Scottish Care
Voice of the independent care sector

BRINGING HOME CARE

A VISION FOR REFORMING HOME CARE IN SCOTLAND

ABOUT SCOTTISH CARE

Scottish Care is a membership organisation and the representative body for independent social care services in Scotland.

Scottish Care represents over 400 organisations, which totals almost 1000 individual services, delivering residential care, nursing care, day care, care at home and housing support services.

Our membership covers both private and voluntary sector provider organisations. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations and associations.

Our members deliver a wide range of registered services for older people as well as those with long term conditions, learning disabilities, physical disabilities, dementia or mental health problems.

- **The Scottish independent social care sector contributes to:**
- **The employment of over 100,000 people**
- **The employment of over 5,000 nurses**
- **The provision of 85% of care home places in Scotland**
- **The delivery of over 55% of home care hours for older people.**

CONTENTS

INTRODUCTION

The journey of home care

Care at home services have a fundamentally important strategic and practical role to play in creating a person-centred, rights based pathway of care and support fit for Scotland's citizens in the 21st century.

Not only do these services deliver care and support to people in their own homes, but they also enable individuals to retain their independence and community connectedness, prevent unnecessary admission to hospital or long term care and improve outcomes for adults and older people with care needs.

However, the historical and recent development of care at home services have prevented this critical sector from fulfilling its potential in best supporting individuals, communities and the already stretched health and social care sector within which these services operate.

Care at home services have tended to be developed almost accidentally; in part as a reaction to the market, whether that be a shaping in response to social care commissioning or a reaction to health and wellbeing policy development.

There have certainly been occasions when the sector has helped to shape, influence and even re-orientate its contribution to the whole health and social care landscape. However, these have been relatively few and far between.

This has caused many problems; a lack of commissioning for innovation and new developments, a stereotypical assumption of the contribution of care at home and housing support and more worryingly, a diminution of its central importance and the effective marginalisation of the capacities and skills of the care at home workforce.

This report will seek to demonstrate that for the care at home and housing support sector to become a sustainable, high quality form of care provision which is self-evidentially an intrinsic part of the whole, we must do a lot more to focus upon and develop some of the major contributory elements of its work.

The following areas of home care delivery will therefore be explored, in relation to how they have changed over time to the present day, and what the future focus of care at home provision is likely to be:

- The role of care at home workers and services
- The development and sustainability of care at home services
- Partnerships, relationships and status
- The value placed on home care provision, and the people they support.

The report will locate the tracking of these changes in a context of:

- Highlighting the loss of relational elements of the care offer and the impact this has had;
- Describing the increase in eligibility criteria and the consequential decline in overall use of care at home services;
- Focusing on the potential of the 'preventative role' of homecare, and
- Relating this to the ADL LifeCurve™ work of Professor Peter Gore from Newcastle University.

In doing so, we hope it will show that the future of care at home services must be developed and commissioned in a way that prioritises time-flexible, relationship-based, preventative approaches to care delivery.

Context

The delivery of home care and support services in Scotland does not take place within a policy vacuum but rather with a defined context which emphasises individual choice and control, independent living, self-management and prevention.

Even before the last decade, there was a clear underpinning of legislation in Scotland to enable individuals to be cared for and supported in their own homes.

The Social Work (Scotland) Act 1968 placed a duty upon local councils to assess a person's community care needs and decide whether there was a need to arrange any services. It was followed by the **NHS and Community Care Act 1990** which was the first legislation to bridge the gap between health boards and local council social services. Social work departments were given the responsibility for community care for older people, and home care, day care and respite care were further developed to help people live in their own homes wherever possible. Then the **Community Care and Health (Scotland) Act 2002** introduced free personal care for older people, which was to be provided regardless of income or whether they lived at home or in residential care.

This foundation was then followed by the **Social Care (Self-directed Support) (Scotland) Act 2013,** which made legislative provisions relating to the arranging of care and support, such as community care services. Any examination of home care in the Scottish context today cannot be divorced from the legislative underpinnings, which this Act provides or at least requires.

Self-directed support (SDS) is itself the continuation of a long process of policy and practice innovation which has sought to put the individual person at the centre of public service delivery. SDS is aimed at giving people greater informed choice and control over the services they want to support them, and how they want to be supported. It stresses the importance of individuals being enabled to achieve the life that they want for themselves.

'The Act creates a statutory framework around the activities already underway across Scotland to change the way services are organised and delivered - so that they are shaped more around the individual, better meeting the outcomes they identify as important. So individuals are seen as 'people first' – not service users.'

Practitioners and providers in social care and health have a major part to play in embedding these values and principles in the delivery of services in the years to come.

The Act also puts into statute the core principles of participation and dignity, involvement, informed choice and collaboration. A major focus of the Act is the emphasis on co-production, not least at the stage of assessment and support planning. Co-production is a newer term and has been used to describe the ways in which individuals and their communities are involved in designing and delivering social care. It emphasises the importance of recognising individual and community assets and strengths as a way of building social capital. It also seeks to embed an approach towards appropriate intervention which is timely, proportionate and prevention-focused.

To drive forward all this work, the Scottish Government has developed a 10-year Self-directed Support strategy with partners, stating the intention as:

'...delivering better outcomes through focused assessment and review, improved information and advice, and a clear and transparent approach to support planning. The strategy is part of a wider reform agenda, and reflects the common goals of current health and social care policy to deliver

better outcomes for individuals and communities.'
The **Public Bodies (Joint Working) (Scotland) Act 2014** highlighted that the integration of health and social care was central to the Scottish Government's programme of reform to improve care and support for those who access health and social care services. It provides the legislative framework for the integration of health and social care services in Scotland.

It has put in place:

- Nationally agreed health and wellbeing outcomes, which apply across health and social care, and for which NHS Boards and Local Authorities are held jointly accountable
- A requirement on NHS Boards and Local Authorities to integrate health and social care budgets and planning functions
- A requirement on Helalth & Social Care Partnerships to strengthen the role of clinicians and care professionals, along with the third and independent sectors, in the planning and delivery of services.

Partnerships are jointly accountable to Ministers, Local Authorities, NHS Board Chairs and the public for delivering the nationally agreed outcomes.

Since both the SDS Act and the establishment of integrated bodies, Audit Scotland has explored the delivery of social care services in Scotland notably in **Social Work in Scotland.** Amongst other points, it stated that councils now spend £3.1 billion on social work-provided services. However, it argued that current approaches to providing services will not be sustainable. By 2020 the report estimated that social work will need up to £667 million more each year unless new ways of delivering services are implemented. It highlighted that:

'Fundamental decisions have to be taken on how services are provided in the future ... More work is also required to involve users in how services are designed, commissioned and run.'

Since 2011/12, social work spending has increased by 3 per cent when overall councils' spending has fallen by 11 per cent. Councils have made savings by reducing services and cutting costs.

It also noted that financial pressures, including costs of the Living Wage, will require an estimated additional annual spending of between £510 and £667 million by 2020. What's more, there is increased demand in some areas with the need for enhanced workforce skills yet corresponding staff shortages.

The report further stated that:

'Councils have adopted a number of strategies to achieve savings; they have tightened eligibility criteria so that fewer people receive services and targeted funding to people in greatest need. For example, the proportion of people aged 65 and over receiving homecare has fallen from just under 70 per 1,000 in 2006 to just over 50 per 1,000 in 2015 . They have also achieved significant savings in the cost of home care and care homes through commissioning and competitive tendering. Costs for these services have fallen in real terms by 7.2 per cent and 10 per cent respectively between 2010/11 and 2014/15.

'Although councils want to deliver more preventative services, there has been a limited shift to prevention, different models of care or better tapping into the support available from the wider community. There has been little in the way of fundamental change in the way councils deliver services. Many councils have taken an opportunistic or piecemeal approach to change, often to meet financial challenges or as the result of initiative funding by the Scottish Government.'

Recognition of the need to undertake the reform work that Audit Scotland's Accounts Commission has called for is evident in the establishment of reform groups by Scottish Government and other stakeholders.

How this report has been developed

The findings contained in this report are primarily based on a recent survey undertaken by Scottish Care of its members who deliver care at home and housing support services.

The survey explored issues such as workforce challenges, including recruitment and retention, financial and operational sustainability and wider stakeholder relationships.

This online survey ran from February to March 2017, and was sent by email to relevant member organisations of Scottish Care.

As a result of this approach, 82 responses to the survey were collected which represents a significant number of care at home organisations across Scotland. Responses were collected at an individual service level to better enable the analysis of trends across Scotland.

Responses were received from a wide range of care at home and housing support services, and were completed by owners, managers and supervisors of these services.

Of the responses, 92% were completed on behalf of private organisations and a further 8% represented voluntary providers of care services, including registered charities.

67% of responding services hold combined care at home and housing support registrations with the Care Inspectorate, and the remaining 33% of services are solely registered for care at home provision.

In terms of service size, these range from those who provided less than 200 hours of care per week with as few as 6 clients, to those who deliver upwards of 10,000 hours on a weekly basis to over 3,200 clients.

In total, the responding services deliver care and support to an average of 15,372 individuals each week. 90% of the responding services provide support to both individuals whose care is publicly funded and those who pay for their care themselves but for 65% of these services, Local Authority funded clients make up over three quarters of their total care provision.

All Local Authority areas were represented in the responses, other than Orkney, Shetland and the Western Isles. This is reflective of Scottish Care's membership coverage across Scotland.

PREVENTATIVE CARE

In order to examine the care at home sector's role in delivering preventative care and why this is important, it is necessary to understand what preventative care is, what the policy ambitions that underpin it are and why it is so significant.

One of the challenges of understanding preventative care is that there is not a commonly applied definition. However, as with most things, simplicity is usually best:

'Prevention: Actions which prevent problems and ease future demand on services by intervening early, thereby delivering better outcomes and value for money'.

The Scottish Government and COSLA paper from which this definition is drawn is also helpful in succinctly outlining why preventative approaches to care are so important:

'*As the Christie Commission made clear, transformational change in service delivery is required to improve outcomes for people, tackle inequalities and maintain financial sustainability in the face of continuing challenges. The demand on public services – created by a changing population, rising unit costs, constrained public-sector budgets... and the historic balance of spending on crisis management – all provide clear imperatives for a shift to prevention.'*

Whilst these challenges – demography, budgets, sustainability and the balance of care – were at the fore when this was written in 2012, they have never been as critical as they are in 2017. It is easy for words such as 'crisis' to be used idly, but they are absolutely accurate for describing particular parts of the health and social care sector at present.

