The future delivery of social care in Scotland
Health & Sport Committee: Social Care Inquiry

Scottish Care response

Introduction

Scottish Care is a membership organisation and the representative body for independent sector social care services in Scotland. We represent 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 includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and family run services. 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.

Working on behalf of a range of providers, Scottish Care speaks with a single unified voice for both members and the whole independent care sector. This includes staff working in and those who access independent sector care services. For the purposes of clarity and understanding, the independent sectors covers private, charitable and not for profit social care organisations.

In Scotland, the independent social care sector across care home, care at home and housing support services for adults contributes to:

- The employment of nearly 96,000 people, which is 47% of the total social services workforce, including approximately 5,000 nurses
- The provision of 89.5% of care home places for older people
- The support of 53% of all home care support provided to adults

Any night of the year, there are nearly 36,000 adults in care homes across Scotland, 62% of whom will require nursing care and 57% of whom will have a form of dementia (this number is higher amongst older people). This is compared to an average of just under 22,000 available staffed beds for all specialities in the NHS in Scotland.

Nearly 60,000 individuals receive home care support, which totals almost 700,000 hours of care delivered annually. The independent sector contributed to the support of 31,290 of these clients, and 69% of the total care hours.

Scottish Care is committed to supporting a quality orientated, independent sector that offers real choice and value for money. Our aim is to create an environment in which care providers can continue to deliver and develop the high quality care that communities and citizens require and deserve. We welcome opportunities for dialogue, discussion, collaboration and partnership with any and all who share our values.

Scottish Care welcomes this opportunity to contribute to the Health & Sport Committee's inquiry into social care on behalf of our large and diverse membership.

What we would like to stress is how important it is that this inquiry moves beyond discussing the well-known challenges in social care towards meaningful and urgent remedial action to secure a sustainable, high quality care future. It must also seriously consider how it will meaningfully engage and involve individuals who work in and access social care services, including older people, in this inquiry.

Our responses to the specific questions asked by the Committee are provided in this spirit.

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

There are, in our view, a number of legislative tools already in place in Scotland to support planning including those relating to health & social care integration and self-directed support. The ambition of these has been, at least in part, to facilitate the voices and needs of individuals and communities being central to the design and delivery of social care services.

The issue is that the implementation of these progressive pieces of legislation has not led to or enabled this to happen and therefore we are not seeing the meaningful engagement of individuals, communities or central local partners in these processes.

Health and Social Care Integration remains, in many places, focused on bureaucratic processes relating specifically to health and local authorities. Inclusion of social care providers and the people they support is often tokenistic or sometimes openly rejected when in fact these groups should be central in determining what social care services are required and desired in order to meet local need and circumstances.

Integrated partnerships must be informed of and engaged with community groups and services in their local areas. This can be best achieved by giving the independent and third sectors an equal voice within Integrated Joint Boards (IJBs), providing the opportunity to utilise their experience, expertise and ability to innovate. Where we already see this happening, there are clear ways in which these areas are already taking positive steps towards addressing the changes required to meet future needs of communities. For example in Dumfries & Galloway, a model is being tested whereby care providers undertake assessments on hospital wards to improve people's experiences of hospital discharge. Unfortunately, positive practice only seems to be happening in pockets across the country and often in very local circumstances. There therefore needs to be strengthened accountability for partnerships in relation to how they ensure there is a consistent and meaningful approach to community involvement in local planning and decision making.

The Self-directed Support (SDS) legislation in Scotland also formalised the replacement of a one size fits all approach with the need to develop and offer bespoke services and supports based on citizen control, independent living, autonomy and choice. The SDS Act enshrines in law and social care practice the core values of inclusion, contribution and empowerment through real choice and respect.

However, there remain significant issues in relation to older people's access to SDS and what options they are provided with in terms of being able to plan and direct their own support. Scottish Care's recent research highlights that most individuals accessing care and support in care homes in Scotland are not been given their full rights under the Self-directed Support legislation, and our 2018 research with care at home and housing support providers indicated that, to respondents' knowledge, at least of third of people they supported were not aware of SDS. Helpful resources have been developed in some areas, for instance the *'7 Self-directed Support Suggestions: Elderly Armchair Advice'* booklet developed by Scottish Care in partnership with older people in Highland (see: https://scottishcare.org/wp-content/uploads/2019/11/7-Self-Directed-Support-Suggestions-Elderly-Armchair-Advice-.pdf) but widespread awareness is still patchy. There needs to be robust and independent systems of scrutiny, audit and accountability put in place with some urgency to ensure that all individuals who require care are suitably informed about their rights within the law to direct

their own care and support. We are not convinced that the current data on social care provision is as robust and independent as it should be.

