<sup>35</sup> has been widely used and adopted to encourage and promote GP input to care and support planning conversations routine for people with long-term conditions and support self-management – it provides a strong graphic and is easy to remember. In most GP practices across Aberdeenshire, GP-led Virtual Community Ward teams bring health and social care professionals together to identify, coordinate, organise and deliver services required to support people. The team provides short-term integrated solutions within the community as an alternative to more-resource-intensive community and acute hospital admissions. As well as reducing hospital admissions teams have felt a positive impact of the approach in building multi-disciplinary relationships, better use of resource with less duplication, quicker access to interventions and a move to more holistic and person centred care.

### Developing the provider network

As well as professionals working together in new and innovative ways, we believe that social care providers should be supported to develop networks of mutual support. The development of alliance based commissioning, provider co-operatives, user-led and community-owned organisational models, and social enterprise models, should be encouraged to help improve quality, flexibility, resilience and responsiveness to people's needs.

All of the above are good examples, but they are not enough. Neither in terms of ambition nor scale are they sufficient to address the challenges adult social care support needs to meet in order to improve the experience of people using it. We believe that a stronger national approach, coupled with local ownership of innovations, is needed to deliver improvements and instil a real learning culture in social care support in Scotland.

35 [The House of Care Model – Health and Social Care Integration \(alliance-scotland.org.uk\)](http://alliance-scotland.org.uk)

## Models of care

Scale-up and spread of innovation is challenging. The idea that new ideas or promising practice can just be ‘rolled out’ is a fallacy. Large scale implementation of innovation needs leadership, design and contextualisation. Given the current variability in the system, we suggest it is necessary to establish additional national capacity for harvesting ideas and preparing the ground for implementation in a National Centre for Social Care Support Innovation. In this regard, the future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service should be considered.

### Recommendations

**We have identified key priorities to realise, consistently and at scale, Scotland’s ambitions to deliver social care services and supports that maximise people’s wellbeing and independence:**

28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible.
29. A national approach to improvement and innovation in social care is needed, to maximise learning opportunities and create a culture of developing, testing, discussing and sharing methods that improve outcomes. The future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service must be considered.
30. There must be a relentless focus on involving people who use services, their families and carers in developing new approaches at both a national and local level.
31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies.



# Chapter 9

## Commissioning for public good

## Commissioning for public good



If the commissioning and procurement model is to be maintained, there is a need for the introduction of more ethical commissioning models that take into account factors beyond price, including fair work, terms and conditions and trade union recognition.”

Over the course of the independent review there can be few things we heard more people speak about than commissioning, even if only in passing, and the need for it to be radically overhauled. Many people and organisations believed if it was done differently and altogether better that commissioning would provide the bedrock for a fairer, rights based, improved social care support system with a relentless focus on quality, outcomes, participation and collaboration. This would drive up standards and improve outcomes for people using services and supports, and the experience of social care support staff. This is one area where the proposal for a new social covenant rehearsed earlier in this report could bear fruit. The current approach to commissioning and procurement is characterised by mistrust, conflict and market forces. We need to radically redesign commissioning and procurement around the common good and stewardship of public money.

An improved approach to commissioning would change how procurement works. Care planning would be based to a lesser extent on costs and more on a range of factors. These could include, for instance, terms and conditions of the workforce, investment by providers in training and support for staff and in the fabric of buildings, flexibility and adaptiveness of services and people’s experience of the quality of care. We were sympathetic to the view expressed by many people that procurement arrangements with providers should include requirements for the investment of a proportion of any profit made in improving the quality of care, and in staff terms and conditions.

Although spoken and written about often, not everyone has a shared understanding of what commissioning is. In Scotland, we used the term strategic commissioning to mean medium to long term planning that determines the choice of services and supports to meet individuals’ needs, rights and preferences to live independently or as independently as possible. This must be underpinned by a robust strategic needs assessment of the whole population that is then segmented to understand the range of local needs, such as those of people from a particular geography or care group. This process is undertaken skilfully and expertly in some parts of Scotland but it is not yet consistent and is not always having the desired result on improving care and support because of the translation from strategy to delivery and the continuing dominance of a competitive social care market. Reformed Integration Joint Boards must give priority to making changes in how commissioning and procurement is undertaken supported appropriately by a national improvement programme.

# Commissioning for public good

## Collaborative commissioning and procurement

As outlined in Chapter 1, commissioning is not synonymous with procurement but procurement can result from the commissioning process, i.e. identify the need to purchase a service from a provider or range of providers to meet identified needs. Over the last 10 years and more in adult social care support, procurement methodology and practices have increasingly driven and occasionally undermined commissioning decisions, where price and a competitive market environment, characterised by competitive tendering between providers, dominates.

We want to see an end to this emphasis on price and competition and to see the establishment of a more collaborative, participative and ethical commissioning framework for adult social care services and supports, squarely focused on achieving better outcomes for people using these services and improving the experience of the staff delivering them. By shifting emphasis in this way we believe Scotland can deliver social care supports more fairly and more sustainably.

We would like to see the split between commissioners and providers narrowed so that we can get the expertise of both, foster innovation, and engage people with lived experience more productively. In return for a seat at the commissioning table, we expect providers to be accountable for new standards of accountability, quality, staff wellbeing and transparency.

Professionals leading commissioning processes are often good at involving people with lived experience, carers, local communities, providers and other professionals to develop the large scale strategic commissioning plans that are statutorily required from Integration Joint Boards, for and with their local populations. We want to see this level of engagement and participation at all levels of commissioning from the strategic planning end of the spectrum through to any procurement of individual services and supports. And we want to see the decisions taken by social workers on people's care needs decoupled in the first instance from questions of affordability. We are not suggesting that it will be possible to meet every need nor that costs do not matter, but we believe assessment should be the product of a full understanding of the individual's needs, rights and preferences, and that when that assessment is translated into a package of supports any unmet needs should be recorded.

People with lived experience told us they want to be more involved, not just in the planning of their own care, but in the planning and design of services and they self-evidently have much to offer in this regard. In some instances peer groups, such as Disabled Persons' Organisations, Collective Advocacy Agencies and other representative groups, can play a very valuable role too.

There are alternative models of commissioning and procurement, including Public Social Partnerships and Alliancing, that are tentatively and selectively being adopted in various parts of Scotland. While these have not been wholly successful in changing prevailing practice, and we heard many have been too complicated and taken too long, we think they, along with other models, offer the opportunity to move away from competitive tendering. In some instances, the whole model of Alliance contracting has not been adopted but the principles have been fully embraced and applied but attention needs to be paid to the timescales for establishing such arrangements and must not take years to set up. New models of procurement need to be adopted more rapidly across services and alternative models put in place across different kinds of services and supports, and across Scotland.



## Commissioning for public good

We do not underestimate the immense culture change implied by what we have set out above. We firmly believe that without radical change and a more collaborative and ethical approach to commissioning adopted at all levels, we will see the disparity between what people require and what they actually get continue to grow, alongside levels of dissatisfaction and people not achieving their desired outcomes or reaching their potential. Costs will spiral, and services will become less sustainable and quality will decline further, which we can avoid by taking decisive action.

People want choice and control in self-directed support options to be a reality, not a slogan, so that they can be supported to live their lives in the way they determine not the way services or commissioners choose.

The Coalition of Care and Support Providers (CCPS) has been working on alternatives to the way that social care support is planned, purchased and funded in Scotland, in close partnership with supported people and support providers, and drawing on academic research. It has developed a number of “Big Ideas”<sup>38</sup> – one of which calls for a pause button to be pressed on the current procurement system to support the move from a competitive process and culture to a collaborative approach. We think this idea has considerable merit but that it needs close consideration for any unintended consequences and careful planning to ensure it does not impede anyone’s care and support. In particular, its success will be entirely dependent on delivering the recommendations for a national improvement programme we set out in Chapter 7. It should be a priority for a new National Care Service.

“Competitive tendering destroys the very relationships that are crucial to success in social care.”

