Independent Review of Adult Social Care in Scotland Evidence Submissions

Volume 1

Contents

Introduction

Independent Review of Adult Social Care in Scotland

From September to November 2020, there was an open call inviting individuals and organisations to submit views, papers and evidence to the Independent Review of Adult Social Care. These four evidence documents contain some of those organisations' and representative bodies' submissions.

Only where permission has been given have submissions been published. Responses from individuals, and any responses containing personally identifying information, have not been published. The Chair of the review and members of the advisory panel are very grateful for these submissions, all of which were taken into account during the review.

This volume contains supporting files from A to C and the Appendix links directly to organisations' and representatives bodies' submissions where they were published on their own websites.

About Dementia

Submission to the Independent Review on Adult Social Care in Scotland, October 2020.

Background to this submission

About Dementia is a five-year project, funded in 2019 by Life Changes Trust and hosted by Age Scotland. We bring together people affected by dementia with professionals in the public and third sectors to influence change around policy and practice in Scotland. We do this through the mechanism of thematic sub-groups. In our first year our sub-groups focused on Housing, Transport & Mobility, Human Rights of Unpaid Carers and Prevention & Living Well. We are adding Technology, Sport & Physical Activity, Human Rights of People with Dementia, and Befriending & Peer Support to these in our second year. This response draws on evidence collected though participative conversations with over 150 people affected by dementia and professionals over the first 18 months of our project. We also draw on policy and research work undertaken by the project during that same period. This response also presents evidence from engagement work conducted with our members in direct response to the review.

Introduction

Scotland faces substantial challenges in creating a human rights based social care system that delivers on the promise of dignity, empowerment, independence, choice and control for all citizens who use it. These challenges precede the current Coronavirus pandemic by a substantial period, but nevertheless this crisis has served to bring them to the fore. While social care has long been undervalued as the poorer cousin of health care, the events of recent months have demonstrated just how vital social care is to enabling the realisation of fundamental human rights. We therefore welcome the review, the focus on human rights as an underpinning framework of values, and the approach already taken to engaging widely both on topics of interest and with a broad range of stakeholders.

We share the concerns of many others in civil society, however, at the short timeframe for publication of recommendations by the review. Social care is a hugely complex and interrelated policy area, subject to well established path dependencies. Users of social care are in no way homogeneous in their needs or experiences of the services they depend upon. Though Scotland benefits from, and is enriched by, a civil society that centres lived experiences of service users, we are very aware that many of those who use social care are often highly marginalised. The restrictions imposed by the current pandemic have only compounded existing causes of social exclusion. Many social care users and unpaid carers are simply too

consumed with the day to day task of survival at present, to be able to engage meaningfully with such an important process. Many more are not accessing, or have never accessed, services through which they might come to hear of the review. Nevertheless, the decisions made by this review will have a substantial impact on their lives for many years to come. The UN PANEL principles are a vital mechanism for making human rights a reality for all citizens. Not least of these is the principle of 'Participation', from which the Disabled People's Movement's mantra "nothing about us without us" is drawn. We are therefore concerned that the short timeframe for a review of such an important and complex issue will inevitably leave too many voices unheard.

We would further like to seek clarification from the review as to the relationship between this process, and the ongoing Scottish Government Reform agenda in social care. This process has likewise involved a wide range of stakeholders, and those with lived experience, and has resulted in a number of pilot projects to explore and enable innovation that could prove useful evidence to this review. It is therefore unfortunate that this review will be unable to benefit from the findings of these projects and may therefore inadvertently undermine the success of that process.

Access to social care for people affected by dementia

A consistent theme in conversations with our members at sub-group meetings over the course of the past 18 months has been challenges in getting access to social care when it is most needed. This included carers not knowing how to initiate the process of a care assessment, delays in allocation of a social worker, delays with the assessment process itself, and then again between assessment and a package of care commencing.

Conversations at both Housing and Human Rights of Unpaid Carers sub-groups over the past 18 months have regularly explored when is the best time to receive information around social care. Some individuals have felt that this needs to be provided as a matter of course through post-diagnostic support. However, others felt that they struggled to take much in at this stage and were unable to then retrieve the information when it was needed. This latter concern was also shared by a carer who responded to our recent engagement activity:

> *I was given two very well presented books, which I found difficult to take on board. One early stage, the other mid and later stage, at my age found it hard to retain any real immediate information. (Carer, Response to engagement)*

Confusion and local variation over entitlement and assessment criteria has also seen people affected by dementia struggle to obtain a package of support in the

community following an assessment. A third sector professional at our Human Rights of Unpaid Carers' meeting in May 2020 commented that 'people with dementia don't get social care until much later' implying that social care for people with dementia tends only to be approved in the later stages of the disease. Often this results in a move from home into a residential care facility and, even then, often long after the carer has reached a crisis point. Carers have routinely spoken to us of the battles they have faced trying to get access to social care, and the lengths they have had to go to obtain an assessment.

> *The greatest challenge for me as an unpaid Carer was the Assessment process, which was lengthy [and] complex ... Dealing with services caused me more stress than my actual caring experience, where I was in control of our situation. (Unpaid Carer, Response to engagement)*

A care worker at an engagement event hosted by The Alliance and Age Scotland on 29th October 2020, observed to us that many families struggle with the idea of requesting help, viewing this as a symbol of defeat or a sign that they are not coping. Institutional barriers and delays therefore mean that many carers will simply give up, with significant risks to their mental health. This in turn makes it more likely that when help eventually materialises this will involve a move to an institutional setting following carer burnout.

Continuity of access and information sharing between agencies involved in the provision of care are also common themes in our discussions. Carers have commented at having to go back to the beginning of a referral process each time their needs change, with no continuity, no regular review process, and no emergency contact should their circumstances change or worsen. This often makes crisis situations harder to manage because there is no access to help when it is needed most. Preventative approaches to care are critically important and must take account of the carers needs as well as the person with dementia, as this carer highlighted:

> *The issue for carers is that the critical/crisis refers in most cases to the person with dementia and not the carer when in actual fact the likelihood is that the carer will reach that pinnacle of critical or crisis far quicker than the person with dementia (Carer, Human Rights of Unpaid Carers sub-group Meeting, 21st November 2019)*

Community based providers have also commented to us that information sharing is often poor between social services and other agencies (including community mental health teams) meaning that referral information into services are often partial or incomplete. They have likewise commented at the lack of parity given to their views and opinions on the needs of clients they support when making referrals back into social care. Whatever stage people require access to social care,

all carers and people living with dementia should be able to easily get access to appropriate social care and within a reasonable timeframe.

Self-Directed Support, Choice, Control and Independent Living

Scotland broke ground in embedding human rights in the legislation introducing Self-Directed Support and we believe that this still represents an important mechanism for ensuring access to personalised, outcome-focused social care that enables independent living. However, we have consistently heard of challenges to making these aspirations a reality. As we have outlined above, people affected by dementia struggle to get access to social care early on enough in their journey to be able to make the sort of difference they seek.

> *Independent living requires an early assessment, to enable a disabled person [to] get Self Directed Support at an early stage of their illness, not when they become more disabled. (Carer, response to engagement)*

This therefore limits the potential to use their care packages in creative and innovative ways to meet their individual needs. Carers of people living with dementia have also reported on barriers they've faced in accessing the full range of SDS options, and that often service users over the age of 65 are not encouraged to explore the opportunity to meet outcomes not related to personal care:

> *Care management [were] resistant to share all care options [with us]. Care manager just said care home or personal care, none which was appropriate for mum. I did all personal care to give mum her dignity. (Carer, response to engagement)*

The delay in accessing care also means that the potential inherent in SDS to promote a preventative approach to social care is yet to be fully realised. The sharp rise in loneliness and isolation among older people, even prior to the pandemic is testament to the importance of remaining independent, physically active, and socially connected in later life. SDS packages could be used to employ a dog walker to enable a much-loved household pet to remain with their owner for company, or to support a befriender to support trips to libraries, museums or the cinema. Likewise, it should be recognised that individual needs may necessitate specialist care packages such as support from Cognitive Stimulation Therapy, or specialist dementia community care provision. Where carers identify and advocate for such services themselves, they are often rejected through the Resource Allocations Process or other procurement measures because they come with a higher unit cost. As a carer at our Human Rights of Unpaid Carers workshop on 3rd November commented: 'It's not about getting any care, it needs to be the right care.'

Evidence from the Age Scotland Helpline also supports concerns that the full range of options available under SDS are rarely presented to those over the age of 65. This concern is again echoed by research undertaken by Community Catalysts and Life Changes Trust (2018). Care users who do access SDS often do so through support from external networks including from third sector organisations and providers. As one of our respondents commented:

> *As someone who thought it would be straightforward to get things in place for us I quickly realised that I would require sound advice to deal with the many issues that people with dementia and unpaid carers have to deal with each day. (Carer, response to engagement)*

The PANEL principles recognise that living a life free of discrimination is an important prerequisite to the realisation and enjoyment of their Human Rights. In order for the potential of SDS to be fully realised, we believe that the opportunity to exercise choice and control must therefore be applied equally to all social care users regardless of age or type of impairment.

Carers have also reported on the challenges of managing the reporting requirements put in place to monitor the use of Option 1 Direct Payments. A carer at our Human Rights of Unpaid Carers Workshop on 3rd November 2020 described the new roles she had to take on to manage her mother's budget, including accountant, administrator, care manager. She received no training or support from her local authority to adapt to these new roles and was left personally out of pocket and unable to claim for the expenses she incurred as a result.

All service users and unpaid carers should be given access to independent advocacy and advice to enable them to assess what form of SDS is best to meet their needs. They should also be given access to training and support to empower them to manage budgets well. Likewise, local authorities should adopt simpler monitoring mechanisms for direct payments packages, recognising that these are private individuals rather than companies involved in competitive procurement processes. Safeguards must of course be put in place to protect the use of public funds and prevent fraud, but a better balance must be struck to enable real choice and control for service users.

We remain committed to Self-Directed Support as a mechanism for enabling choice, control, independent living and empowering social care users to realise their human rights. The challenges outlined above are not a failure of policy, but rather of implementation (See Pearson et al 2017). Self-Directed Support required substantial cultural changes to be embedded in a period of policy overload, without substantial additional resources and at a time of acute fiscal austerity. As we face this review going into a similar period of constraint and reform we urge the review to preserve the system of Self-Directed Support, and commit to working towards the transformational change that was the original promise of that legislation.

Support for unpaid carers

As with the embedding of Human Rights in Self-Directed Support legislation, the Scottish Government broke new ground in the Carers Act (Scotland) 2018. This important legislation enshrined the right for carers needs to be assessed in their own right. A consistent trend throughout our engagement with unpaid carers over the past 18 months, however, has been frustration at the lack of progress in implementing this important law. Too often carers have been unaware of their entitlements under the Act, have been overlooked and ignored in social care assessments, or subject to long and bureaucratic delays.

> *We're not talking about [meeting medical needs], but often about a dire need to get time to pay bills and order food and put things into the washing machine. What is the point of a 'care plan for carers' when even respite for an hour can be impossible, especially due to COVID-19 restrictions? Such care plans have to be meaningful and not as bureaucratic lip service (Ex-Carer, response to engagement)*

Many of those undertaking unpaid care, do not identify as carers viewing themselves as simply doing their duty as a spouse or child. However, this may mean that they lose out on access to support that may be available.

Even prior to the pandemic, carers routinely reported feeling burned out and unable to access support until they reached a crisis. One carer who provided a case study for our recent Covid-19 Impacts and Survey Findings Report (About Dementia 2020) described her anger and frustration at having reached that crisis point:

> *[Margaret] said she felt that she had never been asked if she wanted to take on the role of a carer. She was also frustrated by the social care system that had left them without any support [during lockdown] ... [she] said that the experience had left her feeling side-lined and ignored. (Extract from Case study in 'Locked Down but Not Forgotten, About Dementia 2020)*

As this quote from Margaret also indicates, unpaid carers have also reported how ill equipped and unsupported they often feel in taking on the task of caring for a loved one. A carer attending our Human Rights of Unpaid Carers sub-group meeting in November 2019 spoke of her frustration at having been refused moving and handling training by her local authority, something that would be routine for any paid carer worker. This issue was also raised at our meeting in Prestwick in February 2020:

> *All of the discussion groups felt that access to training was a key issue for carers. The most common areas of training that carers felt they would benefit from were personal care, moving and handling, nutrition and hydration, medication and mood, depression and behaviour (Report of Human Rights of Unpaid Carers Sub-group meeting, Prestwick, 26th February 2020)*

An Age Scotland and Tide webinar on Dementia Carers and the Law held in August 2020 received over 100 registrations in just over two weeks, demonstrating the extent of demand for information and training.