In a broader sense, there has to be robust and honest public dialogue about the role of social care in our lives, communities and country. Positively, there has been growing recognition of the importance of social care but there remains a significant degree of myth, misconception and undervaluing in relation to what social care is and what can and should be provided. The conditions must therefore be created by which Scotland can meaningfully explore not only who and what is provided but what the place of social care in our communities is.

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

We must recognise the challenges that accompany the fact that our social care assessment, funding and delivery models are hugely complex to navigate. If we do not understand and address the fundamental inequalities that exist in the system, such as access to funding and who pays for care, we risk asking citizens to plan for a social care future based on access, equity and quality which they will then expect to receive but which will be impossible to deliver within the existing resource framework.

We should also be promoting early consideration of future care needs and implementing proactive planning and funding processes to ensure that individuals can have their needs and wishes met when they reach a time when additional support is required. This will include the need for leading difficult national conversations around ageing, death and dying, and supporting opportunities for individuals to experience these services earlier in life through, for instance, working or volunteering in community services. There must also be a reformed approach to how social care is delivered. The increasing use of anticipatory care planning resources has been positive yet these continue to be used within a social care system premised on 'last resort' care often in crisis situations due to budget constraints and higher eligibility thresholds. Social care is at its best when it is able to support people in a constructive and planned way in line with their needs and wishes, therefore delivering the best outcomes for individuals.

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

It is worthwhile noting that Scottish Care members wanted to rephrase this question, in that it should be asking how IJBs can commission and procure high quality, sustainable social care. If we get this right, person-centred (or better, person-led) care would be far more universally experienced. Commissioning and procurement processes have a responsibility to facilitate the existence and sustainability of quality services through the provision of suitable resource. Instead, failure to adopt a person-led approach to commissioning and procurement has resulted in people 'fitting in' to existing structures, services and categories of care provision without sufficient support or resource.

There needs to be a revised approach which both assesses for need and delivers on personal outcomes, within a human rights framework, for instance by applying human rights

PANEL principles to the commissioning cycle (see: https://scottishcare.org/wp-content/uploads/2020/02/Human-Rights-Commissioning-May-19.pdf)

There must also be additional powers provided to regulatory bodies to monitor and report commissioning and procurement processes and their impact on the availability, quality, sustainability and person-centredness of care provision in a more consistent, regular and substantial way.

There needs to be a clear understanding of the terms 'commissioning' and 'procurement', which are often conflated or used interchangeably when in fact they refer to quite different processes. Commissioning refers to a broader and ongoing process of strategic planning, reviewing and monitoring service provision and is therefore largely within the responsibilities of Integrated Joint Boards. Procurement is the process of purchasing goods and services and is largely handled in terms of social care by local authorities. As a result of this blurring of definitions, there risks a knowledge and skills gap within national and local teams responsible for these exercises. There needs to be processes of assurance and accountability for those responsible for commissioning and/or procurement to ensure they have the necessary skills and understanding of the complexity of the sector when making decisions about it. This should include Integrated Joint Board members. As an example of positive practice, in Dumfries & Galloway the Integrated Joint Board holds workshops with IJB members to learn more about different areas of provision and different sectors.

There are many positive elements of the procurement legislation and Guidance which emphasise personalisation, human rights, partnership and engagement. However, the reality experienced is that that these are being largely ignored in practice. It is important to note the inherent tensions that exist within procurement processes with the current social care system, which we believe to be limiting the ability to deliver person-centredness and equity within the sector. This is especially apparent in the many instances whereby local authorities act as both purchasers and providers of social care services without being subjected to the same degree of scrutiny and financial rigour for its own provision as those delivered by the independent and third sectors. This inequity fails to put the person at the centre of care provision and instead represents a hierarchical approach to support based on sector rather than quality or outcomes.

This is also true in the competitive tendering exercises which prevail in terms of care at home service procurement, whereby providers are forced to adopt a 'drive to the bottom' approach to costs, time and tasks in order to deliver social care within a partnership area and as result leading to unsustainable support services. This destabilising of the sector flies in the face of person-led commissioning and procurement given the negative impact it has on workforce recruitment and retention, continuity and flexibility of support. Conversely where true partnership takes place, positive and innovative approaches can be developed. In Aberdeen City, the independent sector is leading on the facilitation of stakeholder collaboration in care at home tendering, exploring alliance-based contracting and relationship-based commissioning rather than a 'time and task' approach. In Dumfries & Galloway, a block contracting approach is supporting more sustainable planning and provision.