Considering this from the perspective of acute services alone, the current reality is:

- Unplanned hospital admissions in Scotland cost the NHS and Local Authorities £1.5 billion each year, which is more than expenditure on care homes, home care services and GPs combined
- 61,000 such admissions are due to medication side effects
- The average cost of one unplanned hospital stay is £2,746.

Therefore as well as strong outcomes-based arguments regarding the wellbeing of individuals and where they want to be supported, there are robust economic arguments for investing in a preventative model of community care. However to date, systems which value prevention do not appear to have progressed with the vigour required to effect meaningful change.

This could be because in practice, preventative care is used to cover such a broad range of interventions and supports that it cannot be pinned down to a single evidence-based and replicable model. What is required in one part of the country or even by one individual may look significantly different to another.

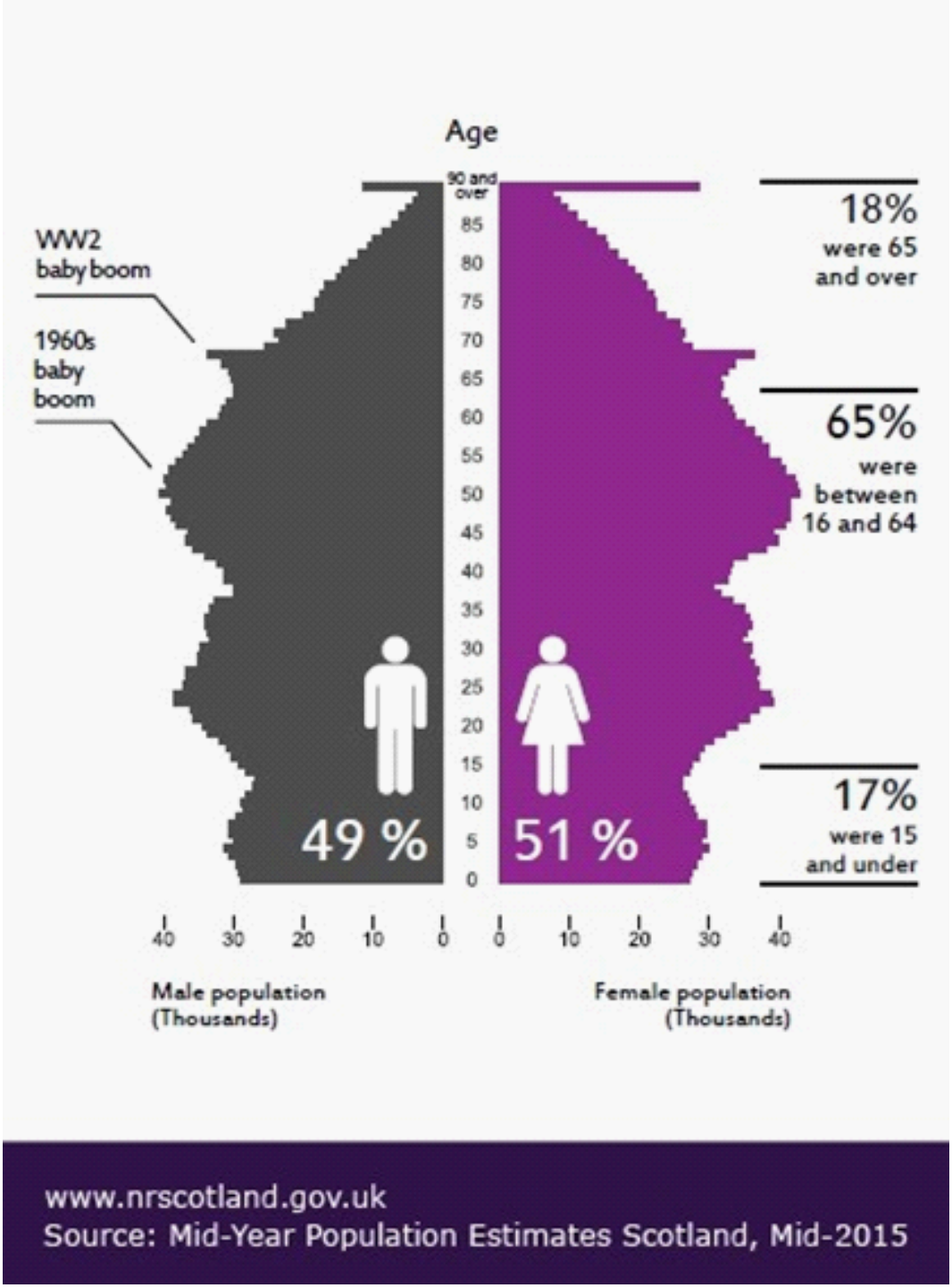
This is further compounded by the fact that the very nature of prevention is that it avoids or reduces unnecessary usage of other resources. It therefore becomes extremely difficult to prove or evidence what successful implementation didn't lead to. In a commissioning culture which is currently premised on cost saving and getting more for less, it can be hard to persuade hearts and minds that significant investment in upstream services now will be beneficial given that success cannot be evidenced with any degree of haste.

What's more, supporting someone in a preventative way does not guarantee that they will not still require access to a multitude of supports, some that may be intensive, in their

journey of care. It simply means that there is less chance that the supports made available to them at different stages will be inappropriate, disproportionate or unnecessarily prolonged.

There is also an argument railed against preventative care approaches, particularly where these prioritise the 'social' aspect of support as opposed to focusing specifically on technical care interventions. Some may critique this dimension to care, arguing that this form of support should be the onus of family and self. These sorts of arguments tend to become even more prominent at times of constrained resource, when difficult decisions around prioritisation have to be made.

However, in these instances it is important to consider the changed demography of Scotland and of familial circumstances.



The Scottish Government's demographic data tells us that:

- *The population of Scotland will rise to 5.7 million by 2039, and that the population will age significantly, with the number of people aged 65 and over increasing by 53% between 2014 and 2039*
- *The number of households headed by people aged 65 and over is projected to increase by almost 54% between 2012 and 2037. In contrast, households headed by someone aged under 65 are projected to increase by just 3%. The number of households headed by someone aged 85 and over is projected to more than double over the same period, from 77,400 to just over 200,000*
- *The average age of death rose from 71.3 in 1982 to 76.5 in 2014. Sixty three per cent of all deaths in 2014 were aged 75 or over.*

Often this data is recounted within a narrative of challenge and pessimism, linked to negative cultural attitudes towards age such as older people being described as a 'burden'. We would argue that this is absolutely not the case – a population who are living longer is something to celebrate and in fact, older people have a huge amount to contribute to society and have the right to lead fulfilling lives. The only 'problem' related to this demographic shift is a system one, in terms of failure to plan services, supports and the allocation of resource accordingly. This is the route we risk going down if preventative approaches are not adopted imminently and integrated into care commissioning and delivery.

What this data does show, however, is that with people living longer they are also more likely to be living with complex needs for a proportion of their lives. 2015 data shows that children born in 2014 can expect to experience between 17 and 18 years of their lives in poor health. For individuals born earlier than this, particularly those who are now aged over 65, these 'unhealthy' years will be even greater. This often places significant pressure on informal supports and the nature of an individual's ill health can often mean they lose touch with their local communities and support networks. What's more, it is not unusual for an individual to live to an age whereby their children are also elderly and with equal or sometimes greater care needs.

The changed economic landscape also means that often, individuals do not live close to their families. Whilst previous decades may have seen larger family sizes and children remaining close to home into their adult years and therefore able to provide care and support to elderly parents or other relatives when this was required, this is no longer the case. Even in situations where older people relocate to be closer to relatives when they require more support, often these relatives will be within the labour market or have caring responsibilities for young children which limits their ability to provide the 'social' element of care.

This means that we cannot assume that someone in receipt of care services will have their wider holistic and social needs met by others or in other settings.

Whilst it is important for an individual to be fed, warm and safe there are also other fundamental needs which an individual wishes to have addressed. The outcomes a person wants for their life - to keep in touch with friends, to continue to be engaged in a pursuit or activity, to continue to be involved in their community and its organisations - are as fundamental as the mechanics of food and drink. It is also increasingly acknowledged that these 'non-basic' elements of care and support have a significant positive impact on well-being and mental health if properly attended to.

In fact the Scottish Parliament's Equal Opportunities Committee undertook a specific **Inquiry into Age and Social Isolation** in 2015. It found that social isolation and loneliness are significant issues for older people in Scotland, and examined both qualitative and quantitative evidence linking these social issues to poorer

health and higher care needs.

"The need for contact is an innate human need in the same way that feeling hungry or thirsty or tired or in pain is": Derek Young, Age Scotland.

The Committee, in its reporting, recommended that the issues of social isolation and loneliness are built into the plans and strategies of health and social care partnerships across Scotland.

It is therefore crucial that formal care services are geared towards holistic support which is time flexible, relationship-focused and proactive rather than reactive in terms of identifying need.

Homecare and The ADL Life Curve ™

The emphasis upon relationship-based preventative support and its positive impacts on both personal outcomes and the wider health economy relates well to the work undertaken by Professor Peter Gore from Newcastle University's Institute for Ageing.