Carers have also highlighted the lack of integration between policies for carers and people affected by dementia, including frustration at carers exclusion from the 2017-2020 National Dementia Strategy for Scotland. Our meeting in Prestwick in February 2020 overwhelmingly supported the re-inclusion of carers in this vital strategic document when it is renewed (originally scheduled for 2020, but now delayed till 2022). They also argued for the creation of a discrete package of post-diagnostic support for carers to run alongside that available for people diagnosed with dementia.

While the challenges faced by unpaid carers are by no means new ones, the recent pandemic has served to exacerbate existing difficulties in getting access to support. Our recent report 'Locked Down but Not Forgotten' into the experiences of people affected by dementia during the Covid-19 Pandemic (About Dementia 2020) highlighted the immense pressures that carers faced during this period. With local authorities withdrawing care packages, and respite, day care centres and voluntary organisations unable to deliver their normal services, carers experienced an exponential increase in their caring responsibilities more or less overnight. Confusion over what activities were or were not permitted under the lockdown heightened the stress experienced by many of those caring for loved ones who did not live with them (see also About Dementia submission to Scottish Parliament Covid-19 Committee, May 2020). Likewise, services and voluntary organisations adapted and responded with no guidance as to what activities they could or should be providing at a local level, resulting in marked variation in the range of responses available.

A carer at a Human Rights of Unpaid Carers working group meeting in August 2020 also raised concerns about facing decisions during the pandemic that struck a balance between deprivation of liberty and keeping their loved one safe during the pandemic, and how ill equipped she felt to make such a decision. This presents the risk of rights violations for both the cared for individual and the carer in addition to the obvious safeguarding challenges at stake.

Our social care system more than ever depends upon the unrecognised and undervalued unpaid labour of (predominantly female) family carers. More must be done to meet their needs and to recognise, value and support their contributions.

Housing

We welcome the review panel's inclusion of housing as part of the remit of their inquiry and recognise that this is a topic that will be addressed at a later phase of the investigation. Discussions as part of our Housing and Home sub-group have highlighted the extent to which housing and home are inextricably linked to questions around access to and provision of social care. Early discussions as part of our sub-group on Housing influenced our decision to broaden the scope of the group to encompass the home. This has allowed us to take a relational perspective on housing, that looks beyond the bricks and mortar. We have therefore viewed housing through the lens of a person's home, as well as somewhere that is closely connected to their local community and the relationships and amenities therein. In conversations we've facilitated across Scotland, people affected by dementia and professionals have highlighted the importance of housing in enabling people to remain independently in their homes, as well as continuing connections to the community following a move to residential care. We therefore felt it important to include discussion of housing within our submission at this stage of the review.

Discussions at our Housing and Home Sub-Group in Musselburgh in November 2019 raised frustrations at planning decisions that consistently locate new provision of residential and sheltered accommodation on the outskirts of towns and cities, cut off and isolated from the rest of the community. We believe that planning departments should work in partnership with local housing departments and integrated joint boards to examine the location of such facilities and prioritise community connectedness. Discussion at the same meeting also highlighted the withdrawal of support for sheltered and wardened accommodation, sometimes at very short notice, and the impact this had for residents and families. The importance of this has only been heightened following the pandemic which has seen older people and people with dementia imprisoned in their homes and even further isolated from society.

Our Housing and Home sub-group have also highlighted the limitations of integration of the integration of health and social care in Scotland, where there is no statutory requirement to involve either local authority or housing association provision, let alone representatives of the private sector. This has implications at both a strategic and an operational level. Our Housing and Home Sub-Group in Kirkaldy in February 2020 brought together a large number of local authority housing and social care frontline workers, many of whom shared their frustration at the lack of coordination between services at a strategic level.

There is a real need for housing and health and social care departments to talk to each other more clearly. Conversations may happen between housing officers and social workers (and these have been improving) but this is not necessarily always the case and there is a real need for this to be joined up better. (Fife Council Housing Official, Housing & Home Sub-Group Meeting, Kirkaldy 26th February 2020)

"Housing officers and social workers do speak to each other at times, however these were often on a case by case basis rather than as a result of being told to do so. Housing staff don't always know who to go to for support for tenants who have social care needs." (Fife Council Housing Official, Housing & Home Sub-Group Meeting, Kirkaldy 26th February 2020)

Housing officers are often well placed to identify social care needs and make interventions before a crisis is reached. Formal referral mechanisms and parity of esteem between these important professions and social work would enable early intervention. We are aware of a number of areas where good practice exists, for example Glasgow City Integrated Joint Board who have a housing sub-committee to ensure strategic connections between housing and health and social care. Likewise North Ayrshire have developed close working relationships between housing and social care that have also had benefits at a local level. There is, however, no mechanism to ensure that these relationships are taking place across the board, or to enable such examples of good practice to be shared with professionals in these sectors across the 32 local authorities.

Housing is not routinely on Integrated Joint Board agendas and when it is it is often left to the end or falls off completely. IJBs are driven by budgets and policies often don't reference each other. (Issue raised at online Housing & Home Sub-Group Meeting 6th May 2020)

There is a significant body of evidence that demonstrates the need for greater integration of housing and social care in Scotland. We urge the review to examine this issue closely and to make firm recommendations to ensure the inclusion of housing at the heart of the integration project. We would also urge, however that the review looks beyond housing in the statutory sector, to address support for older adults living in their own homes. Research has demonstrated that over 50% of older adults live in owner-occupied accommodation (Brown et al 2017). This is an ageing population whose housing needs will be changing rapidly and will increasingly be seeking input from social care, and their needs must be considered and anticipated.

Our housing and home sub-group have also discussed the importance of adapting homes for changing needs throughout the life course. Our members have expressed frustration at the priority given in planning decisions to large executive homes and provision for families. Such properties are often harder to adapt as people age and will therefore require disruptive and often distressing house moves including into residential accommodation possibly sooner than might be desired. As an ex-carer commented:

> *Such poorly-suited housing reduces the human rights of unpaid carers, by a lack of safety for the person who they cared-for. It also means that people who choose to downsize can't, so Scotland has too many family homes without families and a growing cost in adaptions. (Ex-carer, response to engagement)*

A preventative approach to social care must therefore examine the potential to support planning that enables people to adapt their homes as they age.

There is also potential for significant innovation in how we approach adaptations to existing housing stock. The Care and Repair Scotland Dementia Enablement Project (Blake Stevenson 2019), funded by Life Changes Trust, is just one such example of how small changes in existing practice can have a significant impact on improving both housing and health and social care outcomes including independent living. The project supported four regional care and repair services to train and upskill their workforce allowing them to carry out safety checks while also reviewing the needs people living with dementia in their own homes. The project has received a favourable evaluation which emphasised the benefits to individuals in enabling greater confidence and independence, as well as preventing falls. We would urge the panel to explore the Dementia Enablement Project as an example of good practice that could easily be rolled out nationally, but crucially would deliver person-centred support at a local level.

Responding to a proposed 'National Care Service'

We are aware that one of the solutions the review has been charged with considering is the idea of a National Care Service that would put social care on an equal footing with the NHS. While we welcome the aim of parity between health and social care, we share concerns that have already been raised in this process over what a National Care Service might entail. We recognise that there are many elements of the current social care arrangements that do not benefit from localised variation and result in inequalities and postcode lotteries of provision. As one of our partners, responding in a personal capacity, eloquently put it:

> *Our wellbeing should not be a matter of geography either between the NHS and social care or between local authorities. Older people*

> *and those with disabilities must know the services to which they are entitled and feel confident in the ability for them to be delivered. (Maureen O'Neill, personal response to engagement)*

This is especially the case with charging policies, and eligibility for social care. While personal care is ostensibly free of charge across the board, conversations at our Human Rights of Unpaid Carers sub-group have highlighted that many local authorities have yet to implement 'Frank's Law.' This change, though welcome, has also failed to address the inconsistencies in definition between 'personal care' and other forms of care that are still subject to community care charges.

> *The inequity of care for people with dementia under 65 is unfair... [and breaches] their human rights. I paid privately for my husbands care while I waited for assessments, I know the costs personally and financially. If a person [is] taken into care under 65 there is no financial support from social care. (Carer, response to engagement)*

We would therefore urge the review to consider a fundamental revaluation of charging policies across Scotland and the adoption of a model that is free at the point of delivery.

Nevertheless, we also believe that there are many elements of social care, particularly with relation to the delivery of services, that are still best served by localised provision. This is not, however, an endorsement for the status quo. The response of the third sector, in particular, at the start of the lockdown has highlighted the importance of localised approaches to delivering person-centred responses. However, it has also served to highlight the shortcomings of the existing model. The third sector was able to respond with great agility:

> *It was abundantly apparent the extent to which statutory services are underpinned by those provided by the voluntary sector. Day care, support groups, lunch clubs, health and wellbeing, befriending, home visiting, pastoral care, food distribution, counselling, information, listening services, dementia clubs, mental health support, end of life and more. The impact of the pandemic was the withdrawal of many of these services, financial hardship, and consequent redundancies. (Maureen O'Neill, personal response to engagement)*

Third sector has consistently been under funded and undervalued in the wider picture of social care integration (Audit Commission 2018) as well as in their role in provision. We have regularly heard from partners at our sub-group meetings who have struggled to continue providing vital services for the same or less funding year on year. The insecurity of funding makes the contribution of the third sector all the more extraordinary, as does the lengths to which small organisations often

have to go to meet the demands of complicated and burdensome procurement processes.

The lack of parity between social and health care also stems in large part from the differential value placed on the professionalism of the workforce. Engagement with unpaid carers has consistently highlighted how valued social care workers are by social care users, and how conscious they are of the shortcomings in their pay and conditions:

> *We need to quickly address the issues of valuing our care workforce by paying them a decent wage that reflects the importance of their role in keeping our loved ones alive, cared for and loved, so they can live their last days with dignity, comfort, compassionate, respect and love. (Carer and Health/Social Care professional, Response to engagement)*

However, until recently the same value and understanding was not shared by the wider population. From the perspective of equality and human rights, one of our third sector partners commented:

> *The social care workforce is underpaid, undervalued and under-protected. This is because it is a job that is overwhelmingly done by women. (Lindsey Millen, Close the Gap, About Dementia Partner response to engagement)*

Carers have also highlighted to us the challenges of building meaningful relationships when carers rotas change daily and visits are often fleeting. A professional at an engagement event hosted by Age Scotland and The Alliance in October 2020 cited an example of an older person who had to go hungry because the carer was unable to cook the meal provided by the family member because it exceeded their allocated visit time. We urge the review to re-examine the pay, conditions, training and routes to career progression for social care workers to enable their professionalism to be adequately recognised.

Conclusions

Social care is a vital public good that has the potential to enable dignity and independence for people affected by dementia. We believe that these are basic pre-requisites to the realisation of fundamental human rights. The First Minister's Taskforce on Human Rights is examining how best to integrate international Human Rights statutes into Scottish Law. As part of this process we would like to see significant progress on the codification of rights of older people, as well as the creation of a human right to social care. However, as we have seen with both SDS and Integration, it is not enough to enshrine human rights in law. The extent to

which they are realised by the population depends heavily on how they are implemented. What must not be forgotten in this process is the issue of accountability, something many of the people we have engaged with feel is lacking from the current system.