38 [BIG Ideas \[ccpscotland.org\]](https://ccpscotland.org)

# Commissioning for public good

## Care homes

During the Covid-19 pandemic, a great deal of attention has rightly been given to care homes. A previously creaking and fragile system has been exposed, particularly in regard to infection prevention and control (IPC). We know from research<sup>39</sup> that those care homes that have successfully minimised outbreaks of Covid-19 have been smaller, locally run and staffed services, that are part of the local social care ecosystem, operating in partnership with other local services and commissioning bodies. Arrangements have been put in place in each Local Authority area to directly and indirectly support and nurture improved standards of IPC, with increased clinical oversight provided by Directors of Public Health and Directors of Nursing, alongside professional support from Chief Social Work Officers and IJB Chief Officers to ensure a focus is simultaneously maintained on people's wider wellbeing as well as adult support and protection issues.

The safety huddle tool referred to in Chapter 7 has meant that for the first time ever a standard data set is available in real time about each and every care home in Scotland. This data is available to local systems and at a national level, and is helping to ensure support is provided at as early a stage as possible to care homes to ameliorate and better manage risks for residents, staff or the whole care home, identified through use of the tool. This approach has wider implications and opens possibilities to a more partnership-based approach to improvement in care homes, which is not reliant on the Care Inspectorate using its regulatory powers but instead focuses on the priority we heard expressed that local ownership of improvement work needs to be nurtured and supported.

Generally, care homes are not part of a managed market or commissioned set of services. The care home market is largely led by business decisions made by individual care homes or groups of care homes, some of which are large multinational companies. There is currently no oversight of this market and we believe there is an enhanced role for the Care Inspectorate as part of its regulatory activity to undertake this work, drawing on existing work and expertise. A more actively managed market should be shaped and facilitated to respond to a longer term strategic vision that takes into account the balance of providers in the market and local needs, for example, by requiring engagement with Integration Joint Boards before a service can be registered. In this role the Care Inspectorate would provide information and assurance to the National Care Service and to local systems about care home provision.

The extent to which some privately-run care homes yield profits for their shareholders was raised with us repeatedly as an issue of concern<sup>40</sup>. We have reflected on whether nationalisation is practical, desirable or affordable elsewhere in this report. We nonetheless want to record here that we share the unease expressed by many about whether it is right – in a country committed to health-care free at the point of need to all of its citizens, regardless of age or any other characteristic – that an important part of our care system is largely run on a profit-making basis.

39 [Discharges from NHSScotland hospitals to care homes 28 October 2020 – Data & intelligence from PHS \(isdscotland.org\)](#)

40 <https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/>

## Commissioning for public good

Our principle concern is not with profit itself, which plays an important function in any market economy, but with what we have come to think of as “leakage” from the care system in Scotland. Significant sums leave the care economy, some of which could be better used to raise standards of care and terms and conditions for staff. We therefore recommend that the National Care Service should take these concerns into account as part of its development of a new approach to ethical and collaborative commissioning. National contracts, and other arrangements for commissioning and procurement of services must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.

Care home placements are currently purchased by Local Authorities on an individual basis at a price set through annual negotiations on the National Care Home Contract. This contract is in urgent need of reform so that the focus on the price payable per placement does not undermine the vital focus on achieving good outcomes for people and ensuring high quality care is delivered to care home residents, and staff enjoy the benefits of fair work requirements being fully delivered.

Finally, care homes should be supported fully by primary care and integrated health and social care support teams. Access to the NHS is a universal right in Scotland, provided free at the point of care for everyone. We heard that some care homes have excellent support from local primary care practitioners including GPs, and integrated health and social care support teams, but others do not: there can be no justification for denying healthcare to care home residents on the basis of their place of residence. Addressing inequities like this should be a priority for the new National Care Service.

## Commissioning for public good



Living in a good care home is so much better than sitting at home alone and struggling.”

### ▶ Helen Morrison Care Home Resident

I have been living for several years in a wonderful care home, run by the council in South Lanarkshire. I couldn't be happier. The staff do everything for me, I don't need to worry about anything and even during the pandemic I feel so safe because we are so well looked after. We have a hairdressers, a cinema and a lovely café and I am surrounded by friends. The staff are really committed to making sure we have everything we need. I don't think the staff are paid enough for what they do. They have a really difficult job at times and they never complain, they just get on with it and work so hard, particularly dealing with the Covid situation. They are worth their weight in gold.

I know some people dread the idea of going into a care home but it's been a wonderful move for me. I would urge people to look into the care and help that is available. Living in a good care home is so much better than sitting at home alone and struggling. Nothing would persuade me to move from here. It really is my home and I love it.

# Commissioning for public good

## Recommendations

We have identified a range of changes needed in commissioning and procurement practices:

32. Commissioners should focus on establishing a system where a range of people, including people with lived experience, unpaid carers, local communities, providers and other professionals are routinely involved in the co-design and redesign, as well as the monitoring of services and supports. This system should form the basis of a collaborative, rights based and participative approach.
33. A shift from competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace across Scotland. Commissioning and procurement decisions must focus on the person's needs, not solely be driven by budget limitations.
34. The establishment of core requirements for ethical commissioning to support the standardisation and implementation of fair work requirements and practices must be agreed and set at a national level by the new National Care Service, and delivered locally across the country.
35. To help provide impetus and support to the adoption of a collaborative and ethical approach to commissioning, the idea from CCPS of pressing pause on all current procurement should be fully explored in the context of a National Care Service, with a view to rapid, carefully planned implementation.
36. The care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role. Consideration should be given by the National Care Service to developing national contracts for other aspects of care and support. A 'new deal' must form the basis for commissioning and procuring residential care, characterised by transparency, fair work, public good, and the re-investment of public money in the Scottish economy.
37. National contracts, and other arrangements for commissioning and procurement of services, must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.
38. A condition of funding for social care services and supports must be that commissioning and procurement decisions are driven by national minimum quality outcome standards for all publicly funded adult social care support.
39. A decisive and progressive move away from time and task and defined services must be made at pace to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes, to have a good life and reach their potential, including taking part in civic life as they themselves determine.
40. Commissioning decisions should encourage the development of mutually-supportive provider networks as described above, rather than inhibiting co-operation by encouraging fruitless competition.
41. Commissioning and planning community based informal supports, including peer supports, is required to be undertaken by Integration Joint Boards and consideration of grant funding to support these is needed.



# Chapter 10

# Fair Work

## Fair Work

“The carers that came in were worth their weight in gold and should be rewarded or acknowledged for this.”



While carrying out this review we heard from many people about their experiences of working in social care. We also met representatives of the workforce, including trade unions, and employers.

We heard much that is impressive, heart-warming and uplifting about the commitment of the workforce to supporting people who use social care support. But we also heard much about a workforce that is undervalued, badly paid for vital, skilled work, held in low esteem in comparison particularly to the health workforce, poorly supported in terms of learning and development, and generally under-represented.

The social care workforce in Scotland is so notably disadvantaged because it is highly gendered. The sector is about 83% female. Were it 83% male, it simply would not be marginalised and undervalued as it is. The consequences of this are obvious, and highlighted by the pandemic. Turnover is high at roughly 30% p.a.<sup>41</sup>, recruitment is challenging and it is difficult to maintain and improve standards when investment in training and development is low.

We recognise that efforts are underway to improve the situation. We are not the first to listen to the challenges facing the social care workforce and as we have carried out our review we have been careful to understand progress made by the Scottish Government to realise its ambitions on fair work and gender equality at work<sup>42</sup>, and as part of its programme to reform adult social care support, which was launched in June 2019 and includes a commitment to ensuring the workforce is valued and skilled<sup>43</sup>.