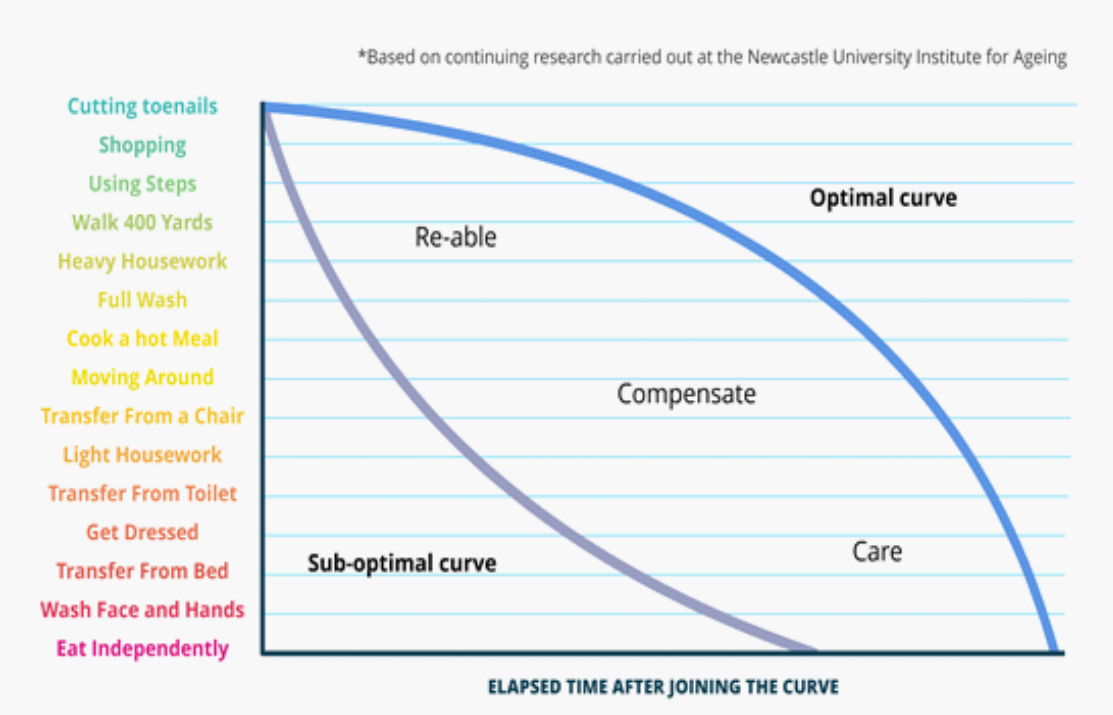
Together with colleagues and partners, Professor Gore has developed the ADL LifeCurve™: a tool which enables the mapping of age-related functional decline.

The ADL LifeCurve™ is premised on evidence that early interventions can have a significant influence on the nature of an individual's journey into old age, and their corresponding care journey.

Most people will start to lose the ability to carry out the 15 daily tasks outlined on the graph in an order similar to that shown. If an individual is able or supported to identify decline against these tasks at an early stage, it is possible to delay further decline or even regain some abilities. Obviously, this can positively impact on the level of care and support that an individual requires and even more importantly, their sense of independence, personal capability and wellbeing.

Conversely, a failure to recognise an individual's difficulty in undertaking these tasks increases the chances of them declining more quickly or losing their ability to complete tasks altogether. The corresponding tendency to then focus on incapacity, lack of confidence and inability reinforces approaches which by their nature are risk-averse and focused on what individuals cannot do rather than adopting an assets-based approach to their support needs.

The foundation of the ADL LifeCurve™ is enablement – early identification and



appropriate support can change the shape on an individual's curve and therefore positively direct their care journey and outlook on their ability to accomplish.

A great deal of policy and practice emphasis has been on advancing self-management and reducing any inappropriate dependency on services. What the ADL LifeCurve™ supports us to understand is how good preventative support can foster and enable self-management. By commissioning and providing services in ways that encourage identification of ability against the 15 tasks, individuals can be supported in less intensive ways to remain capable and to minimize decline. For instance, when difficulties are identified in an individual's ability to independently undertake a task, care workers can work with that person on improvement or amendment. It does not automatically mean doing these tasks for a person and thus making them more dependent.

However, it is important to recognise that this task-based model does not imply nor fit with a task-based approach to commissioning. It requires relationships, trust and knowledge of individuals in order that suitable and proportionate interventions can be put in place and the ability to continue to achieve and improve, even in an overall curve of decline, can be nurtured.

It is therefore easy to see how home care services can play an important role in influencing the trajectory of an individual's life curve, if they are set up to do so within an enabling policy context which recognises the demographic reality of delivering support and values the relational nature of these supports.

THE CHANGING ROLE OF HOME CARE

Home care through the decades

Having stated the wide policy and demographic context, it is necessary to now consider the ways in which the delivery of home care has changed since its inception and also how the role of the home care worker has been conceptualized at different stages over the last century.

In this narrative we will explore the degree to which the issues of time-focused attention, relationship-based care and a preventative orientation in support have changed, emerged and developed over the story of homecare.

Pre-Welfare State, those with care needs living in their own homes would require to be looked after by their families and the quality of this would obviously be dependent on the strength of those familial supports. Wealthier families could rely on servants, or 'domestic workers', to support elderly and incapacitated relatives. These domestic services encompassed a variety of important household tasks but the work was generally undervalued and seen as menial. When care was solely provided by families and informal support networks, undoubtedly this was based on familiarity and knowledge of individuals. In fact relationship-centred care was the only option available, indeed if care was available to people at all.

Whilst geriatric medicine and the care needs of older people were more widely acknowledged in the period up to World War Two it remained low status and priority, perhaps in part because of the existing discrimination against older and disabled people.

The development of home care supports became more prominent during World War Two, particularly owing to recognition of the fact that there were a significant number of people living in the community with unmet care and support needs.

The **National Health Service Act 1946,** implemented in 1948, saw the formal establishment of a role of domestic help in the United Kingdom. This role was initially envisaged as providing support for younger mothers after childbirth, and to give domestic assistance to individuals who for reasons of incapacity needed additional support. Whilst the language of prevention would not have been used, the role of 'domestic help' was centred on exactly that. By providing companionship and low-level support to people otherwise known as 'mopping and shopping', the relationships that were formed enabled intuitive recognition of deterioration to take place. It was outlined as:

'A local health authority may make such arrangements as the Minister may approve for providing domestic help for households where such help is required owing to the presence of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age within the meaning of the Education Act, 1944.'

This Act also set out means by which statutory bodies could charge for home care delivery:

"A local health authority may, with the approval of the Minister, recover from persons availing themselves of the domestic help so provided such charges (if any) as the authority consider reasonable, having regard to the means of those persons."

From there health and social care developed in ways that promoted fairer access for all, but particularly for social care this was in terms of meeting critical needs and providing sufficient yet basic levels of support. Anything above minimum care requirements needed to be funded by the

individual or delivered on a voluntary basis. This marks the beginning of the continuing distinction between NHS services, which are free at the point of delivery, and social care services which are generally means-tested and chargeable. This divergence can be traced back to culturally discriminatory attitudes towards old and disabled people in the 1940s and 1950s, and the lesser importance placed on social care.

There was a growing political, social and economic will to support people to remain in their own homes wherever possible, and linkages of this to the delivery of better value, outcomes-focused care delivery (although not using this language). But it wouldn't be until the 1980s that progression of the independent living movement and the advancement of community-based care saw care at home services become the preferred model for enhancing individual independence for most older and disabled people. By this time, the 'domestic help' role became more commonly known as a 'home help' but whilst care was premised around support with tasks such as shopping and cooking, it continued to be relational in nature and not time-limited.

By the 1990s, many individuals were being supported to remain independent in their own homes into old age as a result of the efforts of this workforce. From this point onwards, the delivery of care in an individual's own home went beyond a list of manual tasks to be completed but became focused on the delivery of more care and support addressed to individual needs.

However, aligned to this progression was an increased directing of resources towards those most in need in order to manage reductions in publicly funded services. This resulted in more care costs being borne by individuals and their families. Simultaneously, the public sector began to increasingly rely on the independent and third sectors to provide care on their behalf or in the absence of statutory support to citizens. It is also around this time that, aligned with the focus of support on individuals with higher levels of need, the home care workforce was directed towards delivering more 'care' in terms of skilled interventions rather than 'support' in terms of relationship-building and intuitive forms of provision.

It is also interesting to note that whilst social sciences as an academic and research discipline were at their height in the 1970s-1990s, there was relatively little work undertaken on the role and impact of home care workers or 'home helps' in this period. In fact, there is relatively little by way of documentation or evidence in relation to the historical development of home care and its role within society. This silence is, in itself, illustrative and indicative of the marginalization – and perhaps lack of understanding - of both the contribution and value of home care and its workforce.

Free Personal Care

The introduction of **Free Personal and Nursing Care** in 2002 brought about the provision of personal support to all individuals aged over 65, irrespective of income, who were assessed as requiring it. The initiative was modelled on the Royal Commission Report, **With Respect to Old Age,** published on 1 March 1999. This Act made Scotland distinct from the rest of the UK, but Scotland has shared in the overarching UK policy initiative to shift the balance of care towards enabling people to live at home, healthy and independent, for as long as possible. This has been a key policy objective of the Scottish Government for a number of years.

However, the introduction of Free Personal Care also signalled the need for and use of a tight definition as to what constitutes "personal care".

The most up to date Scottish Government information indicates that an individual's Personal Care assessment will consider:

- *Personal Hygiene - Bathing, showering, hair washing, shaving, oral hygiene, nail care*
- *Continence Management - Toileting, catheter/ stoma care, skin care, incontinence laundry, bed changing*
- *Food and Diet - Assistance with the preparation of food and assistance with the fulfilment of special dietary needs*
- *Problems with Immobility - Dealing with the consequences of being immobile or substantially immobile*
- *Counselling and Support - Behaviour management, psychological support, reminding devices*
- *Simple Treatments - Assistance with medication (including eye drops), application of creams and lotions, simple dressings, oxygen therapy*
- *Personal Assistance - Assistance with dressing, surgical appliances, prostheses, mechanical and manual aids. Assistance to get up and go to bed. Transfers including the use of a hoist.*

However, it highlights that other forms of support do not fit the criteria of Personal Care and would be subject to additional charges:

- *Help with housework*
- *Laundry*
- *Shopping*
- *Services outwith your home such as day care centres or lunch clubs*
- *Cost of supplying food or pre-prepared meals is chargeable, but support with preparing meals will be provided free*

What is therefore clear is that low-level interventions and those which prioritise independent living and community connectedness are considered ineligible under the provision of Free Personal Care. Tasks relating to the 'social' element of care including those which help to tackle loneliness, isolation and arguably mental health issues no longer fit within its definition or tighter eligibility criteria and signal the most significant move away from the origins of relationship-based home care.