> *Carers are easy pickings because of the constant level of stress they are under. Carers by default are easily ignored and easily exploited. Unless there is accountability and rigour in the system, then nothing is going to change (Carer, Human Rights of Unpaid Carers Sub-Group Meeting, Stirling, 21st November 2019)*

In addition we believe that the current system would benefit from much greater equity between Integrated Joint Boards and providers including within the third sector. We welcome the commitment from Mr Feeley at the Age Scotland and Alliance engagement event on Ageing and Frailty that implementation will be considered as carefully as the recommendations made by the review, and look forward to working towards a social care system through which human rights are realised rather than aspired to.

References

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Blake Stevenson (2019) *Evaluation of the Dementia Enablement Pilot Project.* Available at: https://www.lifechangestrust.org.uk/sites/default/files/publication/files/DEMENTIA%20ENABLEMENT%20PILOT%20PROJECT%20final.pdf

Brown, M., Tolson. S., Ritchie, L., Sharp, B., Syme, K., James, K., and Tolson, D. (2017) Being Home. Housing and Dementia in Scotland. Lanarkshire, University of the West Scotland. Available at: https://www.lifechangestrust.org.uk/sites/default/files/publication/files/Being%20Home%20-%20Full%20Report.pdf

Community Catalysts (2018) *Self-Directed Support in Scotland: Capturing the experience of people living with dementia.* Available at: https://www.lifechangestrust.org.uk/sites/default/files/publication/files/Community%20Catalysts%20Report%202018_0.pdf

Pearson, C., Watson, N., and Manji, K. (2017) 'Changing the culture of social care in Scotland: Has a shift to personalization brought about transformative change?'

Social Policy and Administration 52 (3) pp662-676. Open Access available for download at: https://onlinelibrary.wiley.com/doi/full/10.1111/spol.12352

Links to About Dementia Reports and Evidence

Human Rights of Unpaid Carers Meeting Reports

- Stirling, 21st November 2019 https://gallery.mailchimp.com/131dd5573d6b0ee4551cef947/files/08ffd298-cf63-4236-828d-32a8377ae8ac/Carers_Meeting_21_Nov_2019_Discussion_Summaries.pdf
- Prestwick, 26th February 2020 https://mcusercontent.com/131dd5573d6b0ee4551cef947/files/fded2c1d-26bd-4614-a0dd-e935cfde97a2/Final_Report_Human_Rights_Unpaid_Carers_26th_Feb_2020.pdf
- Online, 27th May 2020: https://mcusercontent.com/131dd5573d6b0ee4551cef947/files/75cdfecc-d87a-4097-b2e5-2aaa9d891253/May_Meeting_Report_Human_Rights_of_Unpaid_Carers.pdf
- Online, 27th August 2020 https://mcusercontent.com/131dd5573d6b0ee4551cef947/files/3b08053e-0d49-485a-9704-07e44e6f8cc1/Carers_Working_Group_Report_27_Aug_2020.pdf

Housing & Home Meeting Reports

- Musselburgh, 28th November 2019 https://gallery.mailchimp.com/131dd5573d6b0ee4551cef947/files/50c35e77-413c-4cdf-8e24-e25b199cec69/Housing_28_Nov_2019_Full_Discussion_Summary.pdf
- Kirkaldy, 19th February 2020 https://mcusercontent.com/131dd5573d6b0ee4551cef947/files/7fd16ecc-44d3-4fb0-bec0-cf5468fb6390/Final_Report_Housing_and_Home_19th_February_2020.pdf

Policy Reports

About Dementia (2020) *Locked Down but not Forgotten: Covid-19 Impacts and Survey Findings.* Available at: https://www.ageuk.org.uk/globalassets/age-scotland/documents/age-scotland-projects/about-dementia/locked-down-but-not-forgotten-about-dementia-report-sept-19.pdf

About Dementia (2020) Response to Scottish Parliament COVID-19 Committee Call for Evidence, May 2020
https://www.parliament.scot/General%20Documents/About_Dementia.pdf

Action On Care

A caring future

Creating a framework for supporting and enabling a personal centred approach to care

A submission to the
Feeley Review on Adult Social Care
by Action on Care

Introduction - Last Chance Saloon

Care professionals welcome that there is a review and acknowledgement that the care system needs an overhaul. Many remain wary and some even sceptical of yet another review process. Common questions include
What happened about the last one?
Did they follow through and implement the recommendations made before?
Is anyone listening this time?
How long is the wait for the implementation of the outcome of this review?

The Care Staffing Act 2019 was the last review proposing to make improvements. This following on from the tradition of at least four previous attempts in the past fifty years to introduce a staffing model that could work. Delays to the implementation and confidence that a bespoke model be developed, specific to each care setting remains a challenge.

A key success of this review avoiding the perception of being another report gathering dust on a shelf. To prevent this happening the review panel has to consider, recognise and resonate with grassroot staff who provide care 24/7, weekdays and weekends. To be different there must be recognition and inclusion to recommend a framework including looking at employer/employee relations. To exclude this would be to simply 'changing the facial make up' or 'rearranging the deck chairs on the Titanic. This review is an important opportunity to make a difference with many recommendations being made not involving cost and those that do, should be seen as an investment.

It's not clear what a National Care Service would do differently or how it would work with the current regulatory framework.

What is clear is that the current silo approach of independent regulators working in isolation with different, contradictory or conflicting approaches is not fit for purpose. Reformed is needed before there is another major incident. The Christie Commission highlighted the benefits and savings of preventive approach in terms of costs and resources. This needs to be brought back and embraced. The alternative is lurching from crisis to crisis with unnecessary and unplanned cost implications.

Care professionals are at breaking point, the covid pandemic has pushed them to limits they didnt imagine possible. Those who do have confidence are hoping that this review brings hope and is a light at the end of the tunnel. There will be catastrophic damage to confidence if this review is seen to fail for the viability of the sector and with the retention of staff.

If this latest review is to have any credibility by making significant change it needs to act on the elephant in the room – how the employer/employee relationship preventing the delivery of quality person centred care.

Action on Care submission

Action on Care was established to raise awareness of the challenges, contradictions, conflicts and compromises faced on a daily basis, by those attempting to deliver quality care. This submission is to give voice to those who should be listened to and properly consulted on the impact of changes on their ability and working conditions to deliver personalised focussed care.

All around the nation, tens of thousands of care professionals with the biggest heart want just to deliver quality care to those they are entrusted to look after. They are prevented from being able to achieve the best care because of systems, policies, protocols, contracts as well and poor support and training. For too long their voice has been marginalised, ignored, discounted or discredited.

Many in the profession wont contribute to another review, they have given up hope anyone is listening or have been so ground down that they believe raising a concern will create rather than resolve problems for them. It's understandable that there is 'report fatigue' when the problems highlighted in Winterbourne and North Staffordshire have not been resolved. Ideally there would have been time to have resources to develop long term studies. Given the limited notice of the review this has not been possible. Its submission is based on the observational experience of daily working of over 2,000 care professionals in over 170 care settings. The care sector attracts a significant percentage of protected characteristic groups under the Equality Act 2010. This submission has tried to be as inclusive and diverse as possible - women, LGBTQ, BAME, those with disabilities, religious and ethnic groups. Examples are real life experiences to give the review panel a realistic insight and understanding of the challenges facing grassroot delivery of person-centred care.

Action on care welcomes the opportunity to contribute to create a practical and realistic framework. The aim has been to improve the quality and consistency of good care without any significant cost but will require a significant change of mindset.

The toughest challenge on society is that there will be an increase in demand for care service not less. Some predict a doubling of need within a two decades. There must be a genuine open informed dialogue in society what standard of service is expected and how it would be resourced.

Section A - Strategic Governance issues

A.1 Do we need a National Care Service?

It is welcome that the Scottish Government doesn't have a preconceived ideological position. However, trying to develop an accurate submission with an unknown beastie in the dark potentially around the corner presents a challenge.

There is previous evidence and examples that can be used to help shape a clearer picture of what is needed if this latest review is to work. Historically, over 30 years ago most care provision was in the public sector some may say with an institutional and regimented service centred approach. Society and successive Governments have moved a long way, with the explosion of provision in the independent sector. Some say we shouldnt have an independent sector just public sector. This is idealistic, we need to look at the reality, the independent sector has twice the population of the NHS with only half the cost. If we are to have fully public service would taxpayers be prepared to fund it? Evidence in England where the UK Government has allowed modest additional visible local taxation to provide for social care, there is resentment. Another example of public sector intervention in an increasingly complicated care provision sector is the Personal care package around 15 years ago. This was one of those idealistic concepts, that there was a sense of equality for all. Not enough attention was given to the consequences. Practical implications and costs the type and awarding of contracts had an impact. Then came austerity and the realisation of becoming a real financial burden, attempts are made to cut costs. This has been through tougher assessments for more expensive continence needs with the cheaper quality products that leak. Arbitrary decisions that only two or three are allowed per shift are not person but service focussed. The current products being used, in many cases, are not fit for purpose in effect resulting in effect of state sponsored abuse. Beds and clothing unnecessarily becoming wet interrupting sleep during the night and embarrassment during the day. This cannot be right nor allowed to continue. There is no grassroot feedback channel which means the purchasers have no idea how bad the products are and waste of taxpayer resources.

There must be an acceptance of three principles to acknowledge the current situation to move forward:

- The Care system is not achieving its potential
- Care system is failing
- Care system is not sustainable

The implications of this failure on society financially, mentally and resources is massive and needs to be acknowledged and the importance and value of developing a preventative intervention approach.

A.2 The impact of the Covid Pandemic on the Care Sector

A.2.1 Breaking point -Many commentators have already expressed the care sector was close to crisis point. What it didnt need was another bad flu season or norovirus outbreak to push it over the edge. Instead it was hit a hard blow in the form of the covid pandemic exposing the best and worst aspects of care. It confirmed the special resources we have in care - tens of thousands of dedicated and committed staff providing quality care in adverse conditions, with staff shortages not being replaced, well known and liked members of the resident family being lost in significant numbers over a short period of time, holiday approval being denied for six months in some cases.

A.2.2 Staff felt abandoned some describing it as being orphaned with no senior management, care regulators or families assisting, monitoring and being visibly present to support staff to deliver quality care. It was lonely, hard and fearful atmosphere, with a clear and present threat their care facility could be next hit. As time went on this left staff exposed to a lottery of home management leadership often erratic, illogical decision making, not explained well, resulting in additional work loads and stress. If the rationale is not explained and appropriate training offered, then the task is done half-heartedly competing with others demands.

A.2.3 NHS v care sector attention There was quite rightly attention drawn on the NHS staff working in challenging times. Care facilities staff often felt ignored or devalued or taken for granted. Many offers were made just for NHS staff, special shop opening times, special offers and treats. Many found it difficult or denied access at special times. NHS staff had overtime special enhanced rates and support. This was very upsetting to staff feeling like second class citizens or lower priority.

A.2.4 Care staff felt frightened of the consequences if they were to fall ill. Some admitted to hospital as a result of work relating exposure health finding they were without financial support apart from basic SSP. Many were forced to return whether they were full recovered from fatigue as they couldnt afford the loss of wages. Staff so became aware that if the had the test and protect app and were told to self-isolate employers stated they would not support or cover this sickness. Most care staff will not install the test and protect app and some even tell visiting families to put their location off to thwart the app.

The mental stress and fatigue of care professional of this pandemic and relentless was is having a corrosive effect on staff. Some openly state that when the pandemic is over is there is an opportunity to leave care then they will.

Recommendation – proactive physical and mental support for staff should be a requirement
Failing to address stress points harms the ability of the care professional to be at their optimum to deliver quality care. Helplines should be offered and recommended. Staff surgeries and meetings should be measured, and legitimate concerns logged in an online record with a reference.

A.2.5 Scottish Government support for living wage for care home staff was a welcome recognition and their continued support despite Westminster tax changes is also welcome. The announcement that care staff would receive £500 Christmas thank you was a welcome moral booster. Many have still to receive it and are unlikely before Christmas. It is also not clear who qualifies and who does not as it appears that if you were hit by covid or were agency, bank or part time may not qualify. Clarity would be welcome. The recognition of care professional has caused a divide that other support staff such as domestic, maintenance, admin and kitchen staff don't feel their contribution is valued.