41 [Scottish Social Services Council Data | SSSC](#)

42 [Fair Work Action Plan – mygov.scot](#)

43 [Social care: Reforming adult social care support – gov.scot \(www.gov.scot\)](#)

# Fair Work

## Fair Work

In February 2019, the Fair Work Convention published its report *Fair Work in Scotland's Social Care Sector*<sup>44</sup>. The report called for urgent reform to improve the quality of work and employment for the 200,000 people who work in social care support in Scotland. It made five recommendations, as follows:

- ▶ **A sector-level body should be established by the Scottish Government with responsibility for ensuring that social care workers have effective voice in the design, development and delivery of social care services.**
- ▶ **Key stakeholders should develop and agree appropriate minimum contract standards for the provision of publicly-funded social care services, consistent with the Fair Work Framework and the Scottish Government's Fair Work First initiative.**
- ▶ **Commissioning practices should be overhauled to ensure that fair work drives high quality service delivery through the adoption of both minimum contract standards and through engagement at a sector level between purchasers, providers and deliverers of social care services.**
- ▶ **Key stakeholders in the social care sector should apply the Fair Work Framework and commit to improving pay, conditions and opportunities for progression for directly employed care workers and for Personal Assistants.**
- ▶ **The Scottish Government should support delivery of these recommendations, and incorporate them into their Fair Work Action Plan and Gender Pay Action plan. A central location within Scottish Government's Health and Social Care Directorate should coordinate policy for the social care workforce, integrated with workforce strategies for the health workforce, and support delivery of these recommendations through its own Fair Work action plan.**

In August 2019 it was agreed that the Social Care Living Wage Implementation Group, whose membership comprises representatives from Scottish Government, COSLA, Integration Authorities, third and independent sector providers and the Scottish Trade Union Congress, would be renamed the Fair Work in Social Care Implementation Group and would focus on implementation of the report's recommendations. The Implementation Group is chaired by Andy Kerr of the Piper Group and is due to report to Scottish Ministers in February 2021.

We agree with all of the recommendations of the Fair Work Convention and support their rapid implementation when the work of the Implementation Group is complete. We recommend that the Scottish Government set an ambitious implementation timetable to ensure progress and momentum.

In setting that timetable, we recommend that priority is given to the establishing of the sector level body as a means to take forward the Fair Work recommendations in partnership. That body should also take the lead in creating national sector level collective bargaining of terms and conditions.

44 [Fair Work in Scotland's Social Care Sector 2019 – The Fair Work Convention](#)

# Fair Work

## Valuing the workforce

Throughout our review we have heard that the social care workforce feels undervalued and under-recognised. The inclusion of social care staff, alongside their health colleagues, in the recent announcement of bonuses in recognition of their work during the pandemic will help here but there is a deeper underlying sense that social care workers have not had parity of esteem with their NHS counterparts. The recommendations made below for training and development opportunities are designed to tackle this issue. However, it will also be necessary to consider some basic terms and conditions on issues like sick pay, time-off, and travel time. But at the root of the sense of value is pay. Social care staff do not feel valued in relation to the work they do. They pointed us to numerous comparisons in the retail sector where an entry level position paid more than an experienced care worker could secure. In order to establish the true value of the skills, competences and responsibilities of social care, we propose that a national job evaluation programme is undertaken.

## Workforce Planning

There is currently no national oversight of workforce planning for social care in Scotland. With many different employers in Local Authorities and the third and independent sectors, and only very limited, recent, arrangements for mutual support, current arrangements make it too hard to ensure appropriately skilled staff are trained, supported, employed and available in the right place at the right time. Experience during Covid-19 has shown us how difficult it is to deploy appropriate staff quickly when there is an urgent priority to meet. Longer-term, problems result from failure to plan ahead for training, recruitment and retention, and failure to work with partners in health and housing in particular to model innovative new approaches that depend on the availability of a suitably trained workforce who understand each other's contributions.

Given both the size of the workforce and its importance to people's wellbeing, this lack of planning, and resulting lack of resilience and flexibility, needs to be addressed. Some workforce planning is undertaken centrally for the NHS in Scotland, but there is plenty of scope to take a holistic approach across health and social care support and improve for both.

“Without tackling the chronic low pay and gendered undervaluation of social care work itself it will not be possible to attract and retain a quality workforce or to deliver substantive improvements in the quality and provision of care.”



## Fair Work

As noted in Chapter 6, workforce planning should be a priority for a National Care Service. An adaptive and nuanced approach will be important as it will not simply be seeking to meet the staffing requirements of local delivery agencies. It will need, for instance, to be supportive of, without taking over, employment arrangements between Personal Assistants and people who use a direct payment under self-directed support Option 1. As well as enabling training for Personal Assistants one suggestion is that a national workforce planning function could establish bank arrangements for Personal Assistants who are available to support people either on an ad-hoc or more permanent basis. Social care needs workforce planning support that is equal to, but not the same as, that provided to the NHS in Scotland, so that it addresses individual requirements like this as well as helping plan for the resilience of small, medium and large providers.

### Commissioning and Procurement

We cover commissioning for the public good in Chapter 9. A key priority for a National Care System should be to establish mandatory parameters within which adult social care is commissioned and procured by Integration Joint Boards, including minimum fair work standards for social care.

As part of this, the Scottish Government should review national commissioning and procurement policy and guidance to support the delivery of these mandatory parameters in commissioning and procurement decisions delivered locally by Integration Joint Boards.

### Training, development and regulation

Significant improvements are needed in training, development and regulation of the workforce, and commitment by employers to workforce development should be a key feature of revised commissioning and procurement arrangements.

As part of the National Care Service, described in Chapter 5, the Scottish Government should establish a national organisation for training and development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development, with appropriate read-across to shared and reciprocal learning with the NHS workforce.

The Scottish Social Services Council (SSSC) has an important role to play in this, along with NHS National Education Services (NES). Neither is currently equipped to meet the needs of the social care workforce in full. A priority for the National Care Service should be to review the role, functions and powers of the SSSC, taking account of activities that could be more effectively carried out in close partnership with NHS NES. This is an important example of a priority task for joint working between the National Care Service and the National Health Service. At the same time, care must be taken not to “medicalise” social care and social work training: what is needed here is better joint working, and joint support, for professionals without losing the core integrity of professions that have developed over many years in different ways in response to different priorities.

Specific attention should be paid to developing professional support and supervision for people who often work in isolation from their peers, providing care and support in people’s own homes and communities. Scotland needs to acknowledge and respond to the power of the workforce in these circumstances to transform people’s lives for the better, to celebrate that contribution and embed a professional culture to support it. The unique importance of relationships and trust between people providing care and people using support as part of their lives should be central to our understanding of “what good looks like” in this respect.

## Fair Work



### ► Carmen Simon

I'm a woman migrant worker. I have been a support worker for adults with multiple/complex needs since 2011. I currently juggle four part time jobs, two of them still in the field of adults with complex/multiple needs.

In one of my social care roles as a Support Worker for a private provider I get paid £10 an hour, the same hourly rate since 2015. In my other social care role as a Personal Assistant, Option 1 Self Directed Support (SDS), I get paid £9.30 an hour. I rely on benefits to make ends meet at the end of the month.

I've been helping someone with complex/multiple needs to access support through SDS since 2015. After six assessments and two complaints against the local authority, this person who has met substantial and critical criteria to access support, is still waiting on a care package. I am aware of another two adults with complex needs that have died waiting on a SDS care package. The current provision of adult social care has been in crisis long before the pandemic, as described by the Fair Work Convention Report On Social Care 2019. I think that a National Care Service is the way forward. Publicly owned and free at the point of need. The implementation of such a system will require time and investment. In the meantime, as a matter of urgency, I think that we should improve terms and conditions for care workers through sectoral collective bargaining and the involvement of all stakeholders: the Scottish Government, Local Authorities, employers and unions.



The current provision of adult social care has been in crisis long before the pandemic, ... a National Care Service is the way forward.”