This is evidenced in Scottish Care's 2015 report, **Home Delivery**, which was premised on independent research on the home care sector in Scotland. It outlined that:

- In 2002, clients receiving Free Personal Care accounted for 56.9% of all care at home clients aged over 65
- By 2013, those receiving Free Personal Care accounted for 93.6% of all care at home clients over 65

In 2004/5 there were 16,440 clients who received home care provision out-with the Free Personal Care criteria. By 2014/5, this figure had fallen to 3,410. We can therefore deduce that a dramatic reduction has taken place in relation to the number of clients receiving publicly funded support for areas outwith the definition of 'personal care', such as 'mopping and shopping.' Instead, those who access services are narrowed significantly to those with high level personal care needs and often, those with lower level needs are left without support.

It is clear that Free Personal Care has had a profound effect on the care at home market in Scotland. It has, deliberately or inadvertently, instructed a move towards models of support that sacrifice and substitute support which prioritises relationships and spending time with individuals for task-based interventions aimed at those with higher support needs.

Time

The 21st century has also seen the introduction of technology-based care systems. For home care, much of this has been centred around the development and introduction of call monitoring systems. These systems have been utilised primarily on the basis of cost, and have been built into tender exercises in order that commissioning bodies can monitor delivery of the care they have paid organisations to deliver on their behalf. Whilst there are certainly benefits in relation to call monitoring, not least around worker safety

and accountability, systems which require a 'clocking in' and 'clocking out' approach to care in individuals' own homes represent one of the most obvious redirections from time-flexible, relational care provision. They instead promote a model of care which inevitably consists of trying to get more for less; in this case, intensive support in as little time as possible.

Scottish Care's most recent survey data reinforces this, showing that over one third of publicly funded care packages are commissioned for visits lasting under half an hour. What's more, even a 30 minute visit means that in reality, an average of only 24 minutes of care can be provided in that time.

This time-restrictive, selective form of care commissioning and therefore delivery is also reflected strongly throughout Scottish Care's recent research projects with front line home care staff.

In **Trees that Bend in the Wind**, a home care worker reflected that:

"Only critical care needs are paid for."

Another worker questioned:

"Who is there the rest of the day? We would love to stay with her. By the time we've changed her pads, we have 7 minutes with her."

In **Voices from the Front Line**, a care worker noted:

"Your job as a care assistant is to care and at times we are penalised for caring because of the pressure on time."

This contrasts quite strongly with experience of care provision as little as 20-30 years ago:

"I loved my job then. We had a lot less people to work with so we had a lot more time with folks... Most of the time we did what we called house tasks. We were called 'home helps'... Now don't get me wrong doing the cleaning, shopping and making meals for folks was very important... It kept people well and healthy... but what we did most of all was to talk.

"Having a cuppa with someone was as important in finding out about how they were. It was then they told us things they didn't tell the doctor or their families. It was then that we could work out how the folks really were. That's the big miss I think for carers today – they simply don't have time."

A reflection back on bygone eras of any professional group tends to risk selective memory and a tendency to be romantic. However, there is some resonance in this in relation to how the role has changed in recent years and what the perceived importance of home care intervention is.

We know that the type of care described above - the delivery of essentially domestic, low-level interventions which are often summarised as 'mopping and shopping' - has largely disappeared from the tasks undertaken by many home care staff working across Scotland. More specifically, these forms of intervention have been removed from the criteria of what is deemed acceptable and eligible for the public purse to pay for.

Self-Directed Support

There might have been a hope that the **Self-directed Support** Act would have brought about a return to more holistic, relationship-based, preventative services, given the transformation in assessment processes that SDS requires.

Traditionally, whenever someone presented themselves to social care services the assessment process concentrated on individual needs and whether those could be met within the eligibility criteria the professional was working to. The problem with a needs based assessment of this type is that it results in services oriented

around task and time and rarely addresses what is ultimately important to an individual. As an approach it tends to emphasise the deficiencies and needs of an individual – 'what is not working' – rather than highlighting their attributes, strengths and abilities – 'what is working.' There is also a potential for individuals, whether the supported person or the care professional, to over-emphasise the needs because that has been the traditional route through which support and services have been achieved.

Social work practitioners are therefore, through SDS Guidance and the Act, encouraged to embed a more holistic approach to assessment. The mechanism for achieving this is through a person centred conversation with the individual. It emphasises the importance of helping an individual discover solutions to their challenges that might not come through traditional service support but from natural, community and social networks i.e. lower level, preventative and informal supports.

What's more, the introduction of personal budgets through the Self-directed Support Act should have brought about a transformation in how services are provided, not least because the legislation is predicated on choice and control resting with the individual rather than the commissioner.

However this has not happened in practice, probably because the focus on older people has massively under-achieved to date. Many of the reasons for this can be traced back to ageist preconceptions and misconceptions of what older people want from their care and what they can achieve: some professionals believe that SDS is either not applicable or at least significantly less applicable to older people because they do not want the level of control it offers or do not have the same aspirational desires around what their care can help them achieve. This is absolutely not true.

In fact when asked in the research for this publication about their assessment of how successfully Self-directed Support is working at present, home care providers were not particularly optimistic. Many felt that, in principle, SDS presents opportunities to develop more flexible, person-centred and innovative approaches to care delivery which would be positive for organisations and their workforce. However, over a fifth of respondents indicated that SDS is not working at all for the people they support, predominantly due to system barriers, lack of understanding and poor communication:

"I feel there is often a short fall in communication as at times, there have been SDS assessments carried out without the social work department having contacted ourselves. I feel this would be a great benefit to them as we would then be able to detail the service we provide at present and how we feel that supports the individual."

"Many social workers don't really promote/ understand it."

"In our experience, the options under SDS which provide the additional choice to individuals are presented to them as negative and more hassle than they're worth. We have had customers who have been told they are not able to use our services, not even a conversation on how they could under SDS, just that we are not a preferred provider - full stop. This leaves our customers annoyed and frustrated and we are angry that their right to choose is being denied."

One could argue that instances such as those described above represent example of denial of choice and ultimately the human rights of older people. This is unacceptable and, to our understanding, a complete contradiction of the principles which underpin the legislative introduction of SDS: participation and dignity, involvement, informed choice and collaboration. These principles can only be meaningfully applied through relational care and support. In other words, that which places value on people and their wishes and which is based on trust and respect.

With examples such as the above proving to be far too common for older people in relation to their SDS experiences, it shows that there is still a long way to go before this policy can meet its full potential.

It is clear that a significant and multi-faceted culture change is required if Self-directed Support is to provide the opportunity to reform services and deliver the care that individuals want and need. Risk adversity, fears over loss of control, perspectives on what 'appropriate' resource allocation and use is, and attitudes to older people and their aspirations all need to be addressed.

Big changes or the same old?

We can therefore see that despite many political, economic, legislative and social changes both generally and pertaining to the health and social care landscape in specific, most of the conditions under which care at home is delivered have not significantly altered since World War Two. Historical and current parallels include:

- A recognition that a significant proportion of the population who require social care are elderly, yet a persistent discrimination against this group in terms of status and resource allocation
- A lack of value being attributed to individuals who work in home care services
- Political ambition to support more people in the community, on the grounds of cost and personal preference
- 'Rationing' of care provision on the basis of limited resource, either to provide only basic care to many or intensive care to few. Either way, this being restricted to critical need
- A residing sense that the 'system' will decide what an individual's needs are and what their choices are as a result of this, rather than people in receipt of support having real control or meaningful options.

However, the type of care commissioned and delivered under the umbrella of home care services has changed almost beyond recognition. We can see that preventative and relational approaches formed the basis of provision in the inception of home care, but that these have been stripped out of the social care system over time. They have been replaced with a model that prioritises only those with intensive care needs and shapes care delivery into 'time and task'.

Whilst potentially saving commissioners a few pounds in the short term, this model does not deliver positive outcomes for individuals or promote equal access to care and instead places an inordinate amount of strain on home care services and their workforces. It is also likely to lead to greater use of other, higher cost resources.

This represents the continuance of a siloed approach to cost saving and planning, rather than positively representing the reality that Health and Social Care Partnerships have responsibilities relating to all services being delivered in their areas and should therefore be adopting a wide-ranging and informed approach to partnership and to the sustainable planning, commissioning and delivery of these services.

THE STORY OF HOME CARE

Early 20th century

Care delivered in people's own homes by family members or, for wealthier individuals, those working in 'domestic service'. Work seen as low status and value.

1948

Formal establishment, through the NHS Act, of role specifically aimed at supporting individuals at home. Distinction between free health services and chargeable social care support.

1940s-1980s

'Home help' role centred around companionship and support with 'mopping and shopping' tasks. Relationship-based and time-flexible but only basic needs met.

1990s

More people being supported at home for longer. Directing of resources towards higher needs to manage constrained budgets and corresponding reduction in 'mopping and shopping'.

2002

Introduction of Free Personal Care to promote access to care and support regardless of income, but increasingly tight criteria for what constitutes 'personal care'. Need for more skilled workforce.

2017

More hours of home care being delivered but to less individuals. Publicly funded care narrowed to those with high level support needs. 'Time and task' commissioning. Severe workforce challenges.

THE CURRENT SITUATION: WORKFORCE

We can see that the present commissioning arrangements and the increased use of call monitoring systems to assess contracts are directly impacting on service delivery and the workforce. It is these processes that affect the ability to be flexible within contracted time, the capacity to develop effective relationships between worker and supported person, and the flexibility to focus upon a preventative rather than a reactive approach to care and support.

The changing role of home care workers

The changed approach to eligibility criteria and care commissioning points to fundamental differences between the more traditional 'home help' role and the role of the modern care at home worker.

The 'home-help' role offered what can best be described as 'relationship-based' care and support. The worker had time to spend with the person being supported; there was a sense of continuity and thus relationships developed. Out of those relationships, the 'home-help' developed an ability to recognise changes in individuals' conditions such as deteriorating health and ability or adverse reactions to medications. What's more, these relationships helped to combat the serious issue of loneliness and isolation often experienced by older people of which the negative health and wellbeing outcomes are well documented.

This 'early alert' system was of uncalculated benefit to the individual outcomes of the person receiving support but also to the benefits and economy of the whole health system in that it prevented unnecessary early admission to acute or location-based care services. This has, by and large, been lost with the stripping out of 'mopping and shopping' and with the development over the last twenty years of a 'time and task' and 'time monitored' system of commissioned home care.

The **Home Delivery** report highlights that:

- The number of hours of care at home provided publicly in Scotland has increased
- The number of publicly funded clients receiving 10 plus hours of care at home has increased.

