Summary of Evidence - Adult Social Care and Support Inquiry

Health and Sport Committee

Preface

The quotation below is from a blog written by Professor Paul Gray, 'Where did I go Wrong', former Director General of Health and Social Care and Chief Executive of NHS Scotland.

"I also knew that we needed a good hard look at the way care services are commissioned, the way they are paid for, and the way good care is recognised and rewarded. Our attitude to the private sector was unresolved. We don't 'procure' hospital care, but we do 'procure' home care and care home services. We know that if people can stay at home, or in a homely setting, their prospects of good quality of life are enhanced – yet we have a system which makes it more likely that cuts will fall in these areas. I should have done more about that.

Despite these things, there were some outstanding examples of health and social care integration, largely driven by people who exercised strong and effective local leadership, who worked collaboratively, and who cared less about institutional boundaries than they did about the people they served. These examples came from all sectors – social work, social care, the third sector, the NHS and privately run care homes. Nobody had the monopoly on excellence."

This quotation is from a longer piece which considers how he could have done things differently in establishing the integration of health and social care to ensure that people experienced no barriers in their encounters with health and care/support services, and that support was truly preventative, and delivered according to what a person wanted, as well as needed, from those services.

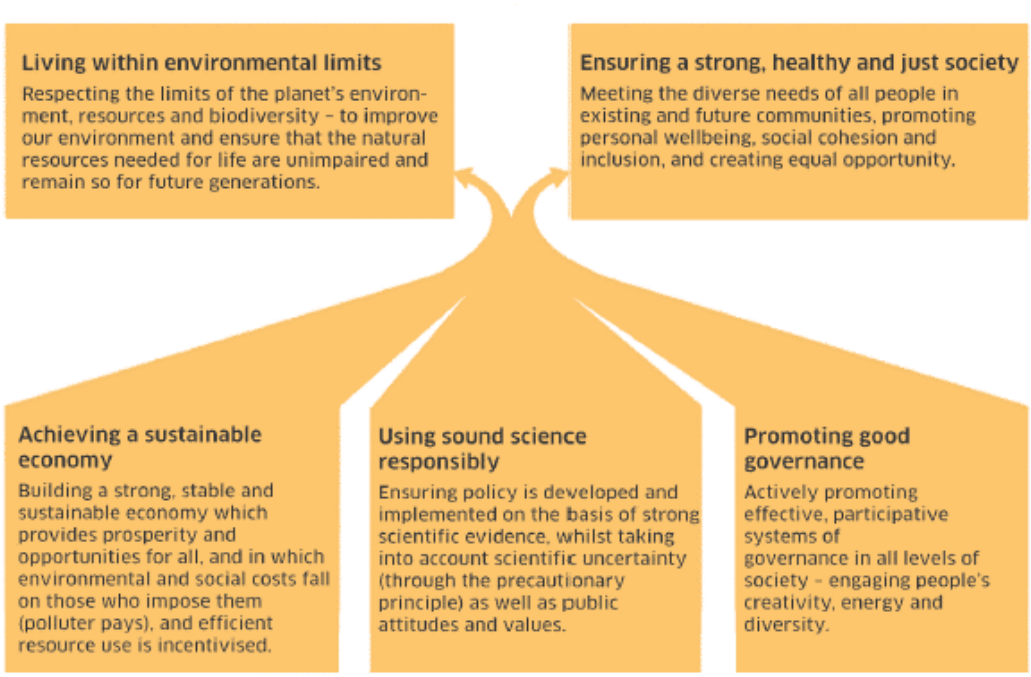
The reform of the organisation and funding for social care has occupied governments in the UK for at least the last 20 years, starting when, in 1999 a UK Government Royal Commission published proposals for reform. This led to free personal and nursing care being introduced in Scotland. There have been reviews, as well as green and white papers published in England, and while Scotland has been active, with the introduction of free personal and nursing care and self-directed

support, the political challenges and the underlying and fundamental issues remain: that, unlike healthcare, social care and support is not free at the point of use; it is means-tested, and it is commissioned by integration authorities(health and social care partnerships), and procured by local authorities – effectively outsourced – for those who are assessed as needing it and not able to afford to pay for it. That said, the NHS was established with health bodies contracting services from private providers: GPs, Dentists, Optometrists and Pharmacists

Introduction

As coronavirus (COVID-19) was quietly replicating in early March 2020, the Health and Sport Committee was preparing to run oral evidence sessions as part of its inquiry on the future of social care in Scotland. This document summarises the written evidence received prior to 'lockdown'. The inquiry was to run from late April to early June, using innovative approaches to engagement and oral evidence gathering.

This innovation was linked to a desire to work towards informing policy and undertaking scrutiny according the principles of sustainable development:



The Scottish Parliament has started to use these principles to inform its scrutiny of policy and to encourage constructive, future focused planning, spanning all portfolios. It coheres with the National Performance Framework.

The call for views for the inquiry closed on 20 February 2020. You can view the written submissions we received here.

We gathered views from people with experience of receiving adult social care or support, or of being a carer for someone receiving care. We wanted to hear:

1. Their story and experience of social care in Scotland

2. What they would change about their experience of social care

We also asked people to submit their thoughts about the future delivery of social care and support in Scotland. We were keen to receive responses to the following questions:

1. How should the public be involved in planning their own and their community's social care services?

2. How should Integration Joint Boards commission and procure social care to ensure it is person-centred?

3. Looking ahead, what are the essential elements in an ideal model of social care (e.g. workforce, technology, housing etc.)?

4. What needs to happen to ensure the equitable provision of social care across the country?

225 written responses were received from a range of individuals and organisations and the Committee is very grateful for the time taken to share views, proposals and experiences. The responses from individuals who have experience of care and support have been summarised in another document. This summary covers the submissions from organisations and from some of those individuals who work in the care and support sector. Views are grouped under themes.

A repeated observation through the submissions is that Scotland has a strong legislative and policy basis covering social care and integrated services but that this positive base is undermined by poor implementation. This is deemed to be mostly because of a lack of adequate resourcing and embedded structural problems, such as procurement practices, eligibility criteria and workforce issues that appear perverse and work against sustainability, innovation and equity.