## Recommendations

Our recommendations for creating a National Care Service provide a mechanism for delivery of Fair Work in social care and support. To improve terms and conditions for the social care workforce, and to properly reflect the value social care brings to Scotland's economy and wellbeing of its people, we recommend:

42. Rapid delivery of all of the recommendations of the Fair Work Convention, with an ambitious timetable for implementation to be set by the Scottish Government.
43. Conduct a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles. This should take account of skills, qualifications, responsibilities and contribution.
44. Putting in place national minimum terms and conditions as a key component of new requirements for commissioning and procurement by Integration Joint Boards. Specific priority should be given to pay, travel time, sick pay arrangements, training and development, maternity leave, progression pathways, flexible pathways and pension provision. The national evaluation of terms and conditions should be undertaken to inform these minimum standards and these should be reviewed as required.
45. Establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development. The current role, functions and powers of the SSSC should be reviewed and appropriate read-across embedded for shared and reciprocal learning with the NHS workforce.
46. Establishing a national forum comprised of workforce representation, employers, Integration Joint Boards and the Scottish Government to advise the National Care Service on workforce priorities and to take the lead in creating national sector level collective bargaining of terms and conditions.
47. National oversight of workforce planning for social work and social care, which respects the diversity and scale of employment arrangements while improving resilience and arrangements for mutual support should be a priority for a National Care Service.
48. The recommendations listed above should apply to Personal Assistants employed by people using Option 1 of SDS, who should be explicitly recognised as members of the workforce, as well as employees of providers in the public, third and independent sectors. This recommendation should be delivered in full partnership with the independent living movement.

# Chapter 11

## Finance



# Finance

“The key issue affecting the social care sector is lack of funding.”

As we said at the beginning of this report, we have deliberately not started with finance. We felt it was vitally important to conduct this review from the perspective of people’s experience of adult social care support, and the role adult social has to play in Scotland’s wellbeing as a whole.

Nevertheless, we must come to money in the end. The proposals we have set out here do not come without cost: but nor are they only about cost. There is clear evidence that social care support is not a drag on our resources; it creates jobs and economic growth. It enables people who access care and support, and their carers, to seek and hold down employment themselves. Accordingly, a major thrust of this section of the report is to describe the investments required to create a system of social care support that will enable everyone in Scotland to get the social care support they need to live their lives as they choose and that promotes and ensures human rights, wellbeing, independent living and equity. As we consider money, we want to reiterate the importance of replacing old thinking with new thinking. Investing in people is beneficial to society: it is an investment in ourselves and one another. As a system, we need to consider investment choices through the constructive, empowering focus of a new mindset:

| Old Thinking                               | New Thinking                                |
|--|---|
| Social care support is a burden on society | Social care support is an investment        |
| Managing need                              | Enabling rights and capabilities            |
| Available in a crisis                      | Preventative and anticipatory               |
| Competition and markets                    | Collaboration                               |
| Transactions                               | Relationships                               |
| A place for services (e.g. a care home)    | A vehicle for supporting independent living |
| Variable                                   | Consistent and fair                         |

# Finance

In this chapter we set out a brief analysis of current expenditure on adult social care; opportunities to spend money better; our recommendations for additional investment; the evidence to support our assertion that that expenditure is itself an investment; and finally some options for raising money to support these changes. We have by necessity used a number of proxies in this assessment to help us “size” the level of investment we think is required. These proxies are often not ideal: for instance, delayed discharge is in many ways an “old thinking” measure, but we have used them here as the best mechanism available to us to understand what needs to happen.

## Current expenditure on adult social care

In 2018/19 expenditure on formal adult social care in Scotland was £3.8bn:

- ▶ **Most funding came from the public sector (84%), with the balance from individuals through Local Authority service charges and self-funding of care home places by residents.**
- ▶ **Almost two thirds of expenditure was on services for older people.**
- ▶ **There was marginally more expenditure on community based services (54%) than on accommodation based services.**

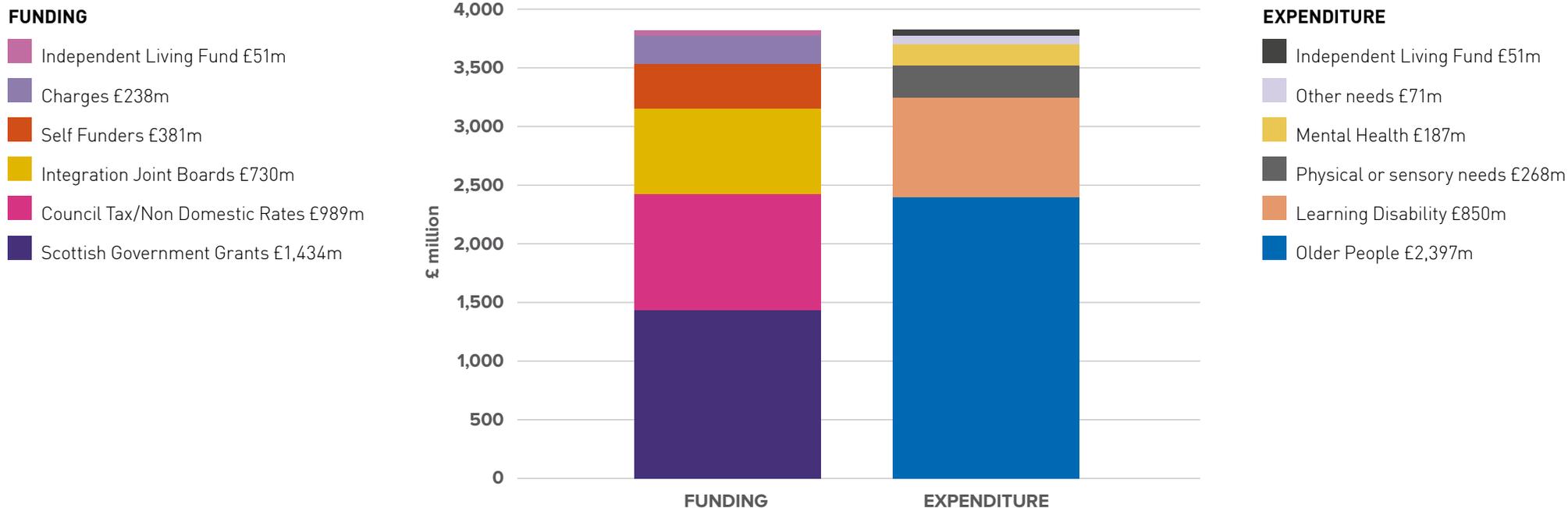
In addition, the economic value of the contribution made by carers is estimated to have been £36bn<sup>45</sup>.

“Social care is not funded in a way which is sustainable or supports transformation of services.”

45 [Unpaid care work worth £36bn in Scotland – Oxfam Scotland \(oxfamapps.org\)](#)

# Finance

Total adult social care funding and expenditure of £3.8bn are illustrated in this chart:



Most of the funding came from the public sector (84%) with the balance coming from individuals through Local Authority service charges and self-funding care home residents.

Related expenditure, on community based health services and unplanned hospital care, which are under the control of Integration Joint Boards, totalled £6.1bn in 2018/19.

The proposals we have set out earlier in this report relate to total health and adult social care expenditure of Integration Joint Boards.

In 2020/21 the Scottish Government became responsible for social security payments, with budgets for adult benefits totalling £3bn. There is considerable overlap between people who use social care supports and people who access benefits, but not everyone who uses one uses the other.

