ScottishCare
Voice of the independent care sector

PUTTING HUMAN RIGHTS INTO THE COMMISSIONING CYCLE

How to articulate your 'gut instinct'

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Introduction

Scotland is a country steeped in human rights. In June 2017 the Health and Social Care Standards were published by the Scottish Government, setting out what we should expect when we access care and support.[1] These standards, based upon human rights, reinforce the principles of dignity and respect and are supporting the sector to articulate and capture how it delivers quality through an experience-led approach.

This ability to articulate and capture is important because it offers a mechanism which has been missing from other outcomes-based approaches. We see this mechanism in action most clearly in the roll out of the Standards to regulatory processes. Providers describe a shift from inspectors spending hours reading papers to spending hours with care home residents and staff. This in turn brings a shift in relationships; fostering the trusting environment which enables improvement and innovation.

Of course there are checks to ensure safety, compliance and governance, but what this new system allows is a way to capture the 'gut feeling' that veteran care staff, citizens and families alike recognise but cannot find the words to describe.

However as roll out has been progressive, starting with care homes, relativity has amplified the confusion for those who provide care at home and housing support services. They are practicing and regulated by the Standards but not yet inspected by them; they are learning to articulate qualitative impact through self-assessment, but are unable to have it formally recognised, nor do they yet have those crucial enablers for trust.

It is exactly this disconnect which we see in situational commissioning and procurement processes. This paper proposes that the Health and Social Care Standards are not yet embraced by those who are designing, planning and purchasing services thus limiting the commissioning process from realising the true potential of accessible resource.

Putting human rights into the commissioning cycle is the key to unlocking this potential.

The commissioning context

"The importance of effective strategic commissioning for the success of integrated health and social care provision cannot be over-stated. It is the mechanism via which the new integration partnerships will deliver better care for people, and better use of the significant resources we invest in health and social care provision."[2]

Commissioning is the '*big picture*' thinking required to ensure that everything which is required is available and accessible at the right time. This delicate balance requires understanding of both local and national demographics and policy, as well as market forces and the interdependencies between these (current or potential). It follows a cycle of Analyse, Plan, Do, and Review.

A sinking feeling: what is really going on?

Procurement

Commissioning and procurement are inextricably linked but often considered in isolation, or increasingly considered as procurement alone, as evidenced by reports to IJBs focussing on the bottom line and missing the totality or opportunity of resource. We also see the move of commissioning teams to sit within procurement departments.

This is an approach which is affecting service sustainability and the continued ability to deliver high quality care and support. No matter the good intentions, the drive to get a better price undermines the system. Cheapest does not necessarily mean best value, and this practice should be considered within the context where it costs double for the Local Authority to provide the same type of service.

There needs to be a return to commissioning leading the way – it is simply not a case of 'what we can afford to do?', but instead a question of 'this is what we need to do, so how do we get there?'.

In addition, the Social Care (Self Directed Support) (Scotland) Act 2013, a laudably human rights-based approach to enabling people to have choice and control over the way that they access care and support is undermined by the tendering process which disrupts continuity of care when contracts come to an end. This is an additional risk where providers are now bidding at a price which is unsustainable just to retain continuity for the supported person. This is the business of care after all.

If the market were buoyant and SDS wholly embraced, it could be a way to avoid tendering altogether, stimulating growth through what is effectively 'pump priming'. However, purchasing care is not the same as purchasing a product and instead we experienced a market not fit to accommodate SDS. Changes to the market must enable choice and control at the same time as preventing negative or unwarranted disruption for those accessing care and support. In addition, the low rollout of Option 2 removed any potential for C to B economic stimulus, nor was there significant guarantee of interim contingency payment from Local Authorities. In essence, it is no use a person having the financial means if neither the system, the market nor the product is in a position to deliver.

In addition, tendering destabilises the market causing waste and bureaucracy through the acquisition and loss of bids – last year, 9 out of 10 of our care at home providers told us that they did not know if they would be sustainable beyond the year[3]. Commissioning and procurement has been designated as an area of the Adult Social Care Reform Programme led by Scottish Government and contributed to by leaders from across the sector including Scottish Care, and whilst this offers reassurance about long-term change, it does not provide the immediacy required.

Instead, we need to consider what changes can be implemented quickly in the interim: a transparent approach to pricing is one proposal which will challenge the need to include it as a high score item in the tendering process whilst we continue to go down that route. The knowledge that the cost of care is 'fair' as work on the National Care Home Contract Indicative Cost Model is seeking to achieve, creates the conditions to measure value and purpose instead.[4]

Scottish Care recommends that this becomes part of the work in developing the National Procurement Framework on which Scotland Excel is leading.

Current proposals for the Framework will reduce administrative burden for those operating in more than one Local Authority, but until there is an honest and collaborative conversation with all involved about how to mobilise and recognise value and opportunity as well as co-producing a method for costing this, it is difficult to uphold the process as the solution to sustaining the high quality care and support which Scotland deserves.