The increasing use of electronic call monitoring systems is also having an adverse effect on providers' ability to deliver person-led care. Whilst such systems can offer benefits in terms of staff safety and real time monitoring, the inappropriate use of them to dictate payment of provision based on minute-by-minute visit billing is extremely problematic and has caused some providers to close their services. In Fife, a positive approach of listening to care providers and working with them to address areas of challenge in electronic call monitoring has supported sustainability. It should be noted, however, that this process did result in the

loss of some local providers as a result of initial poor implementation, which highlights the importance of partnership from the very beginning.

In order to truly achieve person-led social care within an integrated landscape, there needs to be better understanding of existing pathways available for people's journeys through health and social care services in order to identify opportunities for change. For example, there are currently no routes to admit someone into a social care service in the same way that someone would be admitted in an emergency or out of hours situation to an acute setting. This involves working with all parts of the system, including NHS24 and GP services, to change both culture and practice towards a more person-centred approach to support options rather than risk aversion based on data and information gaps or a lack of trust across different parts of the system. Developments in this area include the employment of the first Advanced Nurse Practitioner within a care home (Erskine) which has resulted in a 70% reduction in GP input and technological developments in remote and rural areas which are supporting consultation, assessment and decision making processes (for instance in relation to hospital admission) without face-to-face attendance at a service or in someone's home.

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

Definition and purpose:

Any consideration of an 'ideal' model of social care must originate from a clear and common understanding of social care's definition and purpose, which we do not currently have.

There are many definitions, both legal and aspirational, as to what social care is. Whilst social care may contain services and behaviours which are clinical or medical in nature, it is not primarily about one's physiological health.

Our suggested definition of social care is:

'The enabling of those who require support or care to achieve their full citizenship as independent and autonomous individuals. It involves the fostering of contribution, the achievement of potential, the nurturing of belonging to enable the individual person to flourish.'

In essence social care is about enabling the fullness of life for every citizen who needs support whether on the grounds of age, disability, infirmity or health. Social care and support is holistic in that it seeks to support the whole person and it is about attending to the individual's wellbeing. It is about removing the barriers that limit and hold back and the fostering of conditions so that individuality can grow, and the independent individual can flourish.

Social care is not about performing certain functions and tasks alone for it is primarily about relationship; the being with another that fosters individual growth, restoration and personal discovery. It is about enabling independence and reducing control, encouraging self-assurance and removing restriction, maximising choice and building community.

Value & sustainability:

The only way we will retain and develop the social care we critically require for the future is to fundamentally change the value placed on it as a sector by politicians, the public and partners. This is the biggest issue that the sector faces and it permeates all other areas, from funding to the availability of workers. The sector is truly at a place of extreme fragility and indeed collapse in some areas.

The adult social care sector in Scotland contributes £3.4 billion to the economy, directly through the value of goods and services it provides and purchases as well as through the indirect and induced impact it has, for example in enabling unpaid or informal carers and relatives to remain in employment. Its direct economic impact, measured in terms of Gross

Value Added (GVA) at £2.3 billion, makes it a larger contributor to Scotland's economy than sectors such as agriculture, forestry, fishing, the Arts, entertainment, recreation and waste management.

What's more, the adult social care sector employs more citizens than sectors including transport and administrative and support services. This amounts to it being the eighth largest employment sector and totals 6% of all workers in Scotland.

In order to truly be a country that cares about its vulnerable and older citizens, there must be considerable investment of time, energy and resource into social care development and a radical shift towards viewing it as an economic benefit rather than a cost burden. There needs to be urgent investment not only to ensure survival and sustainability but to foster growth and innovation. Social care must become an economic priority.

Value & workforce:

The social care sector *is* its dedicated, skilled and compassionate workforce. What is required above all is a fundamental shift in how people who work in this sector feel valued by society for the necessary and complex work they do and that they are rewarded and remunerated accordingly. In terms of pay and progression, we need to be repairing the ladder rungs and adjusting the ceiling, not simply raising the floor. Scottish Care's many research reports on the front-line social care workforce highlight the ways in which change can and should be progressed in order to recruit and retain the people we need to support current and future care needs.

In a sector where workers require to travel to work including during antisocial hours and holiday periods, to pay for their own registration and often qualifications, and require to maintain their learning and development whilst often juggling personal caring responsibilities too, it is not inconceivable that for many, the Scottish Living Wage will mean a reality of in-work poverty. This is not good enough for the care of our citizens, and whilst requiring a multi-faceted approach to solutions, there has to be impactful political leadership and a will to change this beyond tinkering around the edges of the issue.