# Finance

## Opportunities to spend money better

Costs arise in our current system because social care supports are often too focused on crisis management and late intervention, and not enough on prevention and empowering people to live fulfilling lives. Costs like these are borne not only by the public sector, but also by people who use social care support<sup>46</sup> and their families and carers, and many are avoidable. We have not carried out an extensive analysis of these costs, but we have looked at examples that we recommend a National Care Service should consider carefully for opportunities to improve. We are not suggesting that the money spent on these areas of activity is currently wasted: we are suggesting that with more effective care planning and delivery it could in some instances be put to better use to support people more effectively:

- ▶ **Delayed discharges accounted for 542,000 bed days in 2019/20, i.e., 8.9% of all beds in NHS Scotland, costing £134m<sup>47</sup>. We know that being delayed in hospital when someone is ready to go home is bad for their wellbeing.**
- ▶ **There is significant variation in the length of time people spend in hospital in the last six months of their lives. In some circumstances, hospital care is exactly right for people nearing the end of life. In other cases, more time could be spent at home, which is what many people want, if better support were available. The average length of stay in hospital in the last six months of life varies by 66% across Integration Joint Boards. In total, hospital care in the last six months of life amounted to 1.1m hospital bed days in 2019/20, i.e., 19% of all beds<sup>48</sup>.**
- ▶ **Similarly, there is significant variation in models of care and hospitalisation rates for people with dementia<sup>49</sup>, the costs of which in total are £2.6bn per year<sup>50</sup>.**
- ▶ **In 2019/20, £58m was spent on out-of-area care home placements for adults with learning disabilities, for reasons other than choice, at a median cost per placement of over £87k<sup>51</sup>.**
- ▶ **Waiting times for adult social care carry a significant burden for people who need support. In 2017/18 the proportion of people with substantial or critical needs waiting more than six weeks for a community care assessment was 7% and 8% respectively<sup>52</sup>. Recent analysis suggests that in 2018/19, older people had 20% fewer unplanned admissions to hospital in the six months after receiving homecare support than in the six months prior.**

46 Follow the money. [www.carereview.scot](http://www.carereview.scot)

47 [Annual summary of occupied bed days and census figures – data to March 2020](#)

48 [Percentage of end of life spent at home or in a community setting. PHS](#)

49 [Care co-ordination in Midlothian report | Focus on Dementia | ihub – Care Co-ordination in Midlothian report](#)

50 [Projections of older people with dementia CPEC Nov 2019](#)

51 [Coming home: complex care needs and out of area placements 2018 – gov.scot \(www.gov.scot\)](#)

52 [Eligibility criteria and waiting times – gov.scot \(www.gov.scot\)](#)

# Finance

## Additional investment

In this section we cover a number of areas in which we believe additional investment in adult social care is needed.

### Expanding access to social care support and investing in prevention

Despite the fiscal effects of austerity in recent years, Integration Joint Boards and Local Authorities have increased expenditure on adult social care in real terms since 2009/10 by 7% in total and by 5% per capita. This is in contrast to the position in England, where expenditure fell in real terms by 1% and 6% respectively<sup>53</sup>.

As the older population has increased and resources have been focused increasingly on those in greatest need, a smaller proportion of the adult population is in receipt of social care support than was before austerity, with the result that the needs of a number of people are probably not being met and for others they are being met in a crisis response rather than to anticipate or avoid such interventions. Some of this reduction may reflect substitution of formal services with asset based approaches<sup>54</sup>, and some may be the result of genuine reduction in need as other supports have improved people's lives, but this is difficult to quantify. As approximate as the evidence available to us is, it nonetheless suggests to us that there is an opportunity to invest more than we do currently in preventative care that can yield benefits for individuals and the system as a whole.

To assess the extent to which there are opportunities for better investment in social care support, the Scottish Government is currently carrying out a detailed analysis exploring the determinants of social care service use across data-zones. This is important work and we are reassured that it is underway. Its results are not yet available so for the purposes of this report we have carried out a higher level assessment as follows:

- ▶ **A longitudinal analysis that used 2009/10 service use data to calculate the expected number of people using social care support in 2018/19, and compared those to the actual number.**
- ▶ **An analysis of variation across Integration Joint Boards to calculate the expected number of people using social care support in 2018/19 based on standardised Scottish average rates (i.e. adjusted for differences in age/sex and morbidity and life circumstances), and compared those to the actual number.**

We found that there were 25,505 fewer people (20%) receiving care in 2018/19 than expected based on 2009/10 levels of access. We estimate that it would cost around £288m to cover that "gap". In addition, there were 10,412 fewer people (10%) receiving care in 2018/19 than expected based on the standardised rates. We estimate that it would cost around £148m to cover that "gap". With the caveats noted above regarding the difficulty of interpreting this data, we therefore estimate that there may be approximately 36,000 people in Scotland who do not currently have access to social care support and for whom it would be beneficial, and that it would cost about £436m to meet this need. We recommend investment in social care is increased in order to expand access to social care support.

We have discussed elsewhere the importance of community connections and low-level preventive support for people, and suggested that Integration Joint Boards should commission and grant-fund community organisations.

53 [Social care 360: expenditure | The King's Fund](#)

54 [ADASS Budget Survey 2019](#)

# Finance

## Fair Work

Our recommendations include implementing the findings of the Fair Work Convention. Investing in Fair Work is an investment in Scottish society, which helps to drive national and local economic growth as well as, in this context, a fair reflection of the importance of the work done in social care supports. We make a clear link between the importance of remunerating the workforce fairly, commissioning social care support ethically and collaboratively, and making good use of available public resources.

We have calculated the costs we anticipate associated with increasing the Real Living Wage to £9.50 per hour, along with ensuring it is paid to all staff working in adult social care support. Increasing the Real Living Wage to £9.50 per hour for frontline adult social care staff would cost £15.5m p.a.. This estimate includes staff working in care homes, home care and housing support, day-care, adult placement services, personal assistants and sleepovers. Extending the Real Living Wage to include auxiliary staff working in adult services would cost an additional £4m p.a.. As discussed in Chapter 10 on Fair Work, we acknowledge that trade unions representing the workforce are keen to exceed the Real Living Wage and are calling for an uplift to £15 per hour. The costs associated with implementing the Real Living Wage represent the 'floor' rather than the 'ceiling'. More accurate assessments will require the job evaluation process described earlier in the report. But in broad terms, every pound beyond the Real Living Wage will increase the national social care support wage bill by about £100m per annum. Of course, there is also a debate to be had about who should bear those costs and how they should be factored into contracts and commissioning.

## Removing charging for non-residential social care support

Our "new thinking" approach extends to what is fair and right for people receiving social care supports in their own homes. People should no longer be charged for non-residential social care support such as care and, support at home, and day care. It does not make sense for people to have access to health care free at the point of need but, in circumstances that are equally related to their health and wellbeing, to be charged for support. It also does not support delivery of their human rights.

In 2019/20 Local Authority income raised from non-residential user charges was £51m. We know from the experience of introducing Free Personal and Nursing Care that the removal of charges may lead to increased use of services. We therefore suggest that planning for the removal of non-residential charges should take account of the likelihood of increased use.

## Free Personal and Nursing Care for self-funding care home residents

The removal of charging for non-residential care should mean that the only cost for people in receipt of social care should be the means tested accommodation costs for care home residents. However, in recent years the cost of providing Free Personal and Nursing Care has increased significantly and the payment made to providers by Local Authorities for self-funding residents has not kept pace with this. This is not an issue for Local Authority funded placements covered by the National Care Home Contract, which contains reasonable provision for the cost of Free Personal and Nursing Care.

Using the National Care Home Contract as a benchmark, the difference between the costs included for Free Personal and Nursing Care and the sums paid by Local Authorities for self-funders were £191 and £230 per week respectively in 2019/20. We recommend that the sums paid for Free Personal and Nursing Care for self-funders using care homes should be increased to the levels included in the National Care Home Contract, and that this would cost £116m p.a..

# Finance

## Care Home Accommodation Costs

Our recommendations mean that all people in Scotland will receive social care free at the point of need. The only costs that will remain are those for accommodation, either directly through fees for care home residents or indirectly through household costs for those receiving care in their own homes. Although in most cases these are higher for care home residents, they are in principle the same.

An individual's contribution to their care home accommodation costs is funded primarily through their own income, with the Local Authority making up the balance on the basis of a means test on the individual's assets. Below the lower limit the Local Authority meets all of the shortfall and above the upper limit the individual covers the total cost, by drawing down the value of their assets.

We considered whether it is appropriate for people to contribute to their accommodation costs in residential care, or whether this too should be free at the point of use. We concluded that it is reasonable for some charge to be made where the individual's means permit, because in other circumstances that person would be paying accommodation costs at home. The National Care Service could in future consider whether adjustments to the means testing arrangements that are used would introduce greater fairness, but we have not considered this complex question in detail during this review. It is worth noting that many of the alternative approaches suggested previously in the UK and overseas tend to be regressive in nature and we propose that any future work should exercise caution in this regard.