Funding of social care

Currently, social care is funded by individuals paying for their own care, and by local authorities procuring care from a wide range of providers for people who have below £29,000 in assets. The hidden costs of care to society are covered by the many unpaid carers, usually family members, who look after their relatives or friends.

One of the underlying questions about future social care provision is how it should be funded. Another, is whether it should be free at the point of use to everyone, as the

NHS is. These are not new questions, as noted above. We did not ask these questions in our call for views, but some respondents did comment.

> "The assumption that Scotland can continue to fund long-term care solely from the public purse is not tenable unless there is a significant increase in public spending/or taxes and/or user charges. Why will it be necessary to raise additional funding? Largely because of demographic change…in the number of the oldest old. Whereas the number of working age Scots is likely to remain roughly constant…those aged 80+ are projected to increase by 32% between 2020 and 2030."(David Bell and Elaine Douglas).

They conclude:

> "Scotland needs to address the issue of funding in a nonpartisan fashion, bearing in mind the need for equity, efficiency and, most importantly, the wellbeing of care clients."

And they suggest a national debate, via a Citizen's Assembly, about funding of social care in a way that is consistent with the Government's National Performance Framework (and Sustainable Development Goals as highlighted above).

A former social worker and wheelchair user and homecare service user submitted a comprehensive response covering a number of areas. They argue that: "There has been a general failure to challenge the 'fake' notion that increasing the level, quality and responsiveness of publicly funded social care and health services can be delivered whilst at the same time reducing taxation and cutting budgets.'

One organisation, a large provider of home care through a franchise model thought that a long-term (20 year) funding settlement for social care was required (Home Instead Senior Care).

Scottish Autism, highlighted through their focus on young autistic people that funding of social care is not only about older people, and that different models of funding might be appropriate. They cite the 2018 report, The Microsegmentation of Autism Spectrum, which advocates invest to save approaches. This approach is applicable to all, but recommendation 5 of the Scottish Strategy for Autism advocates this approach, and the 2018 report describes considerable savings made by using a number of different evidence-based interventions.

Bell and Douglas note that real terms funding to local authorities has fallen by 7.6% since 2013-14, making it challenging to meet current demand, let alone the predicted increase in demand seen in demographic trends data. COSLA are concerned that prioritising the NHS over social care remains an issue. The two might be conflated in policy terms, but not in investment or budgetary terms, nor in governance terms.

The ALLIANCE call for the removal of care charges and 'believes that the receipt of social services should be universally free because of equal participation in society and independent living are human rights that should be afforded to all. They do not suggest ways such an approach could be funded.

COSLA noted that 'the social care system must be recognised for its economic and social value' however. It is not only a drain on resources. In 2018 the Scottish Social Services Council published a report stating that the sector was worth £3.4 billion (Gross Added Value)[1] to the Scottish economy.
COSLA also calls for longer term financial settlements to enable transformation and a move away from input measures, as well as the need for a transparent narrative on the need for reform and redesign. They advocate mainstreaming participatory budgeting to fulfil the principles of meaningful public participation in public service reform.

As discussed further below, in the absence of any data on current needs, future needs or outcomes, there is no visibility of unmet need. Carers Scotland conducted research showing that only 28% of unpaid carers receive any practical support, and only 18% receive a break from caring. Added to the unmet need identified by carers, there is also the unmet need of individuals living alone in Scotland, either those known or unknown to authorities.

Data

The Scottish Centre for Administrative Data Research focus on the equity question and say that basic information to ensure equity, is not available in Scotland.

> "By definition, equity in the provision of social care services implies that those who are in need of care get it. In order to test whether equity in the provision of services is achieved, two pieces of information are necessary.
> Firstly, we need to know who is receiving care and secondly, we need to know who needs care. Clearly, armed with both pieces of the puzzle, one could test the equity hypothesis: do those who need care get it?
>
> Unfortunately, with the existing data, this is simply not possible. Indeed, even the simplest of statistics aren't available. It is currently the case that no data source exists that details the exact number of people that receive social care in any given year in Scotland… (also)the existing data cannot identify those individuals that apply for care but do not get it, despite the fact that their care needs may be substantial. All in all, we do not know who needs care, what level of care they need or if their care needs are being met."

Bell and Douglas, and others, such as the UK Statistics Authority and Lord Sutherland, argue that basic data required to inform social care design and provision is not available. There has been no strategic approach to collecting social care data, as there has in England:

[1] "The direct economic impact in terms of Gross Value Added (GVA), the measure of the value of goods and services produced in a sector of the economy, is £2.2 billion which is higher than the Agriculture, forestry and fishing, Arts, entertainment and recreation and Water supply, sewerage and waste management sectors.
As well as the direct impact of adult social care the report also highlights the indirect and induced impact of the sector, which increases the estimated GVA to £3.4 billion and 198,600 jobs."

> "An improvement in the quality of data is an essential precondition for effective policy action. The recent report by the UK Statistics Authority (UKSA) highlighted some of the deficiencies in the current statistical framework for social care in Scotland:
>
> > *" .. social care statistics in Scotland do not currently provide the range and depth of information needed to fully serve the public good as some fundamental gaps exist. For example,* ***we don't know how many people currently need social care and whether those needs are being met, how many people might need care in future, and we don't know how well social care services achieve their goals of helping people to live independently and maintain a good quality of life****."*
>
> Office for Statistics Regulation (2020) *Adult social care statistics in Scotland, P15"* (Bell and Douglas) (emphasis added.)

The UKSA highlights that more information on future care needs is required, and Lord Sutherland (in 2008 review of Free Personal Care policy) argued that there should be better recording of costs.
Bell and Douglas argue for a longitudinal study of ageing in Scotland, equivalent to those established in many other countries, including England, Ireland, Japan and the US for example.

Commissioning and Procurement

Integration authorities, (Health and Social Care partnerships), through strategic commissioning processes, commission services from a range of providers. The procurement of social care and support services is the responsibility of local authorities.

Strategic commissioning covers all activities involved in assessing and forecasting local needs, linking investment with agreed outcomes. It is not just about social care and support. This 'blurring' of activity and responsibility is at the heart of integration.