We must also see innovative approaches in tackling the critical nursing shortages within care homes. This is a sector which employs 4,450 nurses but which is facing vacancy levels of around 30%. By comparison, recent headlines have expressed concern at the 'all time high' NHS nurse vacancy levels of 4.1%. The recently announced migration proposals represent a complete lack of understanding and appreciation of the importance of social care work and effectively prevent much needed migrants with the right skills and values joining the care workforce in Scotland.

Technology & support for innovation:

We need to support individuals, providers, planners, developers and commissioners to view and utilise technology as a means to empower rather than restrict, and to reinforce rather than replace. This means adopting a human rights-based, ethical approach to the development and utilisation of technology, which priorities person-centredness and building trust. Scottish Care has recently developed a Human Rights Charter and Guidance for Technology and Digital in Social Care (see: https://scottishcare.org/resources/technology/) which outlines key principles and has been created in partnership with service providers, individuals who receive care and leading figures and organisations in social care and technology arenas In order for technology to meaningfully improve health and social care provision, there needs to be focus on the inter-operability of systems, appropriate information sharing, suitable data collection and the use of such data to continuously inform and influence change.

Scottish Care's work with the Glasgow School of Art served to highlight the potential for new roles within the social care sector, premised on navigating, connecting and utilising technology to improve individual wellbeing (see: https://futurehealthandwellbeing.org/future-

of-care-at-home). It is possible to envisage such roles becoming operational within care settings in the near future. However there needs to be real support and investment in innovation within the social care sector, including access to funding. This is a sector which is flexible, entrepreneurial and solutions-focused in nature, when enabled to be.

Distinct palliative and end of life care resourcing:

There needs to a broader focus on community palliative and end of life care needs. There are 245 adult hospice beds in Scotland, nearly 38,000 care home beds for older people and approximately 30,000 people supported at home with care needs relating to frailty and dementia. The vast majority of individuals will be supported by these services up to and including palliative and end of life care and as the population ages, the number of individuals who will be supported at the end of life will likely increase further.

In order to ensure that all of Scotland's citizens are supported to live and die in a setting of their choice with high quality support and their needs and wishes met, we need to prioritise equal investment across all areas of palliative and end of life care provision. The aspiration should be that anyone who requires this type of intensive and sensitive support should have a range of options available to them in their local area, where they can access high quality care including in hospices, care homes and at home. This involves broadening learning and development opportunities for staff across different care settings and investing in community supports, including care home and home care services alongside hospices.

It also includes recognising the impact of delivering palliative and end of life care on social care staff. Scottish Care has been central in a coalition of organisations developing the first Bereavement Charter which sets out national goals and principles for care around death, grief and bereavement. We hope to see this supported and utilised widely.

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

Scottish Care strongly believes that meaningful and significant effort must be made to make health and social care services more equitable in terms of access, pathways and costs.

Scottish Care suggests that a focused and time limited review or commission is undertaken focused on action around particular elements of social care. These elements of review are:

- Best value across health and social care, in terms of what services, supports, sectors and ways of working can ensure quality care and positive and personalised outcomes for people whilst maximising what will continue to be a limited resource pot;
- Funding of health and social care and how funding models can be made equitable, sustainable and transparent for the future. This includes how external services are commissioned and procured;
- The success or otherwise of existing policies including Self-Directed Support and the implementation of the Scottish Living Wage as means of driving equity and sustainability in the social care sector.

We also need to open up a national dialogue around how we fund social care into the future and how we create more equitable access across health and social care. It is essential that we engage with citizens around future priorities for care and have honest discussions about how we make this achievable and affordable for the country.

Ultimately, we must consider health and social care in their entirety and examine the whole system in terms of someone's journey through it. Too often, health and social care are treated as separate entities without a clear understanding of their interdependent relationship and therefore attempts to strengthen an element of the system undermines another part. The

only way to strengthen the long-term future of health and social care services is to prioritise comprehensive understanding of the system and to not shy away from bold decisions about what is required to deliver quality, cost efficiency and support in the right place at the right time.

Equity within social care must involve treating social care as equitable to health, not its poor relation. Our health services cannot operate without a sustainable social care sector. Social care is not equivalent to health but is a critical component to the realisation of health. Social care is profoundly about human rights. It is about giving the citizen control and choice, voice and agency, decision and empowerment. Equity across the sector must be based on these principles.

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