Coupled with the fact that the overall number of people receiving care at home services has continued to decrease each year, this means that what we have seen over the last decade is not that more people are being supported at home, but fewer albeit for longer and with more intensive packages of care and support.

This means that the role of the home care worker in the present day is extremely complex, requiring a vast array of skills but also a number of personal qualities and a high degree of personal resilience in order that they can undertake this demanding role.

However, it seems that this upskilling and increased complexity has not been recognised in any planning or commissioning processes. Instead, it has developed through necessity and outwith the realm of influence of services to any meaningful degree. We continue to ask more of this workforce and expect them to absorb this into their already challenging roles, whilst continuing to woefully recognise or recompense them.

In terms of those expectations, an astonishingly wide range of activities are undertaken by the home care worker of the modern era.

One leading organisation lists the requirements as:

'A care and support worker supports our customers in their own homes, maintaining their independence, dignity and safety at all times. The

type of care that you provide will be unique to the person you support, and will vary from person to person, but may include:

Personal Care

Help with getting up and getting ready for the day or settling in for the night, washing, bathing, and toileting.

Practical Support

Domestic tasks such as laundry, cleaning, tidying, shopping, preparing and cooking meals and taking people out to the shops, doctors or social events.

Specialised Care

Supporting people with more complex needs such as, end of life care, supporting people with acquired brain injury, or those living with long-term conditions such as dementia.

Emotional support

Regardless of the physical assistance provided, it is often the emotional support and connection that people receiving the support have with their care and support workers, which makes the difference to them.'

Another provider outlined the attributes and skills that are required in an individual undertaking the role of home care worker:

'Our care assistants provide each customer with a bespoke care experience, to enable them to continue to enjoy fulfilling lives in their own homes, for as long as possible while promoting their independence.'

'This important role brings challenges as well as rewards. Our customers include people with a wide range of emotional and physical needs. You will need patience, compassion and an ability to listen well, so you can support customers to stay in touch with the things that really matter to them, even on the difficult days. Stamina to meet both the physical and emotional demands of providing care and support is also essential. You could be supporting a young person with a brain injury or a customer who is near the end of their life. The ability to think clearly in a crisis and to keep calm is necessary to provide the best care for our customers.'

This demonstrates just how vast and wide-ranging the expectations on our modern day care workforce are, not only in the details of their role but what sorts of people we expect them to be. It is perhaps best summed up by a home care worker who took part in the **Trees that Bend in the Wind** research and said:

"It really is an enhanced technical and emotional role."

This is particularly true when considering the breadth and depth of knowledge and capability that today's worker requires, to reflect the likelihood that they will be dealing with:

- Personal care
- Mental health conditions
- Behaviour which challenges
- Emotional support
- Sexual health and sexuality
- Palliative and end of life care
- Drug and alcohol-related conditions
- Medication
- Early identification of need
- Dementia – early onset to advanced and end of life
- Advanced care planning
- Neurological conditions including stroke, MND, MS, Huntington's Disease,etc.

Clearly, the role of the modern day home care worker is so far away from the domestic tasks of the 1940s and 1950s as to be unrecognisable. Yet interestingly, there remains a significant degree of variation and uncertainty in how this is captured by organisations that are not involved in the delivery of front line care services.

According to the National Careers Service**:**

Your day-to-day duties may include: getting to know clients and their interests and needs; helping with personal care like washing; using the toilet and dressing; food preparation, feeding and

giving out medication; carrying out general tasks like housework, laundry and shopping.'

The Scottish Social Services Council states that:

'Care at home workers help people in their own homes with personal care activities such as bathing and dressing. Workers may also help with meals, supporting people to eat and drink as well as cleaning and shopping.'

These definitions are much more closely aligned to more traditional 'home help' roles and to relational, preventative care. This points to potential irregularities between how the role of the modern day home care worker is conceptualised and what the realities of undertaking the role are.

This is further underlined by the fact that perceptions of the home care worker's role haven't necessarily evolved at a similar pace as the role has changed.

We know that throughout the development of home care in its different guises, it has generally been carried out by a predominantly female workforce with very little training in relation to the demands of their role. Most recent figures suggest that of the 53,660 individuals employed in care at home and housing support services, 79% of these are female and the same proportion are employed as Class 2 care workers.

An inherent societal sexism may go part way to explaining why the role has remained undervalued, low paid and considered to be unskilled, compounded by the fact that workers tend to support older or disabled individuals; i.e. other groups frequently subjected to discrimination.

Scottish Care's previous interviews with home care staff for **Trees that Bend in the Wind** demonstrated consistent issues in relation to how their role is understood and valued by other professionals and by the general public.

"They still think of us as home helps and treat us as such."

"A lot of people come in thinking it is about holding someone's hand and making them a cup of tea."

This highlights an interesting paradox – the modern undertaking of home care has lost much of the relationship-based care it originated from and requires, and has instead become a much more clinical and skilled role. However, the common perception of home care workers is much more closely aligned with the traditional model, and the role's perceived value hasn't progressed significantly beyond that placed on those working in 'service' many years ago in that it is seen as menial and unskilled.

In fact, we would argue that almost the exact opposite is the direction in which it should have developed – that is, that the role should continue to prioritise and value the positive impact of relationship-building, time and companionship that laid the foundations of home care. At the same time, understanding of what delivering complex care requires from workers should be recognised much more meaningfully and accurately, to the extent that home care staff are rightly considered invaluable, skilled contributors to both the country's economy and its citizens' wellbeing.

Recruitment & retention

It is likely that these discrepancies in information and understanding of the home care worker's role are contributing to the current recruitment and retention issues that the home care sector is experiencing.

Scottish Care's survey results indicate:

- **Over half of participating organisations (58%) have found recruitment harder this year than last, with only 3% stating it was less difficult**
- **Only`11% of organisations have no current staff vacancies**

- **90% of organisations have difficulty filling support worker vacancies**
- **One third of total staff leave every year**
- **Of the support workers who leave organisations, 41% leave within the first 12 months.**

There are undoubtedly a number of factors which impact on the recruitment and retention of home care staff. The discord between understanding of the role and the reality of undertaking it emphasise the need for major reform in how home care workers are valued and how they are enabled to deliver the care required by individuals.

The rigid models of care that the current system restricts provision to and the pressure this places on staff inevitably contributes to the current haemorrhaging of home care workers and the inability of services to recruit new people into the sector.

Respondents outlined how recruitment and retention pressures were impacting on their staff team and service delivery:

- *Pressure on supervisor teams, which leads to supervisors not able to carry out their roles*
- *Limits the amount of new work we can accommodate*
- *Increase in waiting time for people to receive a service and hospital discharge*
- *Lack of growth causes risk to service overall as commissioning practices of council drive the need for a high volume, low margin operation*
- *Other staff overwhelmed*
- *Demotivated staff*
- *Pressure on other staff to do extra hours*
- *Pressure on management to fill in some care hours as well as do their normal role*
- *Less time off for other staff*
- *Difficult to meet the demands of the clients and social work.*

It is clear that the strains of striving to provide good care within a reality of inflexible delivery approaches, staff shortages and a constant pressure to do more is driving this workforce towards breaking point.

Combined with the personal detriment to individuals and the on-going cost to the health and social care system, the loss of relationship-based care with its preventative dimension of time is proving very costly indeed.

Workforce conditions

What's more, Scottish Care's research has found that a number of negative consequences of limited funding and time-restrictive commissioning are impacting upon the existing home care workforce in terms of how they can be properly supported and rewarded for the work they do.

85% of responding organisations use zero hours contracts, with over 56% using these for more than three quarters of their employees.

Many of these organisations indicated that they operate these contracts because staff choose them, owing to their ability to provide flexibility around other commitments and to meet with the changing needs and choices of clients. However, others expressed the view that these contracts were a necessity resulting from the way in which home care services are currently commissioned i.e. the provider is commissioned on a zero hours contract by a Local Authority. This results in:

- A lack of reliability around care packages and care hours meaning that hours cannot be guaranteed for staff
- Extremely tight financial margins and the unpredictable nature of care meaning that if an individual is admitted to hospital or dies, the council will remove the care package and the provider cannot afford to pay the care worker for those hours regardless
- The perpetuation of a non-committal culture within care, which negatively impacts on the consistency and reliability of provision and erodes relationships. The commissioning of zero hour contracts does not encourage loyalty

and commitment, either at commissioning or delivery level. If all that care services can offer is payment for actual work undertaken and no other benefits and supports to staff, it is not surprising that care workers then think that it's ok to say they can't work and to drop out of shifts, or even employment within an organisation.

This demonstrates a way in which flexibility and choice could be positively selected by care workers and the people they support. However, that flexibility is not afforded to providers in the way they are commissioned, meaning the practice of operating zero hours contracts to remain sustainable is often forced upon them by necessity instead. This is not positive for social care employers or their workforces, nor is it likely to offer a model which will prove attractive in the future. We will never have fair work practices which move us away from zero hour working towards salaried staff while the current system of procurement prevails.

49% of home care organisations believe that payment of the Scottish Living Wage has made them less sustainable

Whilst home care providers are whole-heartedly supportive of increased reward, remuneration and recognition of their dedicated workforce, the way in which the method of achieving this has been implemented has proved problematic for many. This is largely because there was no meaningful engagement with the sector at a national or local level about how this could or should be applied, resulting in the mechanics of applying this proving at best precarious and at worst damaging. In a number of Local Authority areas, the rate offered to achieve payment of the Scottish Living Wage in 2016 was so low that it would have meant providers would have to reduce other terms and conditions. In others, the rate offered was such that if accepted, a provider would not be able to sustain their business for any length of time. Whilst these issues were eventually resolved, often marginally and at the eleventh hour, it has created a level of anxiety and uncertainty about the future funding of what is a laudable policy intention.

The current commissioning model also fails to address other funding shortcomings in addressing workforce terms, conditions and value.

Most responding organisations identified their key workforce training, learning and development priorities for the coming year as being registration of their workforce through the Scottish Social Services Council and the achievement of more SVQ2 and SVQ3 awards for home care staff. This reflects the ambition to better recognise this workforce as professional and skilled and to provide positive career pathways within the sector. However, 44% of respondents believed there were insufficient resources within their current contracts with Local Authorities to meet training, learning and development needs. What's more, almost all respondents considered there to be little to no commissioning resources made available around supervision, mentoring and staff support.