Some care is provided 'in-house' or through health and social care partnerships, but most is provided by the independent, not-for-profit or private sector.

The Coalition of Care and Support Providers (CCPS) that represents third sector and not-for-profit organisations, has produced numerous publications over recent years covering all aspects of health, welfare and social care including reports about:

- sustainability of the sector,
- social care procurement and contracting,
- the living wage and the
- inherent tensions in the third sector being both partners and commissioned providers of services.

Their submission sets out how different commissioning and procurement are as activities. Commissioning is done by the integration authority and should be

inclusive, procurement is a narrower activity, based on competitive tendering and contractual obligations, leading, they and others say, to risk aversion and the stifling of innovation as well as a focus on time and tasks and a downward pressure on costs. All these are, CCPS state:

> "antithetical to a person-centred approach…Competitive tendering processes are overly complex, driven by risk avoidance for the contracting authority, rather than risk enablement for the supported person, often highly prescriptive in terms of time and task, and the imposition of related management software and/or workforce monitoring, and structurally incapable of adequately assessing quality, meaning that tender evaluations (and thus contract award decisions) are disproportionately dominated by considerations of price…procurement is simply the wrong approach for social care"

Additionally, according to integration principles and guidance, stakeholders should be involved in the development of commissioning plans. Borders Carers Centre believe that procurement doesn't work well for staff or clients:

> "To be honest I feel that procurement has not always been in the best interest of clients with regards to social services and has been known to reduce the quality of service and skills of staff providing support to those in the community and does not always provide 'best value' or consistency for service users or the working staff, working with agencies who are looking at profit rather than care is never a good combination." Borders Carers Centre

CCPS remind us that the provisions of the Procurement Reform (Scotland) Act 2014, permits and enables authorities to put services in place without obligation to award contracts through competition. They also underline that the Public Services Reform (Scotland) Act 2010 gave broad powers to the Care Inspectorate to scrutinise commissioning and procurement in their broadest senses, although no enforcement powers were conferred in this area as they were for provision of services. This position is supported by SCVO.

CCPS advocate an alliance model:

> "We believe that a fundamentally different approach is required in order to give full effect to SDS principles of involvement, choice & control, and we have in recent years turned our attention as an organisation to supporting providers and councils to develop and design more flexible, collaborative approaches focused on outcomes and based on the development of trusted relationships rather than contractual obligations. Alliance contracting is one such approach."[2]

[2] Alliance contracting is based on collaboration between a number of partners, who might formerly have been competitors or have individual contracts. Risk is shared, and innovation is assumed to improve performance.

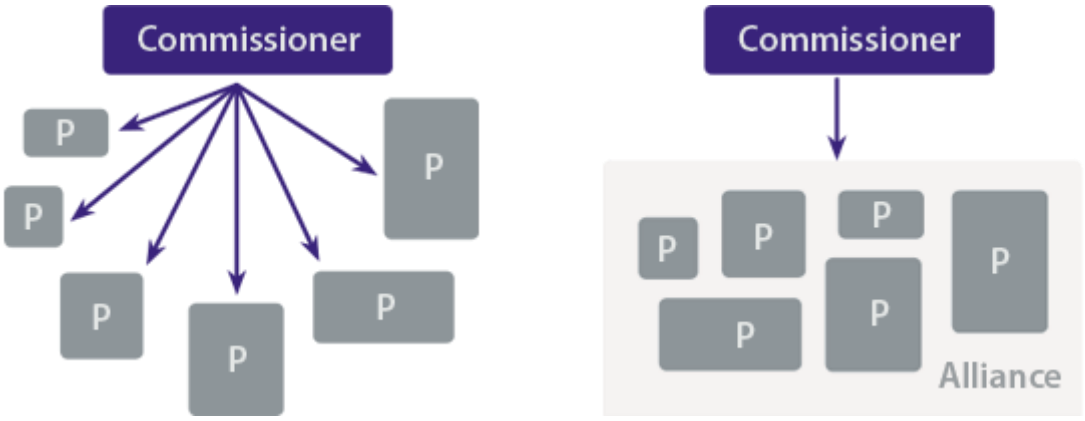
Traditional contracts **Alliance contract**

Scottish Care cite examples in Aberdeen City and Dumfries and Galloway where such alternatives are being explored. Royal Blind also recognise that some local authorities are developing creative alternatives, including Public Social Partnerships, and making use of opportunities offered by the Procurement Reform Act.

Both voluntary sector providers and independent providers remarked on the lack of a level playing field in commissioning and procurement. CCPS remarked that 'in house' provision by health and social care partnerships was not subject to tendering and focus groups organised by Scottish Care, and commissioned by healthandcare.scot, highlight the lack of equity whereby care provided by partnerships has to be charged according to the cost of care, but that local authorities will only pay the national care home contract standard rates to independent providers, which independent providers say doesn't cover the costs of care. Care at home providers also say that hourly rates paid by local authorities don't cover their costs of providing care at home. CCPS published a report in 2019 exploring why third sector organisations are withdrawing from contracts with local authorities.

Scottish Care ran four meetings across Scotland for independent providers. There was a feeling that the sector was misunderstood and misrepresented as being profit-driven, when many care homes are small and struggle to remain sustainable. At the same time, commissioning authorities are reliant on them being able to provide care to those they assess as needing care, because there is no 'national care service'.

Sustainability is further threatened as dependency of individuals increases but is not recognised by funding authorities. Assessments sometimes deny that nursing care



Separate contracts with each party	One contract, one performance framework
Separate objectives for each party	Aligned objectives and shared risks
Performance individually judged	Success judged on performance overall
Commissioner is the co-ordinator	Shared co-ordination, collective accountability
Provision made for disputes	Based on trust and transparency
Contracts based on tight specification	Contract describes outcomes and relationships
Change not easily accommodated	Change and innovation in delivery are expected

Source: LH Alliances a UK based organisation that supports alliancing as an alternative to traditional procurement.

for example is required, meaning that local authorities pay the lower standard rate to the provider.