Recommendation – Care facilities should become living wage employers
There is a strong argument that all staff in care facilities should be living wage. All care facilities should be living wage employers and have the sign on the door to build confidence with families, relatives and visitors

A.2.6 PPE It is well documented in the media how unprepared care facilities were to deal with a pandemic or major outbreak. With stocks that were being held for Brexit were inaccessible, out of date or overpriced. Fortunately, Governments stepped in to assist and the situation although better is not perfect.

Recommendation - PPE availability
All providers should be required to obtain staff sizes for PPE using templates such as the one developed by Scottish Care. Management must be required to proactively demonstrate that they are obtaining a range of sizes to meet the demand on staff. Simply providing medium gloves for example when extra large, large and small are need is not acceptable.

A.2.7 Staff sickness during the pandemic Many non-public care facilities do not offer paid sick leave. That means if you are off sick you simply have no income. Many have no option but to come in when they are unwell endangering themselves and those they care for.

Case example - Staff developing covid 19
I landed up with covid when a resident sneezed in my face. He was dead a week later and I was in hospital. I was off work for three months with fatigue after. I needed counselling and support. Family and friends were saying I was irresponsible wanting to return to care and risking another infection. I had no choice I had no income, mortgage holiday coming to an end and I loved my job

A.2.8 Testing It was welcome that care facilities were supported to test their staff on a regular basis. The length of delays sometimes up to a week getting results was unacceptable increasing the risk and

fatalities. The current death toll is care homes is nearly 12,000. More should and could have been avoided to minimise the risk.

Although many care facilities were covered and supported under the test inspectorate many were not for example agency staff who were having to make their own arrangements as there was no requirement on their employers to have a duty of care to their staff.

Recommendation - testing and support
All Care facilities and employers should have a duty of care to provide testing for their staff. The results should be received with 24-36 hours as standard to ensure management have an opportunity to minimise risk

A.3 Individual Human rights v State

Scottish Care and others have done some excellent work highlighting the need for respect, dignity and human rights of those in care, this is to be commended. With the arrival of the pandemic the dignity, respect, human rights seem to have been the first to have been thrown overboard. The manner and implementation of stopping family and relative contact with resident needs to be reviewed by EHRC and recommendations made. Effectively making resident prisoners or interned in their rooms may have questionably saved lives however the mental and stress caused to residents, relatives and their families may never be fully known.

Case Study - The isolation of resident
When I fought for the freedom for this country and was interned by the Japanese I fear my dying days will be spent under curfew and when I am allowed to see my family, I know what that means I am on way out I dont know if I will see them again before my time is up.

Recommendation - Get the balance right
There must be a way found to balance the needs to protect and respect the human rights of the individual to be allowed to see their family with realistic measures that do not have a prison feel or perception.

A.4 Health and Safety in Care

You would expect in the care sector that everyone should be cared and looked after in the best possible way. I believe TUC and HSE studies have expressed concern that the care sector is one

of the most dangerous working environments. Staff can often overlook their own safety being compromised to try and protect those in their care.

Care Dilemma - the lift doesnt work
Care professionals are expected by management to carry resident up and down stairs in a wheelchair as the lift is out of order. Should they decline? Carry out the instruction risking falling on the stairs carrying a load inappropriately? Should they leave the resident where they are overnight and home the situation improves the next day?

Care Dilemma - Resident at risk of pressure sore
Service users who require regular turning to minimise pressure sores are not always provided with personalised slide sheets to minimise the risk of injury. Should the care professional use another resident equipment risking cross contamination? Do they use the bed sheet as a slide sheet risking sheering forces? Do they not turn them at all?

Care Dilemma - lack of personal care provisions
Care professional feel let down when personal care resources are not available preventing adequate personal care being given. Who is responsible or accountable the care professional or management when pressure sore develop?

Care Dilemma – recording personal injuries at work
Care providers both public and independent don't have a culture of encouraging proactive reporting or support for care professionals. Staff feel intimidated or made to feel stupid if they want to have an accident or injury recorded. If they dont this could have implications should they require DWP/DSS support in the future as a result of the incident. If they do record the incident they fear they could be disciplined or trigger the home to be under investigation. Many employers no longer have accessible accident reporting book but use portals that management complete a record which may not be correct.

Care Dilemma – working with staff shortages
I was informed that to save money the ground floor would be left unstaffed. The fire doors would be left open between first and second floor to listen for noises and personal alarms on the unstaffed floor. I found the idea of being confronted with such a situation was causing me distress. I had a meeting with the manager who refused to

change her decision or understand the compromise in health and safety. I decided the best thing to do was leave immediately the job I loved doing for over a decade.

There are numerous other examples that could be highlighted which will hopefully be explored and resolved during this review.
-Care facility where a spring loaded bathroom door took of a care professionals finger. Door still in use waiting for next victim
-Lift door broken or sensors not working
-broken lift door still being used for residents transport
-use of black bags rather than yellow bags to reduce cost of clinical waste collection
-As will be discussed there is not a proactive culture of Accident/incident reporting
-Many don't record or monitor controlled falls.
-most care professionals can be verbally or physical assaulted 200 times a year. There is no competent recording mechanism to deal with this volume of routine assaults.

A.5 The continuation of ineffective, fragmented, out of date legislation for the governance of care is untenable.

There is some excellent personal in care regulation who want to make a difference and improve processes quickly. They soon find they are restricted by a straight jacket legislative framework, preventing them from designing and implementing a regulation method fit for purpose. This means ineffective and out of date legislation for the governance of the guardians of regulators such as SSSC, Care Inspectorate, Adult protection, Environmental health, fire service. Care professionals know that this is the case and undermines confidence in reporting if there is no evidence of a change only grief for the person whistleblowing.

Care Dilemma experience of whistleblowing
I noticed systemic abuse in a care home, I reported it to my agency they didnt appear to report it to adult protection but continued to send other care staff knowing that they were jeopardising their registration. This was wrong after realising this abuse was continuing after a year I reported it to Care Inspectorate. I was worried they wouldnt take my concern seriously the Saville principle who would listen to people at the bottom? Sadly as reported widely often the person whistleblowing always comes of worse.

A.5.1 SSSC was set up for a particular role, like Lego bricks had new blocks added on without a review whether the structure is fit for purpose. Sadly, it is not as it is too focussed on social work

aspect rather than delivery of care. SSSC staff are people with good intentions but aloof from reality. An example was the belief by assisting with duty support would improve attendance at hearings. There was a clear lack of understand that care professionals need support with the implications of registration at an earlier stage. Remote hearing during the pandemic have helped the hope is this will continue as it reduces stress levels, cost and unnecessary travel to Dundee.

A consultation on review of disciplinary process resulting in 18 responses of which 2 were organisational. It's not connecting with registrants as the importance of making a submission. Promotional posters showing a registrant apparently twisting their back over an elderly person with a cup of tea undermines confidence that the SSSC understands its role, when moving and positioning should be better on posters in the work place. The open badge is of high quality concept another great example which is not connecting with care professionals. Although SSSC believes it independently assesses whether action should be taken by registrant in many cases it does not. The management of the facility are in control whether action is taken or not against an individual. They also supply the evidence often incomplete or clearly biased reporting to leverage action. Many examples of management using the threat of the SSSC to silence legitimate concerns being raised.

Recommendation - Enforce or scrap the SSSC Employers code	
The SSSC has two codes the employees code which is used around 1,000 times a year and an employers code which following a recent FOI does not appeared to have been enforced in 20 years. This sends a wrong message to care professionals that they will be held to account but employers will not. It would be helpful for the review to look whether the employers code should be enforced or scrapped.	

Recommendation - fragmentating regulation needs to change as it does work nor give the leverage it should
The SSSC is not appearing effective or fair as a regulator. Having a broken circle as a logo and SS highlighted in bold does not present an image of a good regime. The SSSC need to either merge with the Care Inspectorate under a new Care Regulator for Scotland or merge with HCPC to form HCPC Scotland

A.5.2 Care Inspectorate is an inaccurate description. Suggesting it looks at all areas of care when it doesn't. A more accurate title or description should be "Aspects of Care Inspectorate"

Grading of care facilities it is acknowledged creates a service focussed approach preventing personalised focussed care. Not having a scientific approach to investigation means that inspections are dependent on favourite topics of inspectors
Personalised grading for residents is needed to ensure a more professional scientific approach and refocus on person centred care.

Care example - Under staffing
When a facility was understaffed by four members of staff for a several days this was reported to the Care Inspectorate. Although they came out, they did not have the investigative skills to realise that management had included kitchen and domestic staff on the rota to give the appearance staff levels were normal. What is the point of reporting if legitimate concerns do not appear to be taken seriously or investigated properly?

Case example - unannounced visits
It was always a mystery understanding how management seem to inform staff that there will be an announced visit next Monday. When the Care Inspectorate was phoned, they denied they were coming out on the Monday or that month. When the person returned after their days off, they found out they had been in Tuesday to Thursday so unable to discuss with them their concerns.

Case example - Inspectors favourite topics
Many feel that care inspectors have their pet topics that they will look at. This is fine and staff get used to that. The problem and issues arises after a period of time when there is a new inspector appointed and they have their own new pet topics. There doesnt seem to be any consistency or continuity.

A.5.3 Care standards - Excellent example of a unifying concept to help bring together a common set of relatable and recognisable standards. This should be acknowledged as an excellent example however something can be applied across silo-based regulation. There is one huge flaw to the agreed outcomes that health and safety is not covered. Although this was raised at the consultation process no action was taken to include the residents health and safety. The assumption is the same reason given at the Care Staffing Bill Committee stage that it is a reserved matter.

Recommendation - to replace service with personalised focussed assessments
The current service grading approach should be abolished replaced by a personalised care school report model for the five standards. All care professionals providing care would be encouraged to complete online reports for each resident encouraging and inclusive approach of self-assessment, self-evaluation and reflection. The grading for a facility is based on the sum of the results of the residents

A.5.4 Environmental health/ Public Health Scotland not proactive availability or accessibility to give advice. Care staff expected to serve food and just expected to muck in not clear if there is food poisoning or health outbreak in practical terms who is accountable and how.

A.5.5 Fire service were excellent after Rose Park and Douglas View incidents. However no doubt in recent years to financial cuts the level of service appears to be retracting not available obviously accessible to deal with grassroot queries. Increasing number of night staff expected to do laundry. This means that the biggest fire risk to a home is in use with minimum staffing numbers. Machines being left unattended and fire doors left open. No training what to do in a fire specifically in laundry. This needs to be addressed. Care facilities seeing fire service arriving rush to close propped open rooms.

The abstract nature of care regulation was highlighted by the apparent requirement to put PPE stations around care facilities. This in reality, meant plastic flammable drawer cabinet with plastic PPE equipment were put as obstacles in a fire corridor. In the event of a fire in as short a time as 90 secs that fire access route could be filled with smoke increasing risk of smoke inhalation. Its not clear whether Fire Scotland was aware consulted or approved this decision.

Care dilemma – Fire safety
Previously when a fire door was hanging off the hinges action was taken by care provider to rectify the fault immediately. More recently a similar door was broken for around a year. This meant in the event of an incident, the fire corridor was compromised, and evacuation would be needed vertically as the horizontal option was not viable with a broken fire door. Presumably pre-pandemic fire service was attending twice a year and should have noticed it. When a care inspection team were visiting a home, the fire alarm test was carried out the fire door didnt close. Although this was pointed out the inspection team there was no indication that they would share the information with the fire service.

A.5.6 COSLA -Welcome COSLA involvement in the review. The reality is questions need to asked who should be responsible for funding care? Who should be responsible for using the leverage of this influence? Should this leverage and opportunity be properly utilised? COSLA is responsible for the contract with care providers. The new national care home contract created an opportunity for a better model in the delivery of care and working conditions for those required to deliver the care. The reluctance of COSLA to proactively engage involve and include grassroot workforce was a mistake. It may fail to ensure taxpayers monies are used in the most effective and appropriate way as an enabling tool. The use of the financial leverage to promote better care and to stem the flow of retention, continuity of staff and care appears missed. Their reluctance to be inclusive, engage and involve grassroot staff to eliminate stress and retention issues is of concern.