Fair work

Perhaps most crucially, this destabilisation is contributing to poor recruitment and retention rates, as tendering removes the capacity of providers to offer job security. The recent report by the Fair Work Convention, of which Scottish Care are members, describes the need for fair commissioning to create the conditions for a valued workforce.[5] This comprises not just of rate setting, but the wider impact of commissioning decisions upon the sector as a whole: "*Some plans contain a high level summary of workforce issues. It is imperative that emergent integrated workforce plans carefully consider and seek to address the panoply of issues for staff in health and social care services, including in the third and independent sectors."*[6] Equity of terms and conditions should help to stabilise a workforce which might otherwise move to the employment of the statutory sector. This must include consideration of: payment of the Scottish Living Wage, for travel time, registration, learning and development, and so on.

In addition, there needs to be a change of culture, to recognise the highly skilled nature of staff across the sector and the underutilised opportunities of interdisciplinary working. The Fair Work Convention report quotes "*There isn't enough money and that's a lot to do with the value of the profession, the way the profession is considered in society*".

Competition or collaboration

It is clear that competition is a false concept within a monopsony and the effect of driving lower rates is pitting providers against each other. There must be greater shift towards trust-based and relationship-based commissioning of which we are starting to see some examples. North Lanarkshire has set wide parameters for care at home providers to work within, and in Dumfries and Galloway there are various projects underway to reduce unplanned admissions to the acute sector. Whilst neither of these are currently working perfectly, the desire to collaboratively facilitate change for the better is still having a beneficial effect for all involved and is at the very least, a good place to start.

It has long been known that collaboration and co-production lead to maximised resource. Regulation and contract monitoring become the only formality so instead of conversing over coins, it is possible to have conversations about shared opportunity and potential between *all* stakeholders, yet there remains an underlying reluctance to facilitate such change with the independent sector. However, even if it were possible to move towards collaboration the time-bound process of tendering promotes instability around contract length which could affect cross-border collaboration.

There is a disconnect between the many facets of health and social care and so long as this continues the future of the sector is brought into question. The Public Bodies (Joint Working) (Scotland) Act 2014 [7] outlines the framework for the integration of health and social care proving yet again that Scotland can offer innovative solutions to complex challenges, but the failure to recognise the independent sector in legislation has required subsequent political support for such collaboration to be considered and only rarely realised to date. Given the increased demand upon resource which Scotland is facing, commissioning and any related strategy or planning must include the totality of opportunity to be effective. To omit the independent sector from this conversation is at best limiting and at worst damaging.

Whilst we await the results of the work on Community Led Support on the impact of co-production and collaboration,[8] Scottish Care's *Partners For Integration* Team has been working with Health and Social Care Partnerships across Scotland to facilitate collaboration and where this has been embraced we have seen significant impact by realising the potential of the whole system.[9] This is not simply about 'on the ground' action but about a holistic approach to commissioning which includes *all* stakeholders. So many positive developments are as a result of 'water cooler conversations' within a context of trust. Independent sector representation at IJB level has been key to the actioning of many of these serendipitous interactions.

Improvement

Improvement is absolutely necessary and cannot be separated from the role of rights-based scrutiny provided by the Care Inspectorate. The criticality of their role in improvement, as an organisation independent from both purchaser and provider, will never be clearer than in the conversation relayed to Scottish Care by a manager who was told by a Local Authority to think about investing in a

different area if they wanted to be paid enough money to earn a Grade 6*: "This is not a Grade 6 authority*". This opens the questions of the inter-relatedness of cost and quality and fundamentally the rights of every citizen in Scotland to access quality care and support. A human rights-based approach to commissioning and procurement would prevent such bias and inequality.

The focus on finance since the period of austerity has created a real push to get things done as cheaply as possible. There is a drive to 'do more with less' or simply just 'do better'. It must also be recognised that there is an increasingly crowded improvement landscape created by the desire to 'do more and do better with what we've got'. Whilst this is not a criticism of improvement per se as it has a definite role to play, there must also be room for innovation. Instead of thinking 'how do we do better with what we have got?', we need to explore if what we are doing and what we have got are the right things. Innovation requires the investment which has been driven out of the system through a focus on improvement and cost despite having a key role in ensuring both the sector and the system are futureproofed.[10]

The work that Scottish Care has been doing with the School of Innovation and Design at GSA has been exactly that – thinking about what is possible tomorrow given what we know today, and is leading to recommendations for the future of the sector such as changing workforce roles towards ensuring ethical care in a digital age.[11] The aforementioned Adult Social Care Reform Programme will be crucial in designing how care and support will look in the future and must not fall into the same limiting trap of solely adopting a solution-focussed approach. SMART goals must be set alongside and within an innovative context to make lasting change.

Intelligence and data

With planning and analysis making up half of the commissioning cycle, the importance of intelligence and data cannot be underestimated. Population needs assessment is a key part of analysis and plays a particular role in implementing the much-heralded preventative approach which reduces access to the acute sector. Yet, Health and Social Care Partnerships are currently making decisions without all the evidence. The independent sector, comprising of the majority of care across Scotland, collates significant volumes of data through means such as care planning which should be utilised in commissioning

for the future, yet it is glaringly absent. Scottish Government is supporting the development of a 'Digital Backpack'; a move towards people owning their owndata digitally, and an idea which has much merit. However the exclusion of the sector in its development is concerning as the impact of the new process will need to be incorporated into the delivery of care whether through the practicalities of accessing hard and soft-ware, staff training or time, or in establishing data sharing agreements.