Self-directed support

Many submissions observed that Self-directed support (SDS) was an appropriate 'vehicle' for people to be involved in their own care. However, repeatedly, effective implementation was seen as the major problem. Self-directed support is framed by four options[3], based on the level of involvement someone wants in controlling the care they receive. These range from receiving direct payments through to the local authority arranging the care, or a mixture of the four options. Statistics tell us that the majority of people, 87.2%, opt for Option three (local authority arranged care), rather than options where they have more control of their budget and the services provided. It was felt that this focus on personal choice, coupled with the use of 'I' in how the Care Standards are written should be enough to ensure that the individual is at the centre of how their care and support are organised. Services are inspected on the basis of these Care Standards, which are:

1: I experience high quality care and support that is right for me.

2: I am fully involved in all decisions about my care and support.

3: I have confidence in the people who support and care for me.

4: I have confidence in the organisation providing my care and support.

5: I experience a high-quality environment if the organisation provides the premises.

> "We would support a basic Charter of Citizen's Basic Rights which stated clearly the level and quality of life that the people of Scotland can and should expect either through their own endeavours, through state support or, most importantly a combination of both…Much of this is already enshrined in the **Social Care (Self-directed Support)(Scotland) Act** or within the Human Rights Conventions but the deployment at operational / local level is already very patchy and our members continue to report a shift away from the values and principles enshrined in law to a more directive, resource driven model of social care, all of which is subject to other local competing priorities." SPAEN

Organisations repeatedly placed the responsibility for the lack of full involvement of individuals, and the selection of Option 3 with the commissioners and procurers of care and support; the local authorities and health and social care partnerships.

There is an assumption that lack of resources drives local authorities towards a 'rationing approach of (sic) care and the maintenance of a task and finish mentality in

[3] SDS Option 1: Taken as a direct payment.
SDS Option 2: Allocated to an organisation that the person chooses, and the person is in charge of how it is spent.
SDS Option 3: The person chooses to allow the council to arrange and determine their services.
SDS Option 4: The person can choose a mix of these options for different types of support.

home care' (Home Instead Senior Care). There is a sense that 'Price is currently the main driver' rather than the quality of life for those requiring support or working in the sector.(Scottish Autism)

> "Social work teams need to become facilitators of good care using the social prescribing model…Commissioners of services (not just providers) must be held to account for the implementation of the Health and Social Care Standards: My support, my life – most notably "I can control my care and support." (Home Instead Senior Care)

CCPS believe that 'competitive tendering runs counter to SDS principles in that it posits the public authority, rather that the individuals receiving care, as the chief decision-maker with respect to how support is provided, and by whom'. CCPS has researched and written on this extensively. (Also: http://www.ccpscotland.org/pp/?s=experience+of+SDS+implementation)

Some complained that SDS was slow, unresponsive and bureaucratic, and not an attractive proposition for someone approaching the end of life and in rapidly changing circumstances. (Scottish Partnership for Palliative Care)

healthandcare.scot recount concerns raised about a significant area associated with people using Option 1, Direct Payments, that of personal assistant services, which are unregulated, and staff do not have to be registered. However, many self-funding individuals will make use of such services, making private arrangements. Social services retain oversight of direct payment arrangements in place for those receiving them. This is seen as an area of risk for local authorities, especially, for example, if a family member is the carer, or little is known about the personal assistant. Option 1 means that the person must become an employer, and fulfil an employer's obligations in terms of pay, conditions, pension and equipment.

A former social worker cautions against a determined push towards Option 1, believing that many service users do want a greater say over their care and support, but that only a minority wants to manage direct payments and staff employment, and that though many care workers might have private clients, few want to be fully self-employed.

Workforce

Beyond Homecare, a homecare provider, describe the view of many that while "a sufficiently skilled and sized workforce is the most essential element of a sustainable model of social care, the reality is that are simply not enough care workers available in Scotland to meet the demands of the population'. They also cite the rate of turnover of staff, the increasing demands on care workers in monitoring, recording training and registration as well as 'actively managing many aspects of health including mobility, nutrition, continence, skin integrity, mental capacity and medication'. Care staff are expected to implement the plans developed by a range of professionals such as occupational therapists, nurses and social workers with little support or training.

The requirements of registration with the Scottish Social Services Council and qualifications are, potentially, also barriers to growing the workforce because for the

same pay, a person can work in a shop, a bar or be a cleaner, without having to meet these obligations.

Beyond Homecare provide a breakdown of costs from the UK Homecare Association and argue that it is impossible to cover wages, overheads and other costs with the average commissioning rates from local authorities. This mirrors the arguments made by the independent care home sector – that the standard rates for residential and nursing care do not cover the actual costs of care.

UNISON highlight a severe staffing crisis, and the consequences of staff shortages. A union rep commented 'care quality really comes down to staff numbers and resources. Without adequate time and staffing there is a limit to how good care can ever be.' They continue:

> "When surveyed in December 2018, 38% of social care providers reported having vacancies. The national average for all sectors is only 20%. The average for the care sector masks some intensely problematic areas: 63% of housing support services had vacancies at the time of the survey and the prevalence of vacancies in care at home services was 60%. Over 20% of social care workers left their job in the year prior to the survey.
>
> Social care has a major problem in attracting and keeping people and this impacts negatively on service user experiences and the working conditions of the staff who remain."

The Scottish Social Services Council, the regulatory and registration body for social service staff, discuss workforce planning in detail and the recommendations from the Integrated Workforce Plan published by the Scottish Government in December 2019.

Alternative models of care

Scottish Care write that the public need to know that social care might be very different from how they imagine and that care homes are no longer 'retirement homes' and home care is not 'home help'

> "If we want to meaningfully involve citizens in the planning of social care, they must be equipped with an aspirational yet informed and realistic sense of what is possible, including fundamental information about the social care sector and what it delivers. Put simply, care homes are not 'retirement homes' but are now small hospitals, delivering highly complex clinical and emotional support up to and including end of life care (see: https://scottishcare.org/wp-content/uploads/2019/11/Care-Homes-Then-Now-and-the-Uncertain-Future.pdf). Care at home services are not 'home helps' but are supporting individuals with dementia and co-morbidities to remain independent and safe in their own homes (see: https://scottishcare.org/wp-content/uploads/2019/11/Bringing-Home-Care-A-Vision-for-Reforming-Home-Care-in-Scotland.pdf).