## Re-opening the Independent Living Fund

The Independent Living Fund plays an important role in supporting its members' wellbeing and independence. The existing fund has 2,600 members and we estimate that there are a further 3,400 people who would be eligible for an award were we to re-open the fund and retain the existing threshold sum for access.

As indicated earlier in the report, we see the Independent Living Fund operating in future as part of the National Care Service. In effect, it will provide a national service of self-directed support to people with the most complex needs in the country. We recommend that the Independent Living Fund should be re-opened. To ensure that the Fund focuses on people with the most complex needs, we recommend that the threshold sum for entry to the new scheme should be reviewed and adjusted. To give some indication of the likely additional costs, if the threshold sum for new entrants was set at £600 per week, an additional investment of £32m would be required, increasing the total fund value to £85m p.a..

## Unpaid Carers

In recognition of concerns we heard about the Carer's Allowance, and the impact of caring on some people's income, we recommend a review of financial support made available to unpaid carers should be taken forward. As part of its focus on improving support for unpaid carers, the National Care Service should also increase investment in a range of respite provision including options for non-residential respite, and for short breaks.

Although charges to carers are waived under the Carer's Act, some Local Authorities allocate charges to the supported person for respite. Removing such charges should be considered alongside other investment priorities.

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## Future funding

On top of the initial investment set out above, Scotland's ageing demography means that more money will need to be spent on adult social care over the long term. This challenge exists for the rest of the UK as well.

Based on Personal Social Services Research Unit (PSSRU) research<sup>55</sup> a reasonable starting point for projections is a 3.5% p.a. real increase in social care expenditure every year to 2035 in Scotland, but more specific Scottish projections will be vital in the future.

The Scottish Government's Health and Social Care Medium Term Financial Framework<sup>56</sup> includes an assumption of nominal growth rates for social care of 4% p.a. gross and 3% p.a. net of savings until 2023/24. Assuming 1.8% p.a. inflation, the growth rate in the Medium Term Financial Framework is currently 1.3% p.a. lower than the rate recommended by PSSRU. We recommend that future planning for investment in adult social care must factor in demographic change.

## Spending on adult social care is an investment in the Scottish economy

When we add up the recommendations we have made above, the total annual additional expenditure we are suggesting is £0.66bn p.a., i.e., about 0.4% of Scottish GDP.

This is a 20% increase in real terms over 2018/19 levels and twice the total real terms increase in adult social care expenditure over whole of the previous ten years (£.3bn). Even allowing for a phased introduction, an investment on these lines will require a long-term and substantial uplift in adult social care funding.

We believe that the scale of this increase in funding is warranted on the human rights basis we have set out, and also that it represents a good investment in the Scottish economy and has a positive impact on women's employment and the gender pay gap:

- ▶ **The social care sector directly employs 205,000<sup>57</sup> people, approximately 8% of the workforce, with 148,000 working in adult social care. In addition, a further 51,000 jobs are generated as a result of adult social care in other sectors. In 2019 women made up 83% of the workforce, and average earnings were 56% of Scottish average in 2016<sup>58</sup>.**
- ▶ **The contribution of adult social care to the Scottish economy extends beyond the care sector. For every £1 spent on social care, more than £2 is generated in other sectors<sup>59</sup>. A recent report<sup>60</sup> estimates that an increase in social care expenditure of 1% of GDP would create three times as many jobs in the UK economy than it would if spent in the construction industry; and the sums recouped by the Treasury through taxes and NI would be 50% higher.**

55 <https://www.pssru.ac.uk/pub/DP2900.pdf>

56 [Health and Social Care: medium term financial framework – gov.scot \(www.gov.scot\)](https://www.gov.scot/Health-and-Social-Care-medium-term-financial-framework)

57 [Scottish Social Service Sector: Report on 2019 Workforce Data \(sssc.uk.com\)](https://www.sssc.uk.com/Scottish-Social-Service-Sector-Report-on-2019-Workforce-Data)

58 [The Economic Value of the Adult Social Care Sector – Scotland \(sssc.uk.com\)](https://www.sssc.uk.com/The-Economic-Value-of-the-Adult-Social-Care-Sector-Scotland)

59 [Investing in the Care Economy – Womens Budget Group \(wbg.org.uk\)](https://www.wbg.org.uk/Investing-in-the-Care-Economy-Womens-Budget-Group)

60 [A Care-Led Recovery from Coronavirus – Womens Budget Group \(wbg.org.uk\)](https://www.wbg.org.uk/A-Care-Led-Recovery-from-Coronavirus-Womens-Budget-Group)

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- ▶ The Women’s Budget Group<sup>61</sup> estimates that the majority of new jobs created by investment in social care will be taken by women.
- ▶ Such investment generates social value. Through the combined influence of emotional wellbeing, health maintenance and sustaining natural support and prevention, social care has a direct, indirect and extended impact: a study of the Independent Living Fund in Northern Ireland estimates that every £1 spent generates £11 of social value<sup>62</sup>.
- ▶ The Social Justice Commission<sup>63</sup> suggests that expenditure on care should be given an equivalence to investment in any other key sector, and should feature prominently in economic policy, not only in post-Covid economic and social recovery, but as a focus of investment supported through organisations like the Scottish National Investment Bank and economic development funding.
- ▶ Both for people who use social care support, and equally importantly for unpaid carers, the availability of high quality adult social care support can help people to engage in and remain in education and also to enter and remain in work.

The additional expenditure we are recommending here should not be seen in economic terms as a revenue cost but rather as an investment that encourages job creation and provides economic stimulus. It should play a key part in post-pandemic recovery plans, particularly in light of the Institute for Fiscal Studies’ analysis that more women are likely to lose their jobs than men as a result of Covid-19<sup>64</sup>.

## Options for Raising Revenue

Should the Scottish Government accept our recommendations on investment, it will need to consider a range of options for generating new revenues. We have outlined broad ideas here, many of them drawn from an analysis of how other countries have gone about funding investments in their social care systems.<sup>65 66 67</sup> It is for the Scottish Government and Scottish Parliament, in due course, to consider what would be most appropriate. Broadly, the following options are available:

- ▶ Introduction of mandatory social insurance;
- ▶ Changes to existing devolved taxes to raise additional revenue;
- ▶ Introduction of a new local tax;
- ▶ Seeking devolved powers for a new national devolved tax in Scotland; and
- ▶ Seeking devolution of existing reserved taxes to raise additional revenue.

61 [Investing in the Care Economy – Womens Budget Group \(wbgroup.org.uk\)](http://wbgroup.org.uk)

62 <https://ilf.scot/wp-content/uploads/2020/07/44188-ILF-NI-Impact-Evaluation-Report.pdf>

63 [reform-of-social-care-discussion-paper-september-2020.pdf \(socialjustice.scot\)](#)

64 [COVID-19 and inequalities | Inequality: the IFS Deaton Review](#)

65 [Social-care-funding-options-May-2018.pdf \(health.org.uk\)](#)

66 [A fork in the road: Next steps for social care funding reform \(kingsfund.org.uk\)](#)

67 [1555059771\\_how-to-fund-social-care-briefing-2019.pdf \(nuffieldtrust.org.uk\)](#)

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These options are not uniform in their deliverability. Scotland has no history of mandating insurance, people have been reluctant to insure against future social care need, and the insurance industry is not well prepared for a new market. Changes to existing devolved taxes or the introduction of new local taxes are within the competence of the Scottish Parliament, but would require careful assessment against the Scottish Government's wider tax priorities, and would have to be consistent with the Scottish Government's stated principles for taxation.

There are also a set of specific challenges when considering the options, in particular:

## Equity and intergenerational fairness

Any funding mechanism should be progressive in respect of ability to pay. It should also be equitable between people of different age groups. This is particularly important with newly established funded schemes, where the demands on the fund from the elderly are likely to exceed their contributions in the short term.