Section B Practical Challenges to the delivery of personalised centred care

Ignore the elephant in the room at your peril

Any review cannot simply look at the hands expected to deliver care but the whole person the care professional expected to deliver person centred care. Seven days a week 24 hours a days there are tens of thousands of care professionals working trying to deliver quality person centred approach but are hindered by obstacles. Without acknowledging or removing those obstacles means those receiving care will never achieve their full potential preventing taxpayers getting the best value of limited resources. This is wrong.

B.1 Pay –

Care is a highly skilled demanding and challenging role. It is one of the most dangerous professions that can have profound effects on your life if you get the balance wrong. For such a skilled role it is poorly paid and undervalued.

Recommendation – Fairness in care through harmonisation
There needs to be harmonisation of pay, conditions and career opportunities between the public, independent and community settings to readdress this balance.

B.1.1 Unpaid 'compulsory' overtime – Many staff face the need to do unpaid or in effect voluntary work with their role. This is wrong and needs to be stopped.
- most important start to a shift is the handover to ensure continuity of care. Many employers simply expect staff to attend a briefing in their own time. Staff need to be paid for handover time.

Recommendation – Handover time must be paid
Handover time is important for ensuring the health, safety and well being of residents. This cannot continue to be done as voluntary time and must be paid

- many are expected to stay on after their shift it's not clear if they are supervised or insured. This needs to be clarified so that they know if they are injured whether they could be blamed as being unsupervised or uninsured.

B.1.2 Unpaid working breaks – increasingly there are reports if there is no structure to breaks then breaks don't happen. Care professionals are unable to take their unpaid breaks as

staff are short, they feel guilty about leaving a colleague alone or have their breaks interrupted or shortened as a result of an incident. Although breaks maybe unpaid there are often conditions imposed for example they cant leave the building, use their mobile or have a power nap to improve their effectiveness. I

Recommendation - Structured breaks and paid if conditions apply
Management need to proactively ensure staff have breaks. 12 hour shift without a break is dangerous and an accident waiting to happen. Where there are any conditions or loss of a break then this must be accompanied with pay

B.1.3 Unpaid for attending training – Care professionals must either attend training and meetings in their own time, face complicated process to try and reclaim pay. Much training is now online and the is a spectrum of quality and relevance. A fragmented approach is not fit for purpose and prevents national messages and retraining getting out quickly embedding change quickly.

Recommendation - a national joined up training must be developed
This is the only way to ensure consistency and continuity across the care sector and eliminating unsafe practices

B.1.4 Rotas and annual leave approval -

- Some only give two- or three-days notice of their shift and are unable to plan a life and get a right work life balance.
- Staff face constant phone calls on days off. Some report feeling bullied, threatened or obliged to come in on their days off.
- The use of social media such as WhatsApp or Facebook platforms means messages are received on days and time off. This means they are effectively surrounded my work 24/7.
- Many staff face challenges to book holiday, finding booking forms, getting approval quickly.
- Some report after being constantly refused holidays they then lose their paid holiday time at the end of the holiday year cycle
- some report issues with cancellation of approved holidays or changes to shifts without notification

Recommendation - a sector standard expectation
This would highlight and prevent unnecessary anxiety and stress caused by bad employers publishing rotas at the last moment, or not approving leave within a reasonable time frame.

B.2 Infection control

B.2.1 Infection control standards -What became clear during the pandemic was that poor understanding of the significance and implementation of good infection control measures exaggerated the devastation of infections and fatalities in care home. Some of the early care facilities badly affected were not a surprise to some as they had poor infection control measures and resources. Compounded with a lack of staff education compounded the spread and impact of covid one of the sadness stories were care facilities that managed to keep covid out during the first wave were unprepared for the devastation and impact of the second wave.

Recommendation - Public health bodies need to provide consistent and clear advice and education on the rationale of good infection control measures
This is to minimise infections and fatalities. We need to ensure that the 12,000 that died in care facilities was not in vain and that lessons are being learnt

B.2.2 Infection control protocols -There is a spectrum of methodology for laundry and infection control measure across the sector. The standard and quality of PPE is questionable in some care facilities. Thin aprons, headless aprons, six or four fingered are not uncommon compromising infection control measures

-Different laundry mechanisms some use red bags for soiled or urine contaminated laundry others dont
-Some have laundry staff other expect nightshift to use washing machines at night in between care duties.
-Very few staff have specific training want to do in an emergency in the laundry-Not clear information or resources on which equipment for example coloured buckets for which areas Proper use of yellow, blue green or red coloured equipment is often not clear or understood.

B.2.3 Recognition of the impact of clothing on resident wellbeing -It would appear many care facilities appear to have a laundry monster gobbling up resident closes causing distress when they cant be found and disappear. No body seems to have any idea what missing clothes or any kind of log on the scale of the issue. Various providers have a spectrum of marking clothes which may or may not help reduce the problem. Resident are often upset when their favourite closes disappear or are thrown on the floor when assisted in getting changed

Recommendation -Measures need to be taken recognising the key component to the well-being of residents

Proper staff training should be given, timing and safe of laundry times need to be considered as well as the safe handling of soiled material

B.3 Representation –

No representation allowed at early stages of disciplinary process. Those in care professional as well as society expect a fair opportunity to defend themselves and be represented. There is no legal requirement for this in care this has catastrophic consequences. Many are invited to hearing after or during a shift with no warning, notification or in writing in advance. This means that care professionals are often caught off guard try and speculate or incriminating themselves unintentionally resulting in the matter being referred for disciplinary process. This is wrong and undermining confidence in justice resulting in retention problems

Case example – Leave before your set up
I knew I would get the blame if something went wrong and wouldnt get a fair hearing so I left before

Case example - no representation at investigatory hearings
During an investigatory hearing the manager said I did something. I had no recollection of her version however she is the manager and must be right. I was told I had to sign the minutes before I left whether I thought they were accurate or not. I regret not being able to get advice or representation as I would have got a fairer hearing.

Recommendation - Staff deserve a fair hearing at all stages of investigation
Through the COSLA contract providers should be required to allow care professionals representation to ensure a fair hearing. It is unjust in some cases with poor investigation techniques staff are finding themselves in disciplinary hearings and possible sanctions by regulators. This approach has worked well for supermarkets reducing costs, speedier resolutions and retention of good staff.

B.4 Noise pollution

Noise disturbs residents sleeps. Some noisy extractors, air flow mattresses that sound like the Hindenburg airship and other technical humming noises.

B.4.1 Buzzers – Noisy buzzers system that sound like air raid sirens, police cars or V2 bombs dont help promote sleep at night and cause alarm during the daytime.

B.4.2 Noisy squeaking and banging doors -It seems almost obvious that opening a squeaky door, or fire door hinge with a shotgun noise is going to disturb or unsettle a resident. The question has to be asked is it acceptable to the public making an entrance entering a room disturbing someone sleep? It seems a generic inherent fault that it is seen to be acceptable.

B.4.3 Inappropriate conversations – Inappropriate conversations by staff about other staff, residents, management contribute to anxiety of resident being attended nor promote restful sleep.

B.5 Light pollution

B.5.1 Lighting in personal room –Hospital lighting is not appropriate in a care facility where a more homely tone is required in recognition that this maybe their new home for a while. Softer light options especially at night should be a requirement to ensure minimal disruption and better sleeping patterns

B.5.2 Corridor lighting – Again hospital style bright lighting is not desirable for a homely environment more pleasant homely light feeling should be used. They should be able to be turned down at night to avoid sunrise moments on night checks.

B.5.3 Living space lighting – some newly built homes have embraced the concept of better living space.

B.6 Diet, Fluids and Health

Many are surprised to learn that although weekly cost can be often be £1-2k per week. The food budget for residents is rarely above £4 per day. Some care providers take time to ensure they have a well-developed, appetising menu choices that inspire good appetites. Some the choices are basic others make bad choices such as a hot chicken vindaloo to a generation to familiar or comfortable eating diversity food which maybe spicy.

Many kitchen staff are barely above minimum wage often below carers rates however with huge responsibilities and legal accountability.

Recommendation – recognition of the vital role of kitchen staff
Better recognition of the value and importance of good quality kitchen staff

It's been reported that over a ten year period around 10,000 people died of dehydration in a care or hospital facility. This is wrong and should not be taking place in a care environment. The correct use and storage of thickener is essential to minimise risk of swallowing difficulties and possible choking.

Recommendation - Introduction of algorithmic monitoring of dietary needs
There needs to be better diligence of the monitoring of food and fluid intake to ensure residents are properly fed and hydrated.

B.7 Staffing levels

B7.1 The management of Denursification - Its clear almost like the dash for gas a decade ago there appear to momentum from a process of denursification. This is not only about cost reduction but about the level of influence in the management of care. This unmanaged uncoordinated rush may help reduce the nurse shortages of the future as significant demographics numbers reach retirement age.
The leverage, professional training and experience of nurses in the management of care cannot simply be replaced by a healthcare assistant without a compromise in standard of care resulting in poorer outcomes in person centred care.

Recommendation - Proper management of denursification
If a decision is made to replace a nurse with a healthcare worker there needs to be an algorithmic matrix of this risks involved and how this should be managed safely. There is evidence emerging that residents are more likely to have an accident or poorer outcomes when nursing management and supervision is removed.

B.7.2 Staffing models - Over the past 50 years there have been numerous models and attempts to address the imbalance in workload that often occurs.
Many of these fail as there is not a centralised approach or tool that is flexible enough to take into account a specific daily or changing units needs.
A simple model that could be applied across the board was disregarded by NICE some time ago. "No single model can be applied across a range of facilities"
The situation can't be left on the hope that somehow it will "self-autocorrect". There is clear evidence that getting staffing numbers and skills mix can have a profound impact on the quality of care being offered Griffith's 2010 highlighted DVT, pressure ulceration, falls and infections similar reports by RCN 2010 and Unison in 2015 also highlighted the dangers.

Recommendation - Localised bespoke tool matrix should be developed to ensure right staff number with a balance of skills mix
Staffing is not and should not just be about numbers but ensuring a complete package of staff skills

B.8 Care at home

Whereas care professionals in care facilities can quickly seek assistance or help those working in community often work alone. Lone working face enormous challenges and have to the ability to multitask as they don't have any back up or support nearby without causing challenges

They often have an impossible time allocation sometimes 15 mins to get up wash, dress feed and medicate. The question has to be asked is how many people can manage that in their own daily lives why then expect care professionals to do something that we would consider acceptable in our own lives?

Monitoring of medical wounds, sores and medications also requires care and support. Realistic times should be given if person centred rather than service focussed care is preferred.

B.9 Personal Care

B.9.1 Teeth and Toes No system of cleaning teeth smiles training not accessible or wide enough and having to teach those providing care to care for themselves
Toe nails and finger nails no algorithm process to look after nail care.

Case study - Mum had beautiful white teeth
One thing I noticed when my mum went into a care home was that her beautiful white teeth. I was shocked how quickly they turned yellow they appear to have smiles charts that are ticked but I find it difficult to believe care staff have the time in their bust schedules to properly look after teeth

Case study -Scratched by a resident
I was scratched by a resident her nails were so long and needed trimming but I was told its not our job.

B.9.2-Assistance with Personal care It quite clear there appear to be a wide spectrum of interpretation what is acceptable as personal care and its significance to minimise pressure sore development
-Some use water and soap
-Some use facecloths
-Some use foam sprays
-Some use moist wipes designed for hand cleaning
-Some don't use anything moist only dry wiper roll which can have abrasive qualities similar to sandpaper.