Many providers referred to the increased complexity involved with caring for people with advanced dementia, for example, and that social care planning and

commissioning need to be adapted to take account of the increase in frailty and challenges presented by advanced dementia.

Ideas and thoughts about alternative ways of providing care and support were included in responses to different questions. However, not many took up the challenge in the call to think radically about what might make fundamental improvements to social care planning and delivery overall, and provided either solutions that they were using to mitigate issues in the current systems, or focused on what was wrong. For example, Glasgow City HSCP said that an 'ideal model of care would mirror the ambitions of the Strategic Commissioning Plan and would maximise all available opportunities to engage across the whole system to support people to live well in supportive communities.' They go on to describe essential elements of any model within these communities;

- Workforce planning and collaboration across sectors
- Access to technology and technology enabled care
- Reablement services
- Housing with care options, homes that are fit for all generations, within communities
- Practical support – respite and short breaks etc – for unpaid carers
- Day-time opportunities

Lifespan services – these remove the dislocations and issues that arise when people transition from childhood to adult and to older people's services, and consider life as people experience it, without arbitrary ruptures dictated by physical age. (Scottish Autism)

In crude terms, services can be split into day care services, supported independent living, care home services and care at home services. Supported independent living does not tend to apply to people who require services simply because of their age and/or dementia, but tend to be used by younger people and those with long-term disability or support needs.

However, this formulation separates social care services from communities, and focuses on an 'individual needs' way of thinking, whereas most respondents call for accessible communities, with a range of opportunities, to be the default.

The Royal College of Occupational Therapists argue that their approach to support starts from the point of someone's ability and desire for independence, rather than need, and that their input and ethos would be useful in inspectorate and commissioning roles. Their discipline embodies thinking that considers the social and physical environment first. They observe that just 7% of homes meet basic accessibility standards and join many others in calling for more consideration of long-term accessibility in planning for housing.

Autism Scotland advocated supported tenancies as the ideal option, rather than care homes for Autistic people. They also said that layouts and adaptations need to be considered prior to planning housing, and that housing is required to meet a wider range of needs.

A former social worker provides detailed information on the Buurtzog approach to community health and care. It means neighbourhood care, and places the individual at the centre, surrounded by self-organising teams and a shrinking of management-heavy 'command and control' organisational structure. Cornerstone has used the model, as have other organisations, such as the Thistle Foundation in Scotland, sometimes adapting it according to particular circumstances.

Highland Home Carers are an employee-owned company that runs home care services and offers complex care, with over 500 staff, and The Care and Wellbeing Co-operative are based in rural Perthshire, and their mission is to develop innovative ways of offering care and support.

Homeshare UK describe a formalised option whereby people in need of support share their home with someone who can provide it, but who also needs a home. A Homeshare Partnership Programme has been running in England and Wales. The scheme entails a matching and vetting service.

Integration of health and social care

The third sector, like the independent sector, do not feel like equal partners within integration authorities, when it comes to planning, commissioning and designing services, and do not feel like there is a level playing field in the commissioning and procurement processes. However, it has to be remembered that it is the integration authority, along with NHS boards and local authorities who have ultimate accountability for how public money is spent. It seems that there is therefore something unresolved in how integration authorities are configured and their relationships with third parties who deem themselves equivalent and essential stakeholders in the provision and design of social care. Given that around 70% of social care is provided by the independent sector this is not surprising.

> "Integration Authorities (IAs) need to move away from traditional models of care and have the courage to do things differently. They must recognise the important role that the third sector can play in the provision of social care, shifting the balance of power to ensure that the sector is an equal partner in health and social care partnerships. With commissioning sitting with statutory partners and the third sector being the commissioned service, a power imbalance exists. This power imbalance should be addressed to allow real and effective collaboration with coproduction at the heart of service planning and design.
>
> Whilst we recognise that IAs must work to strategic commissioning plans, it is vital that the planning and design of any new commissioned service should be informed by the people receiving the service, engaging users of services, as well as the organisations that provide the support. The third sector can bring

> innovation and flexibility that the statutory sector alone cannot achieve." (Third Sector Dumfries and Galloway)

Glasgow City HSCP says that it is moving towards a neighbourhood approach to the planning of health and social care services, and that commissioning 'is viewed as an integral part of the IJB's core functions at both a strategic and operational level. However, this does not seem to translate into the involvement of all stakeholders within those neighbourhoods, according to submissions.

> "From discussion with our members, the vast majority state they have seen no difference in their involvement or access to integrated authorities since the Public Bodies (Joint Working)(Scotland) Act and the development of Integrated Joint Boards and Health & Social Care Partnerships…Most people state they feel this was a "bureaucratic reshuffle" to paraphrase rather than any shift in power, control, access to resources or ability to influence." (SPAEN)

> "If integration was working, then the public would not need to know who was providing the service (health or social work), but it is not working like that. People are constantly told 'that's not our budget/fault" (Borders Carers Centre)

Neighbourhood (localities) planning and integration is about more than social care, and incorporates all services that contribute to the health and wellbeing of communities.

COSLA asserts that 'housing and wider infrastructure are of course fundamental to delivering good social care support and keeping our communities healthy and happy.' They cite transport, arts and leisure, fair work, tackling poverty, public and green spaces, training, ease of migration, education and addressing the gender issues of care and caring (employment and unpaid care) as being inextricably linked to good community-based social care support and prevention of ill health.

East Ayrshire Health and Care Partnership state:

> "Integration Joint Boards are key to ensuring that a complex whole system works in a joined-up way by demonstrating strong relationships across sectors to deliver health and social care services. For example, within East Ayrshire we have worked closely with housing and third sector colleagues utilising the opportunities presented by the Strategic Housing Investment Programme. New supported housing options are achieving increased independence and better outcomes for adults and older people with additional support needs."

They go on to describe and detail numerous ways that they focus on collaboration, preventive focus and public involvement, such as participatory budgeting, running proactive campaigns on loneliness for example and peer mentoring models for staff.