"We tend to 'go it alone', making the most of any resources we come across."

Respondents also stressed that current commissioning arrangements often fail to account for financial outlays of service delivery and terms and conditions for staff in their rates, such as travel time and expense. This is particularly problematic for organisations providing services in remote or rural settings.

"Our mileage costs are horrendous. We have been running at a loss for a long time as the council rate does not cover the miles we are requested to do for very outlying clients."

This demonstrates how the systems which should plan, shape and influence how the home care workforce operates and is supported to develop are not working effectively. In fact in many ways, they are failing. 68% of responding organisations indicated that they have developed a workforce

plan to help their service to anticipate need but what the findings show is that at Partnership level and national level, there is a lack of recognition of the home care workforce's challenges and no effective means of joining up workforce planning mechanisms. If the home care workforce and their employers are experiencing extreme pressures in relation to current provision, this raises serious concerns about how they can positively develop and be supported to deliver the types of preventative and intensive care provision that will be required into the future.

THE CURRENT SITUATION: SERVICE SUSTAINABILITY

The challenges that this report identifies are not just matters of interest, or ideas about what might improve the home care sector in Scotland. In reality, they point to a sector on the brink of collapse in a number of areas. They indicate that the status quo simply cannot continue and that a fundamental rethink of home care commissioning and value is urgently required. Otherwise, we will quickly lose the community based services which, based on the policy ambition, are fundamental to delivering better outcomes.

Nearly 20% of organisations are not at all confident that they can continue to operate at current provision levels over the next 12 months.

Almost all responding organisations identified, at some point in the survey, that finance and the uncertainty surrounding future funding levels, were a significant concern. This was reflected in different ways, including fears around being commissioned to deliver less hours of care, reductions in referrals for publicly funded clients, statutory bodies offering insufficient rates for care provision and higher staff costs. These were all couched in terms of providers operating on a knife-edge at the moment, with no capacity to absorb further challenges which impact on finances.

Some providers were frank about decisions they had taken around service development or were considering in the immediate future:

"I now have to charge our private clients significantly more than the council rate. There will come a point where we stop accepting council clients and just concentrate on our private work. As a minimum we may well have to operate a two tier service where council clients are forced to take what we have in terms of rota availability to further streamline travel costs."

"We chose not to contract with the council. If we did then we would have to close the service or cut corners and deliver an illegal service – guaranteed."

Others expressed real worries about their very existence:

"Unless the council give us a rise accordingly then we will have no future."

"We may not survive."

From a planning and commissioning perspective, this raises questions about how the sector will develop without urgent and substantial changes to funding models. If a failure to address these challenges results in services withdrawing from the market or changes to their delivery models, it will mean that even less high quality, person-

centred, preventative care can be provided to the vast range of individuals who will continue to require it. Subsequently, it is almost certain that the policy ambition to support more people in the community will fail and there will be an even higher human and financial strain on hospital services.

Evaluating value – commissioning & relationships

Interestingly the concerns raised around sustainability were all imparted in a tone of uncertainty and apprehension about what commissioners may do to home care services. They certainly didn't reflect a sense of ownership or collaboration over their service's future or place within a local context of service options.

It is therefore important to consider how significant the concept of 'value' is in relation to commissioning practice and partnership working when applied to the pursuit of sustainable and appropriate home care delivery. By exploring these elements, we are better placed to understand how the sustainability and development of the sector are either enabled or inhibited by its status within the health and social care landscape.

In doing so, it becomes immediately clear that value, commissioning and partnership are inextricably linked and that generally positive experiences in one of these areas is accompanied by positive practice in the others, with the same applying to negative experiences. What can differ, however, are perceptions of positive or negative approaches and by whom.

Home Delivery outlined the findings of Audit Scotland's 2012 report, **Commissioning Social Care**, in which analysis of local commissioning strategies found that most were lacking in detail around the totality of current care provision and how these services can support reductions in unnecessary expenditure on inappropriate admissions:

'Audit Scotland was critical of this and suggested that any strategy should include, as a minimum, elements such as quality, cost, capacity and accessibility of all services in the area. While councils felt that they had good relationships with providers and involved them in this strategic process, providers stated that they were often not involved in this process and if they were, they were not listened to.'

Since that report, Health & Social Care Integration has come into being and places an obligation on local Health & Social Care Partnerships, through their Integrated Joint Boards and Strategic Planning Groups, to engage with the independent sector and secure its representation on particular planning groups. Whilst these bodies are still at a relatively early stage of development, particularly in terms of delivering meaningful outcomes or tangible change at a local level, it is fully expected that they will be well underway in terms of mapping of and engagement with stakeholders in their localities.

However, Scottish Care's survey findings present a less than positive picture in relation to how Integrated Joint Boards work with home care providers in their areas. More than a fifth of survey respondents indicated that they did not feel valued at all by their local partnership, with only 4% indicating that they felt 'strongly valued'. When probed further, most respondents expressed a mutual lack of understanding about each other's roles in the health and social care landscape resulting in, in many cases, not a negative relationship as such but no relationship at all:

"Have no idea who they are or what they do although have heard the name bandied about lots."

"No input or understanding of their role (we see this body as NHS and Council orientated)".

"Nobody provides any guidance to the services on offer to them. They have no interest in our registered service."

"Currently they talk a good show but have yet to do anything useful at ground level."

This raises concerns about how home care services can be supported to remain sustainable, develop their provision and contribute to the wider health and social care offer in a local area if their role is not valued and providers do not see the importance of these bodies in shaping their future practice. It is further compounded by the fact that the independent sector, in its totality, is only represented on 7 of 32 Integrated Joint Boards. It is clear that much more work is needed to impart information, both to and from home care providers, about how they can positively influence person-centred care provision through partnership working at a local level. This issue points to a lack of professional recognition across the health and social care sector, which further damages the home care sector's perceived value.

What is interesting, however, is that 31% of respondents felt that their services were strongly valued and respected by health colleagues, and a further 48% felt it was valued. In contrast, only 17% felt their contribution was strongly valued and respected by Local Authorities and, worryingly, a further 17% felt their organisation was not valued at all by council colleagues. It must be noted that these are perceptions rather than confirmed realities, but that does not make these figures insignificant. What it does highlight is the need for further research on these statutory bodies' relationships with independent sector care providers. It may be that home care's contribution to supporting health services, for example around reducing delayed discharge, is seen to nurture more collaborative and appreciative relationships, or it could be that this history of Local Authorities operating as home care commissioners is having a negative impact overall on providers' estimations of being able to work constructively with them.

This illustrates contrasts between more traditional relationships and those which will influence the future direction of social care planning and delivery. The Local Authority-independent home care provider relationship is a well-established one but evidently, it is also a problematic one from the perspective of many home care providers.

Relationships with health colleagues will generally be newer, and reflect a growing recognition that social care and health services need to support people collaboratively along a pathway of care. However, when these two polarities are merged into Health & Social Care Partnerships as formal integrated working arrangements, their relationships with home care services become extremely worrying in that they are virtually non-existent.

The concept of home care sector value is also a problem at national level. In relation to the Scottish Living Wage obligations, the Scottish Government has stressed that it is the business of private and charitable sector organisations to pay non-care staff the Scottish Living Wage, despite a lack of funding allocation for this purpose. This highlights the way in which the nature of the relationship of national bodies to the home care sector is one of commissioner and contractor rather than equal partners, demonstrated by the Scottish Government's presumptions around the Scottish Living Wage and the lack of awareness that for most 'private' organisations, the majority of their business is in delivering public care. In other words, there has not been a mature re-conception of the commissioner – provider relationship at either Scottish Government or at Integrated Joint Board/ Local Authority level. This negative attitude, which equates non-statutory and private providers with bad practice and detaches the lives of those it supports from others, lives on and creates damaging and discriminatory realities for services, their workforce and the people they support.

The delivery of high quality, sustainable and innovative home care is absolutely critical in meeting the needs of individuals, preventing unnecessary admissions to hospital or residential care, and in using limited resources most efficiently and effectively. However, if Partnerships do

not value the contribution of providers of these services then inevitably they will fail to make use of their vast potential and will undermine high appropriate quality care delivery through the lack of a truly integrated, partnership-based approach.

WHY IT ALL MATTERS

The human impact

Staff in home care services are uniquely placed to recognise changes in an individual's condition or abilities, for example in relation to falls or medication, which other workers or services may fail to recognise. This is due to the frequency of visits and care input to individuals and the relationships and depths of personal knowledge which can, if enabled, be built up over a period of time. Care staff are therefore often best placed to identify and communicate changes or concerns, subtle or significant, to other health and social care professionals in order that these can be addressed effectively. .

However, service delivery which is designed to support older people to live at home for as long as possible, help reduce early admission into care homes and reduce unnecessary hospital admission, is now in short supply. It has been replaced with task-oriented, time-limited inputs which by their very nature are only able to deal with immediate need and prevent care staff fulfilling their potential in being an 'early alert' resource.

Therefore the current under-recognition and undervaluing of time and relationships within the complex role of home care workers often leads to individuals being admitted to hospital or other care settings, either unnecessarily or because these changes haven't been adequately addressed at an early stage.

Similar concerns were highlighted in the Audit Scotland report on **Commissioning Social Care** in 2012, which concluded that:

'People who need less intensive support are not being offered some services that might help delay or avoid their needing more intensive services.'

This clearly matters to individuals in receipt of support too, who recognise that often what they are receiving support for is not necessarily what they would most value help with. A whole series of studies, some outlined in **Home Delivery,** have noted that modern care packages are lacking in adequate provision of 'mopping and shopping' services .

For example, clients in one study in Aberdeenshire were asked to state what tasks they think their home carers could do that they are not doing at present. The following are a list of the main tasks stated by clients:

- Light cooking
- Housework
- Laundry
- Ironing
- Shopping
- Making the bed

It would appear that the policy ambition of increasing the number of older people who require intensive support in the community has been met at the expense of those older people requiring less support in their own homes. While this provides an obvious benefit to those with intensive care needs, the longer term impact for those no longer in receipt of care at home may be

felt in the future in a number of ways.