B.9.3- development of expertise by experience of contact with resident For many care professionals the residents in their care become an extension of their family. They develop an understand of likes and dislikes. Agency or bank staff often introduce a fresh set of eyes and approaches that should also be utilised.
Often their knowledge, experience and observation is often dismissed or devalued as insignificant. These skills, familiar face can help encourage better relations well being and confidence. Sadly, there are often no ways to record or recognise this especially in the prevention of falls

B.9.4 Continence products – warning from history. The continence products contract needs to serve as a warning to the review panel of badly though through state intervention that can undermine the good will and work that existed prior to intervention.
Many residents in need of continence products
-are wrongly assessed,
-receive an inadequate supply
-run out before the new month stock arrive
-face bad distribution and storage
-poor quality product that are not fit for purpose,
-badly designed
-leak
- cause unnecessary distress and embarrassment due to wet bed or clothing
- no visible feedback or quality control monitoring
-care professional are embarrassed at the state sponsored abuse that they feel powerless to improve the situation.

Some estates with a vision have been successful in adapting. Some remain challenge with large lounges with 40 residents in one space. This can be threatening to some residents who may have been accustomed to live on their own or their own space.

B.10 Challenges to the future funding of care

Care dilemma – funding
Person R was out in Glasgow and was hit on the back of the head and suffered a clot resulting in a stroke. He requires 24 care facility support may cost £1k a week for 21 year years would cost £1 million.

Recommendation - Ring fenced funding for activities
Despite typical costs of £1-2k per week for care places there does not appear an identifiable requirement to provide or fund meaningful activities relevant for a centre centred approach. Often an activities budget is based on staff and families fund raising. This is hard work and draining. Where external funds are identified many care providers block applications

Case study grassroot project rejection
The care home lacked enough space for activities. I identified a windfarm funding source to build a outdoor activity room in the gardens. The project of £30,000 was fully funded and they only input from the home financially was £500 for metal ramp. This would mean residents had a space for activities, staff had a training space and we could have a community space to enable community contact with family and local clubs. Despite the benefits and 200 voluntary time the care provider said know as it would be complicated to explain to the landlord.

Case study - Living wage care employer
It was excellent the Scottish Government provided funding for carers to be paid the living wage however it caused a divide with support staff domestic, kitchen, admin and maintenance staff. What a better position it would be for the Government support all care facilities to be living wage employer. The Scottish Government said that it was through COSLA however were prepared to offer £50k to support the idea. The concept would be self-sustaining by more greener methods of heating. Sadly, the employer rejected the idea as they didn’ t want to approach the landlord with the idea.

B.11 Lack of accountable or meaningful training and resources

B11.1 Induction training - There is a wide spectrum of training for new entrants to the care. Common practice is two days shadowing supernumery before become a number pn the third day. Quite often in a unit of 20 residents there are 2000 facts to learn about residents preferences and protocols. Quite often there is little written reference material which means the new entrant is dependent on the habits and skills of the person they are shadow which may or may not have developed good practice. Poor training leads to poor performance and weak confidence.

B11.2 National training strategy - There is a need to pool resources and develop a competent national training framework that encourages ongoing further develop of skills overtime. This is the best way to develop and maintain common good practice and eliminate unsafe techniques such as moving and positioning Sadly many care professional are not presented training as a skill development but rather as a chore to be completed as soon as possible.
Holistic approach to training regardless of NHS, private, charity or community
Moving and positioning practical needs to be done every six months to stop dangerous practices such as Australian hold being used.

B12 Conflict resolution

Care is dependent on personalities not professionalism. Those wanting to developer quality care that is right are often thwarted if they cannot confront and deal with bullying individuals and processes. This is extremely damaging demotivating and resulting in unnecessary loss of good quality staff unable to cope with their own value system of care being compromised
One of the toughest challenges is care is conflict resolution. Bad communication or misunderstandings can result poor rapport with residents. If there is conflict with colleagues this causes stressful working relations and can affect the delivery of care. If the conflict is about the methodology of task there needs to support and encouragement to seek information for a resolution. If the conflict is left to fester
-this can undermine care with the resident
-damage a working relationship with colleagues
-cause stress if there is no management resolution
-may cause problems with retention of staff

Conflict is one of the most corrosive issues in care that affects residents, staff and the management of good care, pathways need to be developed to support conflict resolution.

Section C - Simple solutions through mindset rather than monetary changes

C.1 Creation of the Care Regulator for Scotland
From observational evidence the creation of a national care service without looking at the employee/employer relations framework will be limited. If the Review does not recommend the devolving of health and safety and other reserved functions will be a missed opportunity. We need a clearly identifiable office to have holistic governance for care. Just like you have Office of the Public Guardian there should be the Care Regulator for Scotland. This should not be a social work role but a skill set with knowledge and understanding of personal care and the challenges. Whether this be an individual holder or an office should be determined by dialogue with those supposed to provide umbrella governance.

C.2 Local Facility Governance Panels
Each care facilities needs a 'governance panel' whether it be a board of governors, care council, care panel can be looked at and discussed. This has been the only thing lacking from all models. There needs local knowledge and understanding of the layout, demand, skills mix to ensure that there is consistent, stable good quality staff. This is the best way of embedding and monitoring effectively at a local level the implementation and enablement of good standards at a low cost.

A new admission, change in behaviour of just one resident can make a huge impact of quality of care provided and morale of the team. On resident using their personal call alarm five times an hour for a twelve hour shift requires a significant amount of mental capacity of the team Abusive, difficult or challenging residents that scratch, punch or bite will have an impact on the quality of their care as staff are already on their guard and want to spend minimum time possible in a challenging or threatening environment when there is real fear of assault injury or personal harm.

Having a governance panel with relatives, management, staff and other NHS local authority and community partners is the only way of counter acting a manager or leadership style not open to scrutiny or justification for erratic judgements which can have a devastating impact on morale and retention.

C.3 Development of a Care monitoring matrix
A matrix can and should be developed to monitor care remotely. An algorithmic programme can be developed electronically that can monitor Falls, near falls, controlled falls, assaults of staff. Staff PIN

would be transfer to a new location with them any areas of concern and improvement and staff supported and nurtured rather than punished

C.4 National Training programme for continuity
Care professionals deserve quality, consistent and relevant training with developing the practical skills needed for demanding high skill role to deliver quality care this can most cost effectively be achieved through a national training programme from induction to specialities must be developed to ensure a consistent transferrable message in care

When employers are left to develop their own training programme sadly their is a spectrum on the quality, relevance and support it provides to staff. Some utilise the opportunity well to provide excellent practical support and resources. Sadly a significant number see the training as 'legal cover' to absolve themselves from blame if something goes wrong. Many staff are left confused as their training says they should do one thing when the reality is different. Other countries have learnt quickly from the pandemic to a national standard rather than the current fragmented approach to training by NHS, public bodies, charity and Independent providers.

Care Dilemma - Moving and Positioning
Moving residents in a full body hoist should their arms be in or out of the sling? The leg straps of hoists should they be crossed over or not?

C5 Funding support for all ages wanting to work and develop their skills in care
The Scottish Government supported funding for under 25 to complete SVQ2 and SVQ3 training Whereas this was welcome to improve opportunities and reduce youth unemployment. It has however created a discrepancy that those over 25 with life skills can get training support and leave. Funding should be made for all ages in care to avoid discrimination and disillusionment

C6 A career pathway to retain staff in care
A career pathway to stay in care including HND/Degree in Care as well as Masters in Care promote the sharing and development of the effectiveness of care.

C7 Care reward badges - Rewarding continuous training
Care is currently not based on professionalism but personalities. To change the balance to make it more professionally based and retain good staff is to introduce McDonald stars or Scouts badges armbands approach that are recognised across the sector should be introduced. This will be visible and add confidence to those who have been trained properly

C8 Scrapping the Institutionalised Care plan and replaced by a person centred Living and Lifestyle Plan
An online portal living and lifestyle plan will enable authorised personals to access review and improve understanding of a residents well being. An online resource means that should a resident transfer to another facility in an emergency to hospital the health and care professionals have immediate access to up to date relevant records and histories.

The concept of the care plan was right to get a written record of what the expectation of care is. The reality is that the care plan is at best an aloof document often only read by the named nurse writing it. Those providing the care often find they can access the plan as often they are locked up as can't amend errors or omissions as there is often little opportunity or mechanism to do that especially on paper records. Should a document be created for social work review purposes or living and live document that is real, relevant and a source of reference. If we really genuinely want person centred care then we need to change the name from the institutional name 'care plan' to living and lifestyle plan. Residents should not be a room number but a person.

C9 Design Commissioning standards and principles
Care design principles and standards should be made for enable care and have a requirement to seek input at the design stage from care professionals to ensure not to prevent or create obstacles to care. Where possible basic principles such as bathroom layouts should and can be future proofed

Impact of poor building and physical environment design

Many older designs of over thirty years were often an upgraded hospital design and have left a long term legacy and challenges on the ability to consistently deliver quality personal care. Modern designs are cosmetically improving the appearance to be more homely. However new challenges are emerging due to design oversights. Designers state that they are at the mercy of the personal choices of a care inspector which will then change with the appointment of a new inspector during the design process. Many care facilities once built will often last decades into the future. The impact of poorly designed or logical design can be a long lasting legacy. If ensuites are to be included they need to be designed to promote the access to give personal care, and use stand aid, hoists and other aids safely. Simple design faults such as sloping unmarked shower floors, enclosures, obstacles and obstructions create a trip hazard increasing

chances of falls and hip replacements. This creates additional costs and burdens on the state due to an avoidable oversight design mistake.

Some of the newer facilities have a great homely environment by their decoration by lack any thought for the practicalities of support care. Developers should be required to engage, have processes and stages that seek feedback from care professionals for their input.

Recommendation -All care facilities should have a Designated function space.
It is important that resident maintains social links with their local community family and friends. This can only be effectively achieved by ensuring a designated space for family functions, local bridge club or bingo nights

C10 Developing and sharing of empowering Technology
Like it or not technology is here to stay and creates opportunities to improve and support high standards

Technology should be enabling, is advancing so fast and is creating opportunity to improve and better monitor the delivery of consistent personalised care. However badly designed products and lack of consultation result in technology aggravating or hindering of the delivery of care. Noisy buzzers, pressure mats that are prone to faults or can be bypassed by astute resident hinder quality care. Many care facilities have inappropriate noise buzzer system that disturb and wake up service users. This is wrong. Phones that aren't cordless or don't work where needed especially important for fire or NHS 111. This puts an unnecessary stress on care professionals at a time they are most needed to be focussed.

C11 Introducing Continuity of Care across the sector
The review panel may consider the following options -Transfer of all care staff in the private, public and independent sector under one governance body. This would alleviate the burden of responsibility and ensure a consistent approach to pay, conditions and training. It will also monitor bad practices and professionals that are failing to meet the standard but escape being identified by constantly changing jobs. This can only be done with the merger of Health Education Scotland, Health Improvement Scotland and Care Inspectorate and possibly SSSC under one umbrella of the Care Regulator for Scotland.

No review of care can ignore the increasing burden on society to fund care. The issue is that there is no one size fits all approach. Audit Commission highlighted that someone from a

professional background who worked had a mortgage may enter into the care system at 75 and may require a short period of level of support that the state can sustain. There is however a significant increase of semi or unskilled workers who are entering the care system at 45. This maybe due to alcohol or drug abuse, violent attack or health conditions such as cancer or MS. The care system would require significant levels of funding to maintain the demand.

C11 Income Safety Protection Scheme
There needs to be a government underwritten sickness insurance scheme to enable care staff to have an income safety protection scheme for identifiable and diagnosed sickness and not or not sickness or persistent patterns of paydayitis or pub recovery sickness.

C12 Information points
Similar to H&S at work poster there should be telephone email and website contacts for regulatory agencies so that with genuine and legitimate queries can ask for advice and guidance when management have either not provided it or been obstructive and where there is a clear concern

Thank you

Thank you for taking the time to read this submission which has been completed by a tireless team working right through the Christmas holidays. Action on Care would welcome the opportunity to provide further clarity or information on the issues raised in the submission. An opportunity to help contribute shape and develop a model that enables better person centred care would be welcome. We all want to see a model that is valued, respected and retains good quality staff with a career structure This submission could not have been completed without the support and help of numerous care professionals who had the confidence to speak out and articulate their concerns and hope that this review will improve their working conditions to deliver better care. Without their feedback and support such detailed analysis would not have been possible.