## Hypothecation and the visibility of any new funding mechanism

In the design of any new tax, it is important to consider the degree to which, if at all, new revenues would be hypothecated to protect funding for adult social care. Hypothecation is not commonly used in the UK. It could constrain future options and impact the extent to which funding could adapt over time to meet demand.

There is evidence of public support<sup>68</sup> for hypothecation to fund increased expenditure on social care but it can constrain future allocation decisions and potentially funding across the economic cycle. Consideration would need to be given to whether hypothecation would achieve greater transparency and deliver sufficient funding stability in practice.

Broadly, options could take several forms:

- ▶ **Strict hypothecation, where spending is linked directly to new revenue raised and funding is used only for that purpose.**
- ▶ **Partial hypothecation, where new revenue raised is ring-fenced to fund increased expenditure, but existing baseline funding is not protected. This is the approach that has been recommended to fund increased investment for social care in a report to the Welsh Government<sup>69</sup>.**
- ▶ **Indicated spend, where the raising of new revenues is symbolically linked to adult social care, but in practice the revenue raised is not ring-fenced.**
- ▶ **No form of hypothecation.**

The speed of reform will have a big impact on the viability of funding options, as do options that can be delivered within the existing devolved settlement, versus options that would require new tax powers or the devolution of existing UK taxes.

<sup>68</sup> [A fork in the road: Next steps for social care funding reform \[kingsfund.org.uk\]](https://www.kingsfund.org.uk/publications/a-fork-in-the-road-next-steps-for-social-care-funding-reform)

<sup>69</sup> [paying-for-social-care.pdf \[gov.wales\]](https://gov.wales/paying-for-social-care.pdf)

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In addition, the design of any new funding mechanism needs to be carefully considered to ensure it is proportionate, sustainable, embeds intergenerational fairness and is consistent with the Scottish Government's wider economic and fiscal strategies and outlook.

Addressing these important questions is a sizeable task in itself, which we recommend requires considerable further analysis and careful consideration before decisions are made.

## Recommendations

Adult social care support in Scotland requires greater investment. To secure better access to social care support, better terms and conditions for the social care workforce, better sustainability, the economic benefits of a strong social care sector, and to meet the aspirations and other recommendations we have laid out in this report, we recommend:

49. Prioritising investment in social care as a key feature of Scotland's economic plans for recovery from the effects of the Covid-19 pandemic.
50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.
51. Additional investment in order to:
  - ▶ expand access to support including for lower-level needs and preventive community support;
  - ▶ implement the recommendations of the Fair Work Convention;
  - ▶ remove charging for non-residential social care support;
  - ▶ increase the sums paid for Free Personal and Nursing Care for self-funders using care homes to the levels included in the National Care Home Contract;
  - ▶ re-open the Independent Living Fund, with the threshold sum for entry to the new scheme reviewed and adjusted; and
  - ▶ review financial support made available to unpaid carers and increase investment in respite.
52. Robustly factoring in demographic change in future planning for adult social care.
53. Careful consideration to options for raising new revenues to increase investment in adult social care support.



# Chapter 12

## Summary and recommendations

## Summary and recommendations

We all know from history that major shocks – war, an economic crash or indeed a pandemic – can provide societies with an opportunity for real change. But improvements do not just follow such traumas; they come about as a result of courageous leadership, honesty with one another and a shared will to make things better. The Scottish Government has already displayed bravery, thoughtfulness and foresight by commissioning this independent review in the midst of the Covid-19 pandemic. Next, it needs to act, we hope with support for improvement from across Scottish civic and democratic society, to deliver a system of social care that takes as its central aim the realisation of every citizen's right to participate fully in society, whatever their needs for support. And that system needs to work in full partnership with other aspects of our public services, not least the NHS but not only the NHS either: housing, and justice, education and economic development are all central too.

People have asked us, how can we afford a National Care Service? Given the conclusions we have set out here, we would ask in response – how can Scotland not afford it, ethically or indeed economically?

This is a real opportunity for change. Covid-19 has highlighted more than ever the critical role that social care supports can play in enabling people to live life to the full. The focus however has been on care homes, where lack of visiting, the high rate of deaths early in the pandemic and the lack of PPE for staff were all rightly highlighted in the media and in the Scottish Government's response. There has been a tendency to overlook the many people who receive care and support at home, both formal paid care and informal unpaid care from family members and loved ones.

In the forthcoming Scottish elections there is an opportunity to secure support across all political parties to a vision for the future of care in Scotland and commitments to take radical action to begin to set us on a path to achieve that vision.

This is partly about the fact that Scotland, in common with the rest of the developed world, has an ageing population. By 2036, one in four people will be over 65. Many of us will experience a period towards the end of our lives when we will need some care and support. But, as we have demonstrated in this report, this is not just about an ageing population, or caring well for older people in our society, as vital as those priorities are.

It is too easy for us to think this is about someone else. But this is about our colleagues, our friends, our families, our neighbours, and ourselves. This is about Jack who has dementia. This is about John with cerebral palsy, this is about Jade with autism, Jagdeep with motor neurone disease, Jim the veteran who has lost both legs, Jashree with multiple chronic conditions that limit her mobility, Janet who is in her 90s and too weak to move about her home unaided. Everyone one of us has a right to live a full life. This should be more than whether we can go to the toilet, wash and dress ourselves unaided, though support for these activities of daily living is vital. Everyone should be enabled to live, work and play – to enjoy full citizenship and participation. That means support to get out and about, to join in with groups and activities that we enjoy, to work or participate in adult education and training.

Scotland needs a new approach to social care to make these aspirations a practical, everyday reality across the country. We need to create a National Care Service that is based upon a new narrative, replacing crisis with prevention and wellbeing, burden with investment, competition with collaboration and variation with fairness and equity. And we need to put people at the centre of it: people who use social care supports, their families and carers, and people who work in social care services.

If not now, when? If not this way, how? And if not us – who?

# Summary and recommendations

Our recommendations are as follows:

## A human rights based approach

1. Human rights, equity and equality must be placed at the very heart of social care and be mainstreamed and embedded. This could be further enabled by the incorporation of human rights conventions.
2. Delivering a rights based system in practice must become consistent, intentional and evident in the everyday experience of everyone using social care support, unpaid carers and families, and people working in the social care support and social work sector.
3. People must be able to access support at the point they feel they need it, including for advice and signposting to local community-based resources and help, and for barriers to this, such as the current eligibility criteria and charging regime, to be fundamentally reformed and removed, to allow a greater emphasis on prevention and early intervention.
4. People should understand better what their rights are to social care and supports, and “duty bearers”, primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.
5. Where not all needs can be met that have been identified as part of a co-production process of developing a support plan, these must be recorded as unmet needs and fed into the strategic commissioning process.
6. Informal, community based services and supports must be encouraged, supported and funded to respond appropriately to the needs of local citizens, including for preventative and low level support.
7. A co-production and supportive process involving good conversations with people needing support should replace assessment processes that make decisions over people’s heads and must enable a full exploration of all self-directed support options that does not start from the basis of available funding. Giving people as much choice and control over their support and care is critical.
8. More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.
9. When things do not work well for people and their rights have not been upheld, they must have rapid recourse to an effective complaints system and to redress.
10. Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.

# Summary and recommendations

## Unpaid carers

11. Carers need better, more consistent support to carry out their caring role well and to take a break from caring with regular access to quality respite provision. Carers should be given a right to respite with an amendment to the Carers Act as required, and a range of options for respite and short breaks should be developed.
12. A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights based approach to the support of carers.
13. Local assessment of carers' needs must, in common with assessment of the needs of people using social care support services and supports, better involve the person themselves in planning support.
14. Carers must be represented as full partners on the Integration Joint Boards and on the Board of the National Care Service.