Housing

Housing is perhaps the first and most basic element of infrastructure of integrated communities, but views vary from those who advocate bespoke, contained retirement villages to those who think communities should be fully inclusive and

accessible for all without hiving off the more vulnerable into separate communities with little intergenerational flow. But, more fundamental issues appear to be evident, regardless of what makes community, about what developers are prepared and able to build.

Social Work Scotland highlight some of the problems with creating a flexible housing stock, adapted for life-long living.

> "There are tensions and barriers to more productive working with housing developers, largely due to the planning system and financial pressures on housing associations which prevent ambitions around accessible housing – for older people and housing for life – to be built. The best practice guidance issued by Scottish Government for more accessible housing is not a requirement and has proved challenging to comply with, and we think there is merit in examining industry standards for accessibility to consider whether they are fit for purpose. There are some very positive examples of best practice driven by the Scottish Federation of Housing Associations such as technological solutions in housing, but these are limited in spread."

Housing for the future could almost be a subheading for alternative models of care in the context of social care. A number of submissions discussed housing in relation to future needs and technology, and that the housing sector is key to the future provision of successful social care support.

> Blackwood Homes and Care have developed an accessible home 'the Blackwood House and currently have a programme to build 150 new homes in Dundee, Glasgow and Edinburgh.
>
> "The Blackwood House is designed to be beautiful, affordable, highly accessible and connected. Key features are:
> • An automatic door entry system that operates from a key card and has been fitted with an external camera for added security.
> • Pocket doors that slide open and shut at the touch of a button, eliminating the need for manoeuvring around the door as it disappears into the wall.
> • Electric blinds that can be controlled from an app to suit a range of scenarios are installed in each room.
> • Underfloor heating throughout and temperature control in each room gives maximum use of space without having radiators fixed to walls.
> • Rise and fall surfaces and wall cupboards, and a rise and fall hob in the kitchen.
> • A fully adapted bathroom with an adjustable rise and fall sink fits any height and equipment such as the grab rails that slide along the wall and lock wherever is comfortable. Also, in the bathroom is the Geberit toilet with remote control so the individual or a carer can operate from within the bathroom or a carer can wait outside and control the automatic cleaning system.
> • Solar panels keep the home green and cost effective ensuring temperatures which help residents to remain healthy.
>
> The Equality and Human Rights Commission (EHRC) report in 2018 recommended that Scotland should increase its supply of accessible homes.

> With our ageing demographic now is the time to cater for a big increase in mainstream accessibility so that the design of the home can also support the effective delivery of health and social care services."

Royal Blind argue that the most simple adaptations can transform support needed, such as better lighting, grab rails, lever taps and non-slip flooring.

Use of Technology

Most submissions recognise and comment on the real and potential value of technology in social care and support to enable better engagement, data gathering that produces useful insights regarding service provision. It is recognised that there is space for further innovation in various technologies, and more use to be made of existing technology. However, most also express caution that technology should not be used as a substitute for human contact, nor that it is an outright solution where geography is challenging.

CCPS make the more general point that the competitiveness that tendering for providing services fosters does much to inhibit the sharing and collaboration of innovation in technological solutions as in other areas of practice.

Scottish Care are working with the Glasgow School of Art and state that in the development of technology to support social care:

> "We need to support individuals, providers, planners, developers and commissioners to view and utilise technology as a means to empower rather than restrict, and to reinforce rather than replace…
>
> …Social care is not about performing certain functions and tasks alone for it is primarily about relationship; the being with another that fosters individual growth, restoration and personal discovery. It is about enabling independence and reducing control, encouraging self-assurance and removing restriction, maximising choice and building community."

HRM Homecare services see the potential in technology to provide data to improve planning of services:

> "Embracing and funding the latest technology, such as handheld mobile devices with appropriate software making clever use of data, will help transform adult social care. Innovation gives both service providers and service users more control of what support they need. It allows through more detailed analysis of need to make support more targeted. This would take us away from the current 'one size fits all' model for service users"

Some submissions recognise the connection between overall design of services and environments with technology. Blackwood are enthusiastic about various developments and ideas.

> "We believe there is major scope to use design and technology to give people and communities better tools to live as independently as possible, preventing or reducing the need for social care in many cases… Our proposal would be

> to create a single investment fund/framework for Scotland, bringing universities, industry, public services, providers and commissioners together to develop data tools and products, giving each of us the ability to monitor our resilience and take action to increase the likelihood of remaining as independent as possible as we age. Current examples of medical 'prediction' tools, similar to the SPARRA (Scottish Patients At Risk of Readmission and Admission) tool could be translated into diagnostic data. This information must be 'owned' by individuals…

Range of provision

Many submissions commented on the range of provision available being very variable across the country, and often limited, often removing choice for individuals and making it impossible to achieve the outcomes they sought.

The National Carer Organisations highlighted disinvestment in many vital supports, closures and access, despite the policy focus being on community-level care and support. They argue that some of this is because of the lack of joined up involvement in decision making, suggesting that strategic commissioning planning sometimes misses the potential and needs that exist beyond the direct remit of public bodies.

Human rights approach and inequity in social care

Human Rights based approach to social care

The following sections cover discussions on rights as well as the reported inequities in the system, some of which have already been covered.

Comments about human rights tended towards an overall approach to thinking about social care. A number of submissions felt that the PANEL[4] principles should underlie any social care modelling.

The ALLIANCE asserts that social care should be reframed as a human rights issue, arguing that it would help "to shift it from a 'demand' and 'drain' on resources to a positive investment in the people of Scotland, underpinned by a set of internationally agreed principles' such as universality, non-discrimination and equality. They seek to dispel myths that such an approach is purely legalistic or a bolt on/wish list. They state:

> "The HRBA (human rights-based approach) is a different and positive way of doing things in both policy and practice. Rights provide a common language to address and overcome seemingly separate and thorny issues in a joined up, fair and transparent way. The HRBA is a practical way to explore the purpose and value of social care and drive the cultural shift away from the stigmatising medical and charitable models of disability to people being

[4] PANEL stands for Participation, Accountability, Non-Discrimination and Equality, Empowerment and Legality. More detail is provided in the submission from the Scottish Human Rights Commission.