I am grateful to the following organisations who help provide support and information and reference points

Royal College of Nursing
Scottish Care
Care Inspectorate
Scottish Social Service Council
East Renfrewshire Council
East Renfrewshire Health and Social Care Partnership
Mackay Hannah
Disability Action ER
Audit Scotland
Audit Commission

Action on Care is grateful to the Cabinet Secretary for Health and Sport Jeanne Freeman for a determination to make progress in this area since taking office. Her willingness to engage parties is to be commended. If there had not been the pandemic more progress would have been made earlier with this review. Action on Care is saddened on her decision not to stand as a candidate at the next election meaning that a new Health Secretary will be appointed. Whereas we understand that she has new challenges she wishes to embark. We hope that consideration will be given to do a Tessa Jowell and find a new role to support the momentum for the reform of care which is so desperately needed.

Action on Care actiononcare@gmail.com

Angus Carers Voice Network

Angus Carers Centre
supporting carers

Independent Review of Adult Social Care

Evidence and written submissions
People at the Centre – Open Call

Angus Carers Voice Network

A poem written by unpaid carer in Angus which sums up why investing in unpaid carers is a national priority.

Just for one day
Being a carer tough and hard
A different life I've never had
One of blessings and of joy
One of sadness and destroy
Helplessly trying to do your best
Strength and sorrow, a mighty test

On your knees and battling hard
Reaching out for something they've never had
Trying to give them all you can
Only to be stolen by the misinformed man
Fighting every basic need
In a world caught up in shameful greed
A care system that is caving in
Only love will conquer and seize a win

Snared in a trap, that's lost direction
What happened to love and mutual affection?
Barriers that are often all man made
Oh how I wish that they would all just fade
Shining bright are those that need us most
Humanity, love, they do not cost
You can't put a price on life and wellbeing
If only our politicians would all start agreeing
Why can't they see what we are all seeing?

At the heart of it all are the people no less
The ones that survive this shameful mess
Those who deserve so much more
They are the ones that pick you up off the floor
They are the loved ones that ensure you don't give up
Even when they're down on their luck

A developed county that's broken and bruised
Leaving people hurt, lonely, lost and confused
A right to life, health and well being
If only everyone could see what a Carer is seeing

Walk in my shoes just for one day
Then you will see cuts and reform don't pay
Lives shattered and relying on desperate hope
It is no wonder carers and the cared for just can't cope

Let's make a stance now and stand up and fight Carers…..and those we care for - we all have a RIGHT

Introduction

Angus Carers Voice Network (ACVN) is a network of unpaid carers in Angus, founded in 2016, who are registered with Angus Carers Centre. This is a generic carer's support service provided on behalf of Angus Health & Social Care Partnership.

(Please find more information on this network at the end of this submission).

ACVN considered putting together local engagement events, in the short 'consultation window' in response to the call out for their views. However, they concluded that the engagement work they have recently completed with local carers including; the development of Eligibility Criteria; the development of the Adult Care Support Plan and the Young Carers Statement; and the development of the Angus Carers Strategy 2019 – 2022, (see attachment) thus bringing together the voices of over 200 carers, aged over 18 living in Angus, would be representative.

Priorities

At most recent ACVNs' meeting in October & November 2020 carers highlighted the main areas they wanted to feed back to the Review Board

3) the second sentence under the barriers section could possibly be written to be more concise? (in decision in making)

Barriers to a Life Outside of Caring & Access to Short Breaks
Replacement Care

- Paid care workers should complete pre and post qualifying training which better values the job they do within agreed qualification frameworks.
- Paid care work should not be provided by companies who operate a 'for profit' business
- Paid care workers should have a remuneration package which is commensurate with the responsibility of their role.

Barriers to Carers having choice
Self-Directed Support

- The bureaucracy involved in accessing and maintaining SDS Budgets adds to carers stress and anxiety.
- The bureaucracy and inconstancy in decision making exacerbates carers stress and anxiety significantly. Different teams across the local authority interpret operational guidance inconsistently resulting in confusing and conflicting decisions on how SDS budgets, both for Supported People Budgets and Carers Budgets are made.

Quote form carer: "My feelings are that carers must be listened to when they are asked what would help you to continue in their caring role with regards to carers budget. Not told, their request isn't possible".

- Continued lack of clarity on what is included in "Waiving of Charges" for Carers and the lack of consistency of how statutory guidance is interpreted at a local level, is a source of frustration for carers, carer support staff and their colleagues who are trying to support them.

- The way to resolve this is to completely retrain front-line, social care staff and management, all the way up to Strategic Planning Groups and IJB's and ensure outcomes based SDS is a major element of pre - qualifying training.

Information Sharing
Carers having to share the same information multiple times

- An independent national database of carer information should be developed, perhaps based on the NHS CHI (Community Health Index) number based on the principles of GDPR "Legitimate Interest" with input, managed, and controlled by, carers. This would ensure that it should always be current, and it would avoid carers having to fill in form after form, often on an annual basis for the same department particularly when the condition of the cared-for person is permanent, or when benefit names and allowances, or Government departments, change.

- This would also increase awareness/legitimatise the role of unpaid carers within the wider health & social care system.

A National Care Service/National Care Standards
Right to Independent Appeal

- At present unpaid carers are the only population who do not have the legal right to an independent tribunal or access to an ombudsman in the event of a deadlock with their HSCP or Local Authority. This relates to the services and support provided for the person they care for as well as the support of their own caring role. This should be a core principle of National Care Standards.

Carers Conversations

Carers views gathered at 'Carers Conversations' events in 2018 and 2019 hosted by ACVN, supported by Angus Carers Strategic Partnership, have been used for responses to the "Experiences" & "Priorities" questions posed in the People at the Centre – Open Call.

Overall principles

It was agreed that the following principles which should be included in Carers Impact Assessments completed.

- All reports and policies, when planning & delivering services with Health & Social Care, should be checked for carer impact under the Equalities Act.
- Income Support for those who are not able to work because of caring role and GP support and understanding should be fundamental in Adult Social Care
- The rights of the person being cared and the rights of the carer need to consider together.
- Consistent and up to date information to meet the needs of both carer and cared for person should be available by phone.
- Employers need to recognise carers, allowing them to do their job, realising personal needs, and supporting them to keep them in employment by offering flexible working hours and making it safe for workers to talk about their caring responsibilities with their employer without feeling they will be punishment or disadvantaged for doing so.

This next section re-presents the conclusions of the work completed at our annual Carers Conversation events in 2018 & 2019, building on the agreed outcomes for carers in Angus and are provided as a response to the following questions in the Open Call:

Experiences

What are your experiences and/ or of those you represent in accessing social care support?
What are the things that work well currently for you or for the people you represent?
What are the key barriers or issues?
How do you/people want to access social care support?
How do you/ people define person centred care in social care support?

Priorities

What are the things you would like to keep and that work well?
What changes need to occur within social care?
How do we make those changes?

Carers are recognised and supported as key partners in the planning and delivery of care.

1. Greater focus on quality of life and supporting carers to continue in their role.
2. Sympathetic assessment and timely action to meet physical and mental wellbeing.
3. Discharge from hospital; carers need to be a part of the conversation; communicating the diagnosis with the carer.
4. Easier access to advocacy
5. Carers should be recognised as a diverse population and the role suitably rewarded.
6. The future should be planned for earlier to avoid crises, there is a need to work ahead of time on the emergency plan.

Carer's needs are fully assessed, and ongoing support offered.

1. Greater focus on quality of life and supporting carers to continue in their role.
2. Sympathetic action as and when physical adaptations are needed.
3 Planning for the future for individuals and for the wider picture.
4. Emergency planning needs to include post bereavement support and what happens when the carer is ill.
5. Diversity of caring role – whose needs are we meeting – children and young people do not come under the Integrated Joint Board and there needs to be effective transitions put into place.
6. Caring for young; planning for the future, changing carer roles – can be caring for the elderly and young at the same time.
7. Opportunity to enhance support through adult support; a safety net provided (and groups like men's shed, University of the 3rd Age, etc. need to be encouraged to provide activities and wellbeing)
8. Discharge at hospital; carers need to be part of the conversation; diagnosis needs to be communicated with carers and families.
9. Regular reviews of assessments / support plans (with support offered if needed) and carer integral to process.

Carer's financial needs are addressed

1. Carers should be suitably recompensed for the extra expense and reduction in their income associated with their caring role
2. Planning for the future – for individuals and for the wider family prior to reaching crisis point
3. Information needs to be available and consistent
4. Caring for young people /adult children – planning for the future, changing role
5. Greater focus on quality of life and supporting carers to continue in their role

6 Young Adult carer's transitions into adult life should include information on benefits

Carers are supported to have a life outside caring

1. Greater focus on quality of life and supporting carers to continue in their role
2. Reframe the myth that a break from caring is a 'reward'! It is about wellbeing and allows the carer to continue in their caring role.
3. Respite from caring is something to look forward to. There needs to be a desire to provide it from those who design service
4. Lack of availability of suitable facilities for the cared for
5. Information needs to be clear and available to carers

6 . Registered carers need to access available services

7 Not only should information be available, but it should targeted to help those who do not identify themselves as a carer. (NB the National Carer Awareness Campaign starting in Nov 2020 is cited as an excellent response to this issue)

8. Carers need time away from caring role, social outings are necessary for mental and physical wellbeing
9. Carers need friends outside of the caring role and the carer's support service environment
10. Carers need time away from caring role out with paid work
11. Full time employees are entitled to 28 days paid leave annually – why not full time Carers?

Carers wellbeing and mental health is improved

1. Mental health of carers needs to be taken as seriously as the carer's physical health. This is still not happening.
2. It is vital to have Emergency Plans in place in order to relieve stress and worry for carer and cared for person.
3. Support for families to have more open conversations about the future and their wishes and aspirations
4. Need to have pro-active engagement with carers opposed to crisis management.
5. Employers need to be more supportive to carers to keep them in employment

What is Angus Carers Voice Network?

Meeting every 6 weeks, ACVN offers all carers in Angus a genuine opportunity to ensure that their voices are heard and that their views influence the ongoing strategic development of the Health & Social Care Partnership.

Driving adherence to best practice and transparency in care-practice, any Angus-based carer is welcome to come to the Angus Carers' Voice Network.

Why get involved in ACVN?

- ACVN influences local & national strategic and policy development of the Health & Social Care Partnership which affects carers
- ACVN assists in the design and delivery of workforce development plans in partnership with colleagues from statutory services
- ACVN ensures that all staff in the Health & Social Care Partnership are aware of the "Equal and Expert – 3 Best practice standards for Carer Engagement" developed by the Coalition of Carers
- ACVN ensures that all strategic activity and plans in the Health & Social Care Partnership evidence the "Equal and Expert – 3 Best practice standards for Carer Engagement" developed by the Coalition of Carers in their work
- ACVN ensures that the communities represented by carers are represented at relevant groups and meetings both locally and nationally.
- ACVN ensures that work produced by the Health & Social Care Partnership is developed through dialogue with communities of carers
- We always provide clear and concise information and feedback to carers as outlined in a Communication Plan, which includes a timetable and minute of all meetings
- Carers are recognised & supported as key partners in the planning & delivery of care. Through ACVN, Carers' needs are fully assessed before ongoing support is offered.

Balhousie Care Group

COVID-19 in Scotland's care homes

Balhousie Care Group's experience and learning during the COVID-19 pandemic

Submission to Independent Review of Adult Social Care in Scotland

About Balhousie Care Group

Balhousie Care Group is a family-run care provider, founded over 30 years ago on the principle of providing high quality care to the people of Scotland. Balhousie is now an operator of 26 care homes providing care to more than 1000 people and employing more than 1500, making it one of the country's leading private care providers.

Introduction

The social care sector has been on the frontline of the response to the pandemic. Care home workers, alongside the NHS and other key workers, have demonstrated exceptional dedication, care and bravery in the fight against the virus. The sector has proved its agility to respond and adapt to the immediate challenges presented by the crisis to protect the most vulnerable in our society - care home residents.