In addition, in the significant period of time it is taking to develop such capability, existing data remains underutilised. One must question whether the impact of not sharing data is greater than the legislation which prevents it. Scottish Care welcomes the invitation to explore access to and the analysis of data as part of the wider SOURCE programme, and recommends initiatives such as the extension of NHS email addresses to care homes to enable secure data transfer such as in Edinburgh.

It is not possible to mention data and human rights without mentioning Electronic Call Monitoring. The product is helpful in its approach to billing and rostering systems, but its implementation to deliver time focussed visits of sometimes only 15 minutes wholly undermines the intent of social care. The current frustrating focus on measuring outputs limits our possibilities; impact can never be measured in time. Analysing the amount of time spent with someone cannot capture what was done in that time or indeed what could be done, thus making it a wholly inappropriate method for measuring effectiveness or potential. We hear stories of providers being penalised for spending more time with people than they are authorised to do so – most harrowing when they involve the need for urgent medical intervention, or waiting with someone until the ambulance arrived when their loved one had passed away.

The need for a more dignified approach extends to staff, some of whom describe feeling as though they are 'electronically tagged'. In addition, the unreasonable costing parameters are unsustainable for providers leading to non-payment for travel time. This can mean that an eight hour shift in total means getting paid for only six.

How to put human rights into the commissioning cycle

This report has aimed to contextualise a selection of instances where commissioning and procurement practice has undermined the Health and Social Care Standards and therefore the human rights of some of our most vulnerable citizens as well as the social care workforce. Whilst this is not an exclusive or exhaustive list, its existence evidences the requirement for action. Whilst this paper contains some recommendations to combat the issues contained within, actioning this list will not in itself prevent future occurrences; especially those currently unknown.

In remedy, this paper recommends that an indicator based upon the PANEL principles which underpin the Health and Care Standards should be introduced to measure the potential impact of commissioning decisions. This would provide the appropriate intelligence required by members of Integrated Joint Boards to enable them to clearly and easily see the direct and indirect effect of decision-making upon the human rights of the local population. Using PANEL would enable focus on the central importance of participation, built in accountability, and the setting of outcomes which are non-discriminatory in nature and ensure equity of allocation regardless of age or other inequalities. As such, commissioning would become empowering through engagement, involvement and inclusiveness as well as accepting of the legalities of not just the Human Rights Act but wider social care legislation such as SDS.

Whilst the issues raised in this paper can be used to guide the development of the resource, they should not become a checklist and risk missing crucial components in a sector which has the ability to adapt and change rapidly as required when working in a sector which champions personalisation. Instead, a multidisciplinary approach to the development of the process and methodology by which such evidence should be gathered and presented should be employed as is it important to ensure that it captures the totality of risk without being over-burdensome. It must also ensure that whilst implications are all-encompassing, they are easily interpreted in a tangible way.

This paper calls for the resource to enable such a method to be explored and implemented rapidly to prevent the further deterioration of a system which is perpetuating instability.

[1] The Scottish Government, *Health and Social Care Standards: My Support, My Life*, 2018 https://scotgov.publishingthefuture.info/publication/health-and-social-care-standards-my-support-my-life

[2] Scottish Government, *Strategic Commissioning Plan, Statutory Guidance*, 2014 https://www.gov.scot/publications/strategic-commissioning-plans-guidance/

[3] Scottish Care, *Contracts and Sustainability Report*, 2018 http://www.scottishcare.org/wp-content/uploads/2018/01/SC-Care-at-Home-Sustainability-report-2017.pdf

[4] CMA, *Care Homes Market Study Final Report*, 2017 https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

[5] Fair Work Convention, *Fair Work in Scotland's Social Care Sector*, 2019 https://www.fairworkconvention.scot/wp-content/uploads/2018/11/Fair-Work-in-Scotland%E2%80%99s-Social-Care-Sector-2019.pdf

[6] The Scottish Government, *Health and Social Care Integration Strategic Commissioning Plans*, 2016 http://89.145.103.204/~alliancescotland/health-and-social-care-support-and-services/wp-content/uploads/sites/4/2017/09/Scottish-Government-Strategic-Commissioning-Plans-Review-October-2016.pdf

[7] http://www.legislation.gov.uk/asp/2014/9/contents/enacted

[8] https://www.ndti.org.uk/our-work/our-projects/community-led-support

[9] Scottish Care, *Focus on Partners for Integration,* 2018 http://www.scottishcare.org/wp-content/uploads/2018/09/PRESS_Focus_Report.pdf

[10] Scottish Care, *Care Homes: Then, Now and the Uncertain Future,* 2018 http://www.scottishcare.org/wp-content/uploads/2018/11/Care-homes-then-now-and-the-uncertain-future.pdf

[11] https://futurehealthandwellbeing.org/future-of-care-at-home

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