For example, older persons no longer in receipt of any service are denied the benefits of support that would allow them to live independently for as long as possible in their own home. This has negative implications in relation to individuals' human rights and personal choice.

The economic impact

In a landscape where only those with the highest level of need qualify for care at home services and therefore lower-level, preventative support is effectively eradicated, it is inevitable that others will access 'upstream' support instead. For instance, it may lead some older people to move to a residential setting earlier than would otherwise have been the case if they had received adequate care at home support or even to presentation at A&E departments and hospital admissions that may have been preventable with the appropriate support at home.

Analysis of the concept of the 'Care Pound' in **Home Delivery** highlighted that expenditure on care at home, combined with expenditure on residential care services, is less than what is spent nationally on emergency admissions to hospitals. The report found that the average cost of one emergency admission for an individual aged 65+ equates to caring for 27.7 care at home clients for one week.

What's more the commissioning environment for external care at home services, which currently prioritises 'time and task' inputs, negates staff's ability to provide preventative care to the best of their ability and instead requires them to meet little more than basic care needs, to the detriment of the individual's outcomes and to the public purse when these individuals then access more intensive forms of support.

We therefore need to ensure more older persons with intensive care needs are cared for in the community without compromising the care of older persons who require lower levels of support, as this will have adverse human and economic consequences in the long term.

LOOKING TO THE FUTURE

New models of care

So if the current home care planning, commissioning and delivery system is neither desirable nor sustainable, what reform and reprioritisation is required?

Scottish Care conducted a number of focus groups with providers in the winter and spring 2016-2017 period at which a range of participants were invited to explore both the principles which should be at the heart of any reformed delivery of care and support and what some of the new models of care might look like.

Approximately 250 people working in the sector attended these sessions and the views collected around home care services are summarised below. There was considerable unanimity around what should be considered core principles for the delivery of any re-modeled care at home supports and services:

Principles at the heart of home care:

- Outcomes focussed
- Flexible
- Person centred
- Good communication with person and between professionals
- Allowing people to continue their life – promoting an individual sense of independence
- Quality
- Choice – opportunity to make real informed decisions
- Real partnership with services – respect for all contributions
- Dignity
- Respect
- Responsive team around the person
- Integrated planning and delivery based on the person and their needs.

To achieve this, participants articulated that new models of care need to based around:

- Shared working/ training with acute/public body staff and care home staff
- Trust, mutual respect and collaborative team working
- An emphasis on palliative care
- Appreciation of clinical complexities
- Respite at Home
- Integration of care home and care at home services
- 'Step up' and 'step down' care
- Rehabilitation and reablement
- More short term care
- Recognition that one size doesn't fit all
- More technology.

The above indicates a remarkable degree of consistency amongst independent sector home care providers in indicating what they consider to be the key elements of any new delivery of care and support at home. Participants highlighted many important elements of provision which are being stifled by the time-restrictive, competitive, task-based and reactive reality of currently delivering home care services.

What's more, the future role of home care workers is likely to continue to reform to incorporate a much greater skillset and suite of responsibilities, including:

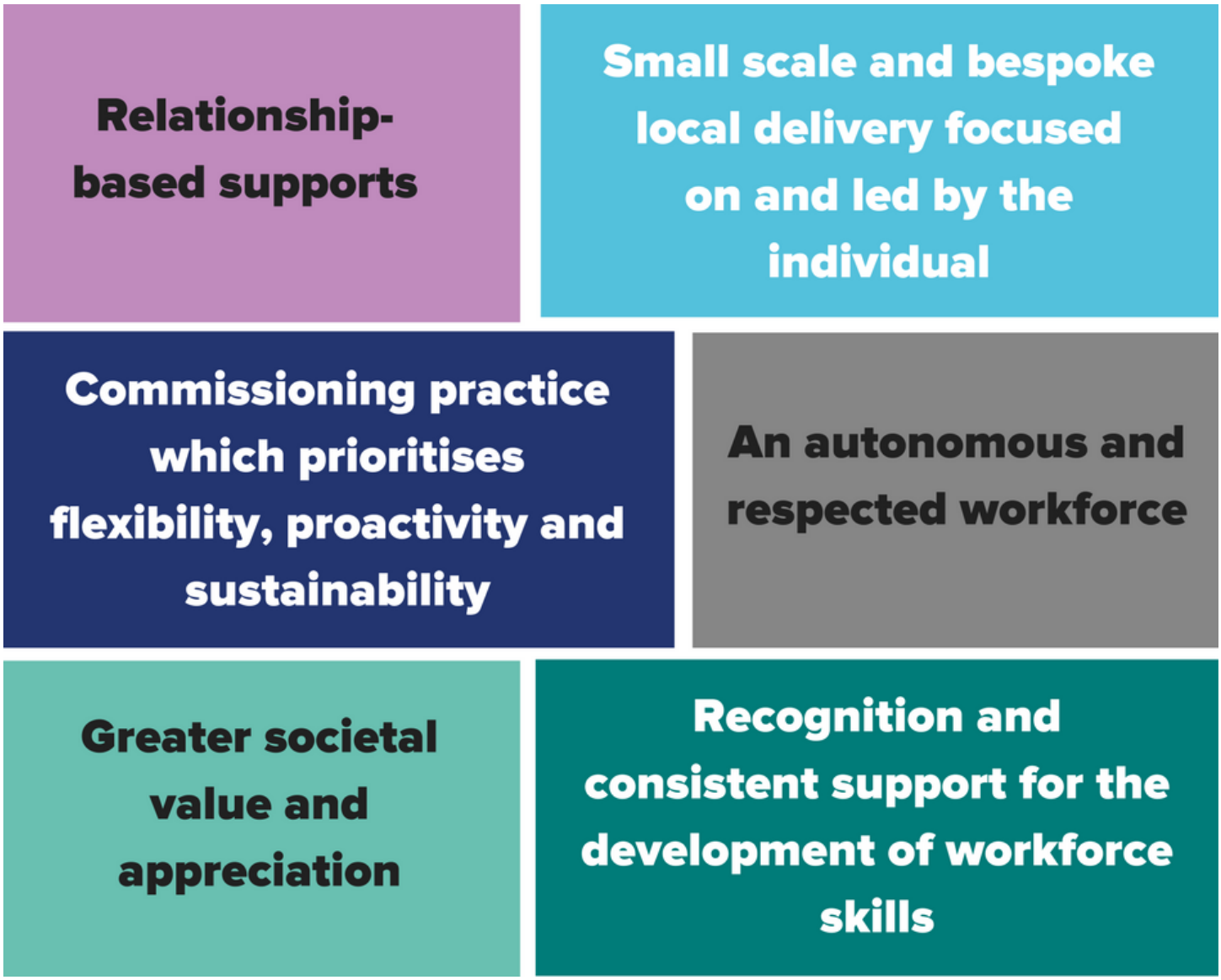
- Greater self-management in teams
- Autonomous, yet increasingly collaborative ways of working
- Being part of integrated multi-disciplinary teams, with increased blurring of job roles and a wider range of health and care responsibilities
- Leadership of health and social care intervention

- Health education role
- Anticipatory care planning role
- More enhanced clinical skills – especially medication support
- Occupational therapeutic intervention.

This undoubtedly demands a lot of an already stretched workforce, but could represent a realm of opportunities in relation to career pathways and how the home care workforce can positively contribute to preventative health and social care if managed, planned for and supported appropriately.

Principles in action

In order to achieve these aspirations for home care delivery, it would seem evident that the following priorities need to be consistently and equally recognised by all stakeholders involved in the planning, commissioning and delivery of health and social care:



CONCLUSION

Whilst all social care services play an important role in the preventative care agenda, the independent home care sector and its workforce have a particularly significant contribution to make.

However this report shows that there are a number of inhibiting factors which mean that independent sector social care services cannot contribute to the preventative care agenda as fully as they have the potential to.

By examining home care's journey of development over the last 80-90 years, we can see that these services emerged on the basis of relationships and retained this as they evolved into preventative services, delivering the assistance determined by an individual's needs rather than a system's resources. As needs, budgets and priorities changed, so did the focus of home care. From a 'mopping and shopping' support, the preventative dimension of provision became obscured as needs, budgets and priorities changed. This is particularly evident in examining the impact of Free Personal Care and tightened eligibility criteria. Now, home care tends to consist of 'time and task' delivery around an extremely complex set of activities.

The home care workforce emerged from the 'domestic service' industry and seem to have retained a similar level of status and recognition in society: minimal. Whilst the workforce of years gone by would have undertaken a set of tasks to support an individual, they did so within a context of time flexibility and mutual companionship meaning their job had a high degree of job satisfaction, even if it wasn't highly valued more widely. Now, the role of the homecare worker has become vastly more complex and skilled, yet retains the same level of belittlement in public conscience and time has been replaced by pressure. This gives it much less appeal, evidenced in the recruitment and retention issues facing the sector.

However the importance of prevention is beginning to re-emerge, not least in recognition of the intolerable strain on acute services. Whilst this should present an opportunity for home care to thrive, it is constrained by contradictions in commissioning approaches, workforce planning and conceptions of the value of prevention and of home care's contribution.

The services, workforce and time of home care are commissioned at levels akin to a traditional 'mop and shop' service, but are actually delivering high level, complex support to individuals with intensive needs.

Preventative care now requires a home care worker to have an astonishing knowledge of a multitude of medical conditions, interventions, medications, social, religious and cultural practices and personal preferences. Yet this workforce is conceptualised as unskilled and unimportant, partly because the misconception is that they are actually delivering 'mop and shop' services.

Older people are the majority recipients of home care services and a substantial proportion of the Scottish population, yet their care provision is located in a reality where older people are still subject to discriminatory practices in relation to their perceived value and the value of the services which support them, leading to unequal resource allocation and social stature.