## The case for a national care service (NCS)

15. Accountability for social care support should move from local government to Scottish Ministers, and a Minister should be appointed with specific responsibility for Social Care.
16. A National Care Service for Scotland should be established in statute along with, on an equal footing, NHS Scotland, with both bodies reporting to Scottish Ministers.
17. The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers. Integration Joint Boards should manage GPs' contractual arrangements, whether independent contractors or directly employed, to ensure integration of community care and support provision, to respect and support professional interdependencies, and to remove the current confusion about where responsibility for primary care sits.
18. The National Care Service should lead on the aspects of social care improvement and support that are best managed once for Scotland, such as workforce development and improvement programmes to raise standards of care and support.
19. The National Care Service should oversee social care provision at national level for people whose needs are very complex or highly specialist and for services such as prison social care that could be better managed on a once-for-Scotland basis.
20. The National Care Service's driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce.

# Summary and recommendations

## A National Care Service for Scotland – how it should work

21. The National Care Service in close co-operation with the National Health Service should establish a simplified set of outcome measures to measure progress in health and social care support, through which to oversee delivery of social care in local systems via reformed Integration Joint Boards and national care bodies.
22. A Chief Executive should be appointed to the National Care Service, equivalent to the Chief Executive of the National Health Service and accountable to Ministers.
23. Integration Joint Boards should be reformed to take responsibility for planning, commissioning and procurement and should employ Chief Officers and other relevant staff. They should be funded directly by the Scottish Government.
24. The role of existing national care and support bodies – such as the Care Inspectorate and Scottish Social Services Council – should be revisited to ensure they are fit for purpose in a new system.
25. The National Care Service should address gaps in national provision for social care and social work in relation to workforce planning and development, data and research, IT and, as appropriate, national and regional service planning.
26. The National Care Service should manage provision of care for people whose care needs are particularly complex and specialist, and should be responsible for planning and delivery of care in custodial settings, including prisons.

## A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

27. A National Improvement Programme for social care, along the lines of the NHS Patient Safety Programme, should be introduced by the National Care Service, and should address the three following key areas:
  - ▶ **The experience and implementation of self-directed support must be improved, placing people using services' needs, rights and preferences at the heart of the decision making process.**
  - ▶ **The safety and quality of care provided in care homes must be improved to guarantee consistent, appropriate standards of care.**
  - ▶ **Commissioning and procurement processes must be improved in order to provide a vehicle for raising the quality of social care support and for enhancing the conditions and experience of the social care workforce.**

# Summary and recommendations

## Models of care

28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible.
29. A national approach to improvement and innovation in social care is needed, to maximise learning opportunities and create a culture of developing, testing, discussing and sharing methods that improve outcomes. The future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service must be considered.
30. There must be a relentless focus on involving people who use services, their families and carers in developing new approaches at both a national and local level.
31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies.

## Commissioning for public good

32. Commissioners should focus on establishing a system where a range of people, including people with lived experience, unpaid carers, local communities, providers and other professionals are routinely involved in the co-design and redesign, as well as the monitoring of services and supports. This system should form the basis of a collaborative, rights based and participative approach.
33. A shift from competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace across Scotland. Commissioning and procurement decisions must focus on the person's needs, not solely be driven by budget limitations.
34. The establishment of core requirements for ethical commissioning to support the standardisation and implementation of fair work requirements and practices must be agreed and set at a national level by the new National Care Service, and delivered locally across the country.
35. To help provide impetus and support to the adoption of a collaborative and ethical approach to commissioning, the idea from CCPS of pressing pause on all current procurement should be fully explored in the context of a National Care Service, with a view to rapid, carefully planned implementation.
36. The care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role. Consideration should be given by the National Care Service to developing national contracts for other aspects of care and support. A 'new deal' must form the basis for commissioning and procuring residential care, characterised by transparency, fair work, public good, and the re-investment of public money in the Scottish economy.
37. National contracts, and other arrangements for commissioning and procurement of services, must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.

## Summary and recommendations

38. A condition of funding for social care services and supports must be that commissioning and procurement decisions are driven by national minimum quality outcome standards for all publicly funded adult social care support.
39. A decisive and progressive move away from time and task and defined services must be made at pace to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes, to have a good life and reach their potential, including taking part in civic life as they themselves determine.
40. Commissioning decisions should encourage the development of mutually-supportive provider networks as described above, rather than inhibiting co-operation by encouraging fruitless competition.
41. Commissioning and planning community based informal supports, including peer supports, is required to be undertaken by Integration Joint Boards and consideration of grant funding to support these is needed.

### Fair Work

42. Rapid delivery of all of the recommendations of the Fair Work Convention, with an ambitious timetable for implementation to be set by the Scottish Government.
43. Conduct a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles. This should take account of skills, qualifications, responsibilities and contribution.
44. Putting in place national minimum terms and conditions as a key component of new requirements for commissioning and procurement by Integration Joint Boards. Specific priority should be given to pay, travel time, sick pay arrangements, training and development, maternity leave, progression pathways, flexible pathways and pension provision. The national evaluation of terms and conditions should be undertaken to inform these minimum standards and these should be reviewed as required.
45. Establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development. The current role, functions and powers of the SSSC should be reviewed and appropriate read-across embedded for shared and reciprocal learning with the NHS workforce.
46. Establishing a national forum comprised of workforce representation, employers, Integration Joint Boards and the Scottish Government to advise the National Care Service on workforce priorities and to take the lead in creating national sector level collective bargaining of terms and conditions.
47. National oversight of workforce planning for social work and social care, which respects the diversity and scale of employment arrangements while improving resilience and arrangements for mutual support should be a priority for a National Care Service.
48. The recommendations listed above should apply to Personal Assistants employed by people using Option 1 of SDS, who should be explicitly recognised as members of the workforce, as well as employees of providers in the public, third and independent sectors. This recommendation should be delivered in full partnership with the independent living movement.

# Summary and recommendations

## Finance

49. Prioritising investment in social care as a key feature of Scotland's economic plans for recovery from the effects of the Covid-19 pandemic.
50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.
51. Additional investment in order to:
  - ▶ **expand access to support including for lower-level preventive community support;**
  - ▶ **implement the recommendations of the Fair Work Convention;**
  - ▶ **remove charging for non-residential social care support;**
  - ▶ **increase the sums paid for Free Personal and Nursing Care for self-funders using care homes to the levels included in the National Care Home Contract;**
  - ▶ **re-open the Independent Living Fund, with the threshold sum for entry to the new scheme reviewed and adjusted; and**
  - ▶ **review financial support made available to unpaid carers and increase investment in respite.**
52. Robustly factoring in demographic change in future planning for adult social care.
53. Careful consideration to options for raising new revenues to increase investment in adult social care support.

**JANUARY 2021**

# Addendum

Independent Review of Adult Social Care in Scotland

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# Addendum

You can find background information about this independent review of adult social care in Scotland, including details of meetings, our engagement exercise, submissions made to the review and background papers, here: [Independent Review of Adult Social Care – gov.scot \(www.gov.scot\)](https://www.gov.scot/Topics/health-social-care/independent-review-of-adult-social-care).

The review was chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. Mr Feeley was supported by an Advisory Panel comprising Scottish and international experts as follows:

- ▶ Malcolm Chisholm, Former Scottish Minister for Health and Community Care 2001 – 2004
- ▶ Anna Dixon: Chief Executive, Centre for Ageing Better
- ▶ Caroline Gardner: Auditor General 2012–20
- ▶ Stuart Currie: East Lothian Councillor
- ▶ Göran Henriks: Chief Executive of Learning and Innovation, Qulturum, Jönköping County, Sweden
- ▶ Ian Welsh: Chief Executive, the ALLIANCE
- ▶ Jim Elder-Woodward: Chair of the Scottish Independent Living Coalition (SILC)

Secretariat support to the review was provided by a team of officials from the Scottish Government’s Health and Social Care Directorates:

- ▶ Alison Taylor
- ▶ Christina Naismith
- ▶ Lorraine Davidson
- ▶ Paul Leak
- ▶ Mary O’Toole
- ▶ Susan Craig
- ▶ Gillian McDonald
- ▶ Madihah Iqbal
- ▶ Jack Walker
- ▶ Kelly Martin
- ▶ Morna Macleod
- ▶ Sophie Downie



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