> treated as rights holders who should not be discriminated against or denied their right to equality because of a condition or disability"

The Scottish Human Rights Commission argue that a human rights approach provides a framework for an approach to social care, and that human rights standards such as the Convention on the Rights of Persons with Disabilities provide guidance for underlying principles of any social care policy. Also, the right to live independently and the right to a private and family life, equality and non-discrimination are all relevant.

The submissions that refer to human rights do not vary greatly in their vision for social care from those that don't frame their ideas through human rights: that people should be involved in planning services that will impact them, that they are accessible, adapted to a local context, that they are of high quality and safe as well as provided equitably.

The question, then, perhaps relates to where legislation is appropriate. An example where rights were apparently enshrined in legislation, but could not be fully legally enforced, is the Patient Rights (Scotland) Act (2011), and the attendant Treatment Time Guarantee. The caveats to rights to treatment are based on clinical judgement – an individual cannot insist that their rights to treatment come above someone else's whose clinical need might be more urgent. The Act also seeks to balance rights with responsibilities and there is an associated Charter of Rights and Responsibilities. Misunderstandings about the extent of entitlement in this Act has led to frustration and disappointment for those seeking to exercise their right when they have been left waiting a long time for treatment. However, the Act undoubtedly helped in health boards streamlining processes and shortening waiting lists as well as in improving transparency of waiting times.

The Glasgow Disability Alliance (GDA) present many frustrations and limitations experienced by people's engagement with social care and support services, as well as a continuing 'blindness' to access issues in attitudes, and across portfolios and public services. They call for equalities monitoring alongside measuring unmet need to launch a collaborative, preventative approach.

Eligibility criteria meet lack of resources

One of the structural issues associated with social care and support, despite the broadly admired basis provided by legislation and policy, is the inequity associated with national eligibility criteria. The progressive tightening of eligibility criteria as resources diminish exclude many from care and support they need as well as threatening any attempt at foregrounding and focusing on prevention: someone is only deemed as needing support if they are in substantial or critical need. Services then, are put in place, to manage crises, not to prevent deterioration, positively manage risk or support independence. SCVO make the even more pointed observation:

> "We echo the concerns raised by the Health and Social Care Alliance over the perceived narrowing of eligibility criteria. As outlined in their response, this means some individuals will be denied a small amount of support which could

have maximised their independence and prevented, or at least postponed, a more expensive intervention such as admission."

MND Scotland cite a Sue Ryder report that found 'if someone with MND was to receive reactive care they'd have more frequent and extended stays in hospital. This would result in the average costs of their care being up to £193,000 compared with around £84,000 for someone who is receiving proactive care and support at home.'

Social Work Scotland also point out that:

> "the existing eligibility criteria should be reviewed. Current eligibility criteria are deficit-based assessment of levels of risk to an individual if care is not provided. They run contrary to the principles of personalisation, as they drive time-and-task service provision. They are applied differently across Scotland and result in unnecessary variation in outcomes for individuals."

Western Isles HSCP highlight other unintended impacts, describing the effect of Free Personal Care:

> "These progressive policies can have unintended impacts. Free Personal Care has in effect created a situation where the state monopolises the funding of care, which wouldn't be problematic if care were funded at the levels needed. As it is, we see increasing levels of unmet need in community settings as rationing tools like eligibility criteria are applied."

The GDA are cynical about policies that promote 'maximising independence':

> "Glasgow is currently pursuing policies which explicitly seek to lower expectations of entitlement to statutory support services. Polices including 'Maximising Independence' talk about 'redrawing the social contract' to place more reliance on families, neighbours and community-based supports' to meet people's care needs."

The GDA write this under the heading 'Erosion of Rights'. What the above observations highlight when put alongside many submissions that make no mention of human rights, is that the same issues, problems and perceived unfairness are common, regardless of the lens used. The ALLIANCE cite universality as inherent to the human rights approach. This confuses the notion that each individual has specific needs, or even denies that groups such as those with a disability, or older people, might have little in common. This means that rights quickly become reduced to one person's rights set against another's. When resources are limited, the tensions between groups and individuals become more pronounced.

Rights, then, are usually discussed in terms of a group or individual that thinks theirs are being threatened or eroded in relation to an undefined/unidentified and undefinable 'other' or 'others'.

Gender

A number of submissions comment on the over-representation of women in the sector and remark on features such as:

- low pay,
- job insecurity,
- unpaid travel, training and induction and
- undervaluing of care work and the
- invisible skills entailed in the significant emotional labour of care work.

Close the Gap state;

> "Scottish Government measures to increase pay for the lowest paid workers by facilitating the payment of the Living Wage are welcome. However, the Living Wage is not a panacea for the undervaluation as it does not address the crux of the low pay problem, which is that social care work is undervalued because it is mostly women who do the work."

They go on to say that no mechanism has been devised for job evaluations and raising the pay of those with greater skills and experience, leaving a very flat pay structure and little incentive to take on further responsibility. Healthandcare.scot also quote a care home manager saying that the Scottish Living Wage for all care staff creates divisions among staff, because domestics, laundry staff and catering staff might not be getting that rate.

Some other areas of inequity highlighted

Many described situations and scenarios that were not explicitly about a 'human rights approach, but nonetheless demonstrate structural inequities in the current system. For example, Bell and Douglas remark on the reduction of care homes and care home places since 2007.They acknowledge the preference that people are cared for in their own homes, but if people are living longer, alone, in very poor health, with greatly impaired mobility and/or with severe dementia, then this is not necessarily in their best interests.

Pressure on local authority budgets, they say, has led to a downward pressure on care home fees, weakening the viability of the care home sector. It has also created a two-tier system whereby self-funding residents subsidise those funded at a fixed, nationally agreed rate (£714.90 a week for nursing care and £614.07 a week for residential care) by local authorities for receiving the same service. They go further, stating that "the lauded Free Personal Care element paid directly to care homes (currently £180 per week for FPC and £81 for nursing care, pending parliamentary approval), has declined in real terms by 30% since the introduction of FPC in 2002." This undermines the principle of FPC.