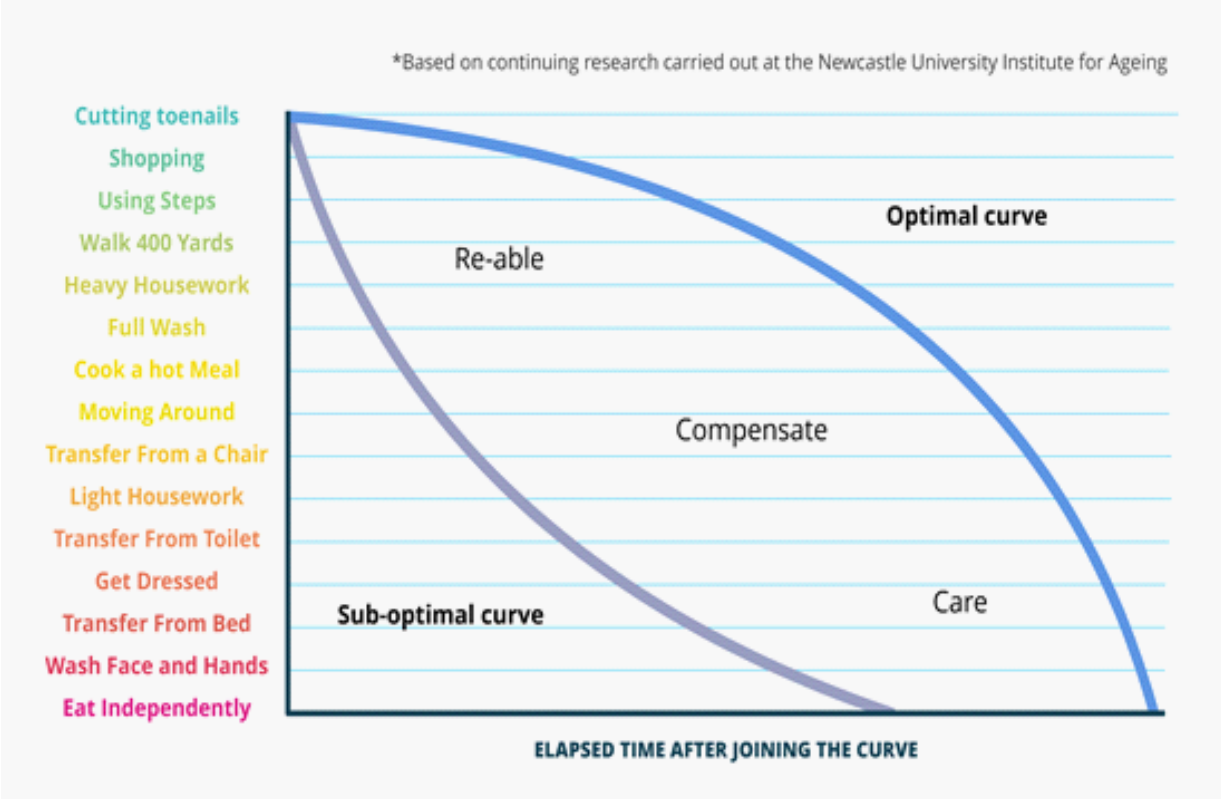
It is a wonder that home care services continue to deliver the high quality care that they do within this set of circumstances. But it cannot continue forever and this report has demonstrated that the reality of failure may be upon us sooner rather than later without the necessary reforms.

The report has demonstrated that direction of this reform must be from reactive to proactive commissioning, workforces and care delivery. This proactivity needs to be the modern understanding of prevention, and prevention can only be enabled through relationships and time. We must ensure that the workforce delivering care and the people in receipt of care and support are at the heart of decision making and that what is right for them in enabling them to live well takes precedence over what's easier, or what's cheaper. The latter always prove counterproductive in the longer term.

If we want to succeed in supporting people to remain in their own homes, happy and healthy, for as long as possible, we can only do so through preventative and relationship-based home care.

Homecare and The ADL Life Curve™: revisited

This report has demonstrated that, in terms of the ADL LifeCurve™, the majority of home care intervention in previous decades took place at the upper stages. Today, the majority happens much later.



In order to increase and prolong healthy independence, we must invest in a home care sector and workforce which has a distinct preventative dimension to its role. This will not only result in better outcomes for the individuals being supported but will make a significant impact to the expenditure on health and care.

We are intervening too late, and the public purse, the home care sector and Scotland's citizens are experiencing the detrimental effects. The only way to overcome this and ensure that we are genuinely promoting enablement and independence is to emphasise the preventative and relationship-based dimension of home care and its workforce.

In terms of self-management the report's findings, when viewed through the lens of the ADL LifeCurve™, reinforce that preventative support does not encourage or lead to inappropriate dependency. In fact, a lack of early intervention and support can paradoxically lead to over-dependency later in an individual's life and can reduce the ability, especially of the older person, to develop self-management processes.

The report has sought to demonstrate that an increasingly professionalised home care workforce playing its critical, collaborative role in the delivery of health and care in the community does not need to be at the expense of a relationship based, time-flexible, preventative contribution from the same workforce. In fact, these two components of care delivery are entirely compatible and equally necessary.

NEXT STEPS

This work has detailed the journey of home care in Scotland to the present time. It will have been clear to the reader that it has been an intriguing and interesting one but one which has been often accidental and reactive to circumstances rather than necessarily self-directed or strategically planned. What will be important is that the next steps for the sector and its workforce are properly grounded in the analysis of the sector which this study has articulated. So how do we continue that journey? We offer the following suggestions as some stepping stones for moving forward. They are addressed to all stakeholders with an interest in ensuring better health and wellbeing outcomes for our population.

Workforce

One of the major challenges facing the care at home and housing support sector relates to workforce. We have already evidenced in this work the difficulties existing organisations are facing in recruiting and attracting staff to come and work in the sector. We have highlighted that despite the implementation of the Scottish Living Wage that terms and conditions remain a major barrier to retaining and recruiting staff. We are faced with an ageing workforce which remains predominantly female in an environment where there is likely to be increased demand and where more and more individuals are wanting male carers. Faced with these challenges we need to seriously re-conceptualise the role of the home carer. We would argue that the re-modeling of home care articulated in this work provides us with the basis of re-conceiving the role of the worker. We need a workforce oriented around prevention, with autonomy and self-management at the heart of delivery, with the ability to assess, initiate and decide. We require a workforce skilled in reflective practice, person-centred communication and in supporting decision-making on the part of the supported person.

In addition we need to recognise that the enhanced skills of the workforce required to deal with increasingly complex co-morbidities and a population living longer in the community necessitate sustainable resourcing and development. Equally importantly, as we move towards increased joint-working and co-professional teams, there needs to be serious work undertaken at advancing the understanding and mutual respect of the distinctive contribution of care at home services. This includes the need for greater access to equitable training opportunities and support for the achievement of qualifications which enable the workforce to register with the Scottish Social Services Council and encourage home care staff to be recognised for their skills in ways comparable to their colleagues in other parts of the health and social

care sector. We are convinced that the workforce challenges in part would benefit from a national media campaign which highlights the skill level of this workforce and the benefits of a career in care.

But as well as this, we have to recognise that the Scottish Living Wage should be seen as a starting point not a destination. We simply do not accept that it is sufficient to recognise the diverse skills of this workforce by paying what is effectively amongst the lowest salaries in the country. Nor does it address the need for a multi-faceted recruitment and retention strategy which appreciates the complexities of supporting current and prospective home care workers. This includes, for instance, recognition that the autonomous nature of this work may lend itself to older workers – with over 50s being the fastest growing workforce – and understanding the challenges presented by tax credit schemes, which encourage people into work but can have an adverse effect on benefits if they work over a certain number of hours per week in what is a largely part-time workforce with fluid working hours.

Commissioning

Commissioning practice, despite some attempts at reform in some parts of Scotland, remains stubbornly rooted in former relationships and processes which have clearly failed to serve their purpose.

The dynamic of purchaser and client has fostered a competitive dimension which has not only failed to serve fiscal best value but has diminished the capacity of both parties to form the sort of trust-based long-term relationships which should be at the heart of social care contracting.

Faced with austerity, more and more authorities are utilising call monitoring systems in order both to make cost savings but also to demonstrate contractual compliance. We do not believe that the use of this sort of model to purchase home care is appropriate for either the workforce or for ensuring best quality. We would like to see a more flexible and equitable use of call monitoring systems in particular to take account of the importance of time flexibility in the formation of holistic and effective preventative relationships. This is especially the case where the majority of encounters at present are in palliative and end of life contexts.

We would like to see a move towards outcomes commissioning and a rejection of time and task purchasing of care – regardless of the lengths of time that might be involved. This requires the development of real trust-based relationships between providers and commissioners.

To achieve these ends Scottish Care would want to explore the potential of focused work in a number of Integrated Joint Boards using outcomes based commissioning based upon the ADL LifeCurve™ work described in this study.

We need to move away from a contractual basis of purchasing care to a relational model and by doing so, we will ultimately return to a much-needed relational approach to care delivery.

Prevention

We have articulated throughout this work that preventative support and care needs to be recognised as a major contributor to effective personal and societal outcomes from care at home services. Scottish Care will engage in a study of the use of the ADL LifeCurve™ for the home care workforce later in the year but we are confident that this will highlight the potential value of home care as a preventative, early intervention service and resource. In order to maximise the potential of home care as preventative support, Scottish Care would like to establish a prolonged test of change in a number of Integrated Joint Boards, independently developing a baseline of data to evidence the positive personal and fiscal outcomes which an early preventative model could result in.

MOVING UPSTREAM

The prevention of unnecessary admissions to hospitals and long term care settings through better use of home care services can result in positive personal outcomes and significant savings to the public purse.

Care at home and housing support settings need to be seen as an essential part of the solution to reactive planning and spending, and need to be able to act as positive partners in the preventative agenda.

However this requires widespread commitment, at national and local level, to the level of reform required to ensure sustainable, proactive and high quality home care services are available for the individuals who require and deserve them. It also requires sustainable, positive and increased engagement and utilisation of the independent care sector.

We hope this report provides a starting point to take forward constructive dialogue around its findings and recommendations. Scottish Care is committed to engaging with all partners who share a stake in the future direction of health and social care in Scotland.

Preventative care is the only way in which social care can deliver – for current and future demand, for constrained budgets but most importantly, for people's lives. Preventative care is not the opposite to greater self-management but a natural ally and requirement. And preventative care can only be enabled through the valuing and prioritisation of relationships, time and home care services.

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NOTES

Report written by Becca Gatherum
Policy and Research Manager and

Dr Donald Macaskill
Chief Executive

If you would like to discuss this report or it's findings, please contact:

Scottish Care
54A Holmston Road,
Ayr, KA7 3BE
01292 270240
Co. SC243076