Other inequities are discussed above, including the higher rates of fees paid by self-funders, subsidising local authority funded places in order to maintain the viability of the independent care home sector.

Personal communication with a provider also highlighted the fact that someone living in supported accommodation is able to live independently in the community,

sometimes receiving 24/7 care. An older person who has developed a neurological condition for example, would be unlikely to access this type of setting. There is a complex association between supported accommodation and the benefits system, as this House of Commons Briefing, Supported Accommodation, explains, and which is beyond the scope of this summary report.

Community focus and involvement in planning

The overarching sentiment was that consultation and involvement was not easy, and that to do it properly requires engagement on peoples own terms, according to their specific needs. While it is obvious that one size doesn't fit all, which came up in a number of submissions, the legislation and policy clearly has person-centred planning as a starting point. Accessibility is key to good consultation, whether it is an individual, group or community.

> "Again, we have often seen, particularly in relation to adult day care services, a lack of stakeholder engagement where statutory bodies lead and facilitate discussions...Giving communities a blank sheet of paper and asking them to re-design services with no access to resources, working examples, other stakeholders or a resource envelope is an almost impossible task…Integration authorities should facilitate individuals and communities to come together to discuss and explore the shared needs and desires of the community or particular groups within the community and enable them, through available resources, to consider and then commission services that will meet their needs…This would be much more like a partnership approach to procurement, commissioning and investment and less of a statutory led model which leaves people feeling disenfranchised and disengaged." (SPAEN)

> "Using real groups based in their communities and providing financial help to local trusted groups listening to the real voices of people and workers who care for all people who use all services." (Women's Support Service)

Health and social care partnerships acknowledge and strive towards the ideals of two-way communication and meaningful public engagement, but many third sector organisations felt that it was frequently tokenistic.

Co-production, Carers Scotland Organisations suggest, is not yet embedded. More pointedly, they quote individuals' accounts of not being heard or involved in decisions made on their behalf: 47% of carers surveyed did not know that they had a right to be involved in the planning of carer services for example, and 42% were not aware of their role in discharge planning when the person they cared for was to be discharged from hospital.

COSLA warn of 'the impact of consultation fatigue among the public', and that 'engagement should be done on a multi-agency, partnership basis and through the lens of community planning.'

In light of this, it is worth noting the existence of the Scottish Health Council's (part of Healthcare Improvement Scotland) Citizen's Panel, comprising 1150 members

drawn from across all 32 local authorities. Three Panel reports provide feedback on social care support. (see reports via hyperlink above).

The Scottish Partnership for Palliative Care said that 'The health and social care system is often reluctant to admit that people will, inevitably, die. ...a narrative which omits death, dying and loss fails to engage and involve the public honestly and effectively in planning of care'. In the stakeholder roundtable session held in Parliament early in 2020, the view was put that people in their 50s should be encouraged to think about the support, care and housing they might need in the future, rather than leaving it until crisis hits.

Third sector

To return briefly to Professor Gray's reflections, this is what he said about the potential, and contribution, of the third sector:

"Speaking of esteem, what of the third sector? They have some amazing insights and ideas, and make a huge contribution to supporting those who are most in need. They also have some really valuable community connections, which give people who are in need of support a voice which really is essential to understanding what works and what doesn't. Yet they are too often treated as hired hands, to be picked up and dropped every time a budget is reviewed – with the loss of continuity and erosion of trust that such an approach inevitably generates. I should have done more to insist on treating them as equal partners."

The submissions from the third sector demonstrate that their approach to supporting people is that the person is at the centre of their care and how they are supported. Many health and social care partnerships value the sector's ability to flex and innovate.

Highland Third Sector Interface develop some common themes:

> "It appears that generally 3rd sector organisations believe that health and social care integration has not delivered the expectations embraced within the concept. There needs to be a review of processes, impact and strategic planning at a local level. Equally, however, the government should consider changing the emphasis of measurement within the health and social care structures to better understand impact and quality rather than quantity; facilitating the ability to innovate and exercise initiative within health boards is necessary.
>
> There needs to be a review of risk appetite as it relates to social care, that isn't to say that any individual's provision should be compromised nor that person's safety, but the degree of risk aversion which exists at the moment stifles innovation and generates a culture which facilitates the lack of personal responsibility and accountability in the discharging of their duties and obligations for fear of being held to have done something wrong."

Accountability

Some thought that local authorities and social workers were not accountable enough to the public, and to the individuals they support. It was also felt that local authorities did not follow the policies or that the policies were not robust enough (Western Isles Community Care Forum).

Voluntary Health Scotland point out how blurred they believe accountability is in social care:

> "During a roundtable meeting held by VHS to inform our response to the inquiry the difference between legislation and how it is implemented as well as the role of accountability was raised. Decisions regarding the model of social care are made at a national level but are implemented locally which blurs the lines of accountability when things don't work. We recommend that the Committee explore what needs to change in order for legislation and policy to be implemented more effectively at a local level and also to identify where accountability lies."

CCPS press their point that the CI and Scottish Social Services Council, as the relevant bodies in terms of regulation and scrutiny, need to be able to scrutinise and inform all parts of the system, including planning, commissioning and procurement to ensure and enable improvement and innovation across the system, not just in-service provision and workforce.

Beyond Homecare summarise, in discussion about their relationship to the health and social care partnership, some of the issues and conflicts in a system that is regulated centrally, are funded regionally by single purchasing bodies that procure services from a range of providers (creating a monopsony – a single customer and numerous providers).

> "the Health and Social Care Partnership are clearly working towards the goal of supporting vulnerable people to remain in their own homes. However, the outsourced nature of the homecare framework often means the risk and responsibility…is passed down the supply chain. The Scottish Government and local authorities create the social care framework. The Care Inspectorate and health professionals set the standards and expectations in relation to care delivery. The challenges and often unrealistic expectations of these standards are then passed to the care provider to deliver."

There seems to be frustration that despite the legislation and the policy being in place, that successful implementation has not followed. Some of the consequences of this have been covered in this summary, and are reiterated frequently through submissions. The questions to ask, partly answered here, are what are the barriers to implementation of good policy.? Resourcing and procurement practices appear to be the main underlying issues identified.

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