The virus has disproportionately affected care home residents, who are clinically most at risk[1]. Ten months into the pandemic, care home outbreaks and deaths continue to be reported in the media on an almost daily basis.

As a leading care provider, Balhousie has felt compelled to speak out on behalf of care home residents and social care staff. Throughout the pandemic, Balhousie has publicly highlighted government failings in the handling of COVID-19 in care homes and emphasised the need for urgent reform. This report will outline Balhousie's experiences and make recommendations.

PART ONE

Experiences of the COVID-19 pandemic

Guidance

On 11 March 2020[2], twelve days before the UK and Scottish Governments announced national lockdowns, and in the absence of guidance, Balhousie took the difficult decision to suspend all non-essential visits to our care homes in order to protect residents from risk of transmission. Balhousie implemented its COVID-19 contingency plans in February, weeks before the first clinical guidance for care homes was available on 13 March[3].

[1] Currently, deaths in care homes account for 37% of all COVID-19 deaths in Scotland, despite care home residents only representing 7% of the population https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/general-publications/weekly-and-monthly-data-on-births-and-deaths/deaths-involving-coronavirus-covid-19-in-scotland

[2] This decision was made after The World Health Organisation declared a world pandemic on the 11 March 2020 https://www.who.int/emergencies/diseases/novel-coronavirus-2019/interactive-timeline/

[3] Health Protection Scotland, COVID-19 Information and Guidance for Social, Community and Residential Care Settings version 1, publication date 13 March 2020

Balhousie contingency planning prior to 13 March:

- enhanced infection control policies
- critical response incident management process
- mandatory daily COVID-19 briefings for Home Managers and Senior Management Teams
- Coronavirus Policy
- workforce planning
- additional food and PPE provisions

During the early months of the pandemic, guidance from Scottish Government and regulatory bodies changed rapidly. Between 13 March and 1 June there were 30 separate guidance documents issued by regulatory bodies[4], which required reading, interpreting, communicating to staff and implementing in all care homes.

In Scotland, there is evidence of disparity and tension between national and local bodies over the guidance issued and the autonomy of application of this guidance by various local authorities. The delegation of decision making to local policy organisations has been problematic in this crisis due to conflicting application of guidance. Examples of this include different requirements for visitation and risk assessment by local authority areas. Scottish Government guidance on testing of new admissions from hospital has also varied in practice from one local authority to another.[5]

The situation has been made worse by the fact that, in publishing new guidance, regulatory bodies routinely remove previous versions from the public domain. This makes it incredibly difficult for providers to identify and implement the changes in the guidance quickly.

Because of the volume of guidance issued, it was difficult at times for social care providers to determine the difference between guidance, sector obligations and legal obligations. Furthermore, there are nuances in the sector, such as sheltered housing, and guidance was not always fully applicable to their needs. Often, in the face of a lack of clarity, care providers simply had to plough through the guidance and implementation themselves..

Discharges from hospitals to care homes

In March 2020, several local authorities contacted Balhousie to block-book beds to transition older people from hospital into care homes, with the objective of freeing up NHS hospital beds. Balhousie requested that all admissions from hospital be tested for the virus prior to admission to care home, but were advised by local authorities this was not possible.

Public Health Scotland has confirmed that 5204 people were discharged from Scotland's hospitals to care homes between 1 March and 31 May 2020. Of those, 59% (3601 people), were not tested prior to discharge[6]. Care homes in Scotland received an average of six discharges per care home.

[4] Guidance was issued from Health Protection Scotland, Scottish Government, NHS Scotland, local authorities and the Care Inspectorate

[5] Scottish Government, National Clinical and Practice Guidance for Adult Care Homes in Scotland during the COVID-19 Pandemic, 15 May 2020, page 15 stipulates that one negative test is required prior to admission to a care home from a non COVID-19 pathway, in practice; this was two tests for a number of months.

[6] Public Health Scotland, Discharges from NHS Scotland Hospitals to Care Homes between 1 March and 31 May 2020, 28 October 2020, p16

The level of hospital discharges without testing was particularly concerning in March 2020, when 2309 people (90%) of all those discharged to care homes from hospitals were released without any testing. In its report of 28 October 2020, Public Health Scotland asserts that this was in line with clinical guidance at the time, which restricted testing to those with symptoms of infection. The number of discharges from hospitals to care homes reduced from the month of April as non-elective surgery in the NHS was paused, and at this time, testing also became more widely available. In April, 713 people were discharged to care homes without being tested prior to admission, representing 53% of all discharges from hospital to care homes in that period. This reduced to 39 people in May, 3% of all discharges in that month.

Care homes play a critical role in not only providing a safe, homely environment for people but also helping support NHS capacity issues. However, they are not clinical settings. While it is right that people are discharged from a primary care setting to residential care as soon as they are ready, it is clear that government strategy to free up hospital beds by transitioning residents from hospital to care homes to protect the NHS, without a functioning testing system, put vulnerable care home residents at unacceptable risk. Care homes were left to pick up the pieces.

Balhousie has had five cases of residents discharged from hospital untested to a care home. Two of those residents were residing within the same care home and their discharge coincided with a subsequent outbreak in the home.

The Public Health report includes a statistical model, which presents a number of risk factors associated with an outbreak in a care home. It concludes that while hospital discharges are associated with an increased risk of an outbreak when considered on its own, that risk of a care home outbreak increases progressively as the size of the care home increases.

The risk factors presented in the report were not helpful to us in understanding how best to protect our residents. In our experience, the virus affected homes of different sizes indiscriminately, in the same way as happens in the community. The social distancing principle is based on the premise that limiting human contact means a reduced the risk of transmission. Therefore, we can deduce that larger care homes have more people living there and that a risk of an outbreak would naturally be higher. It is worth noting that the model does not contain any analysis of care home by geography, despite the virus prevalence being up to six times higher in urban locations than rural[7].

The Public Health report provides no real clarity on the outcome for the 3022 people who were discharged without being tested between March and April, nor the care homes they were discharged into, prior to a peak in infections in Scotland's care homes. For that reason, we believe the report did not go far enough in shedding light on the impact of discharges from hospitals to care homes during the first wave. .

Testing

Testing has been inconsistent throughout the pandemic. Until June 2020, Polymerase Chain Reaction (PCR) testing was generally only available for staff and residents in cases where the individual was presenting symptoms or where a member of their household had tested positive. Mass testing was

[7]Office of National Statistics, England and Wales Age-standardised mortality rate of deaths involving the coronavirus (COVID-19), Rural Urban Classification, deaths occurring between 1 March 2020 and 31 July 2020 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/deathsinvolvingcovid19bylocalareasanddeprivation/deathsoccurringbetween1marchand31july2020

available sporadically during outbreak situations from May and weekly testing for all staff testing began on 15 June.

What was an encouraging and efficient testing system over the summer months went into rapid decline when schools and universities returned in August. From August to December 2020, turnaround times averaged 4-7 days, with up to 93% of test results not being returned on a weekly basis[8]. This has been incredibly frustrating and presented a significant risk of potentially exposing vulnerable residents to asymptomatic staff. The poor testing regime contributed to the problems of keeping outbreaks under control.

Hundreds of false positives, lost tests and inconclusive results have also presented a significant challenge for care home providers, often resulting in the forced temporary closure of care homes by Public Health for further investigation.

Testing appeared to improve in late 2020 as progress was made to transition test results from The Lighthouse lab to NHS labs. This has, however, presented a new problem as care homes are not receiving confirmation of staff results unless positive. We are not confident that NHS labs receive and test all samples. It is critical that care homes receive confirmation of test processing, due to the existing lack of confidence in the system.

Balhousie met with the Cabinet Secretary for Health and Sport on 23 October to discuss our concerns with the testing system and to propose the solution of rapid response lateral flow device (LFD) testing. We proposed this not only to support safe working and facilitate visitation, but also to remove some pressure on the Lighthouse and NHS labs. Balhousie began its own independent trial of LFD testing for staff on 23 November. Scottish Government rolled out LFD testing for care home visitors from 14 December and made it twice weekly for care home staff from 4 January.

Testing technology in care homes is undoubtedly a significant step forward in protecting vulnerable residents from exposure to the virus. LFDs have already supported swift detection in a number of cases in Balhousie Care homes. However, we must recognise the additional workload that this means for care homes, who are administering up to 500 tests per week. This includes: time to carry out the test on all staff; logging results on the NHS portal which takes up to four hours each day; arranging couriers; and liaising with Public Health.

Balhousie has recruited COVID-19 service coordinators to oversee the end-to-end process of all testing and this has been hugely beneficial in addressing the time and logistical challenges of extra testing. However, we are aware from talking to care homes across the sector, that fellow care home providers - particularly single care home businesses who have limited capacity and support - are opting to not use LFDs or not log the results in the portal because they view it as a cumbersome process. It would be a tragedy if care home operators do not adopt LFDs simply because of operational challenges, as we know how critical they are for early detection of the virus. Balhousie wrote to the Cabinet Secretary for Health and Sport on 9 January to ask for her support to resolve these operational issues a matter of urgency and received a reply, with reassurances, on 16 January.

[8] Week commencing 24th August only 6 out of 846 tests completed were returned

COVID 19 outbreaks and subsequent deaths of Balhousie residents.

The first confirmed resident case of COVID-19 in Balhousie was on 2 April.

Between 1 March and 21 June, 348 of Scotland's 1084 adult care homes had a laboratory confirmed outbreak[9] (32%), compared to six of Balhousie's 26 care homes (23%). Seventy-two Balhousie residents have tested positive since the beginning of the pandemic, of which 22 have died across four care homes. A further three residents had COVID-19 listed as cause of death on their death certificate within this period, despite refusing a test and being in receipt of a negative result.

Balhousie experienced the highest number of deaths from COVID-19 in May (17). Deaths in this month were 2.31% higher than the four-year average and the number of deaths normally in December or January influenza when other winter illnesses are prevalent. The average age of residents who died after testing positive for COVID-19 was 90. All residents who passed away had several existing co-morbidities.

During an outbreak, staffing is a significant challenge due to staff illness from the virus. Deployment of the central clinical care quality and operations team ensured continuity of high standards of care during an outbreak. To minimise pressure on frontline carers, members of Balhousie's head office team called families to provide regular updates on the health and wellbeing of their loved one.

Balhousie had no positive cases among residents between June and 28 December 2020. We are currently managing two new outbreaks and our initial experiences indicate that this could be the new variant, given the level of transmission in the care homes. As at 15 January, this second wave has seen 35 new resident cases - 18 in one care home and 17 in another. As of mid-January 2021 there had been eight resident deaths in one of these care homes and four in the other.

Families and visitation

Balhousie's decision to suspend visitation to our care homes twelve days before the Scottish Government announced a national lockdown received overwhelming support from 98% of our residents' families and 95% of staff[10]. Positive cases across Balhousie homes have been significantly fewer than the national average. Although this may be partly down to good fortune, we firmly believe that our visitation policy, as well as rigorous infection control, have also contributed to this.

The pandemic has presented a heartbreaking challenge for care home providers attempting to balance the right to family life with the right to preserve the life of family members[11]. There are significant wellbeing benefits to residents having time with their loved ones. However, Balhousie has first-hand experience of the devastating effect of an outbreak of COVID-19 in a care home. Protecting our residents and staff from exposure was paramount in all decision making.

In taking these difficult decisions, and given the backdrop of a failed testing system, there has been some divergence and at times conflict between Balhousie and the Scottish Government's approach. On May, the Care Inspectorate advised Balhousie by phone that it would have three of its services downgraded if it did not change its policy to allow end of life visitation inside its homes. Balhousie requested that visitors be tested prior to entry to the home, which was declined by the Scottish

[9] Public Health Scotland, Discharges from NHS Scotland Hospitals to Care Homes between 1 March and 31 May 2020, 28 October 2020, p28

[10] Balhousie staff and family survey June 2020

[11] Human Rights Act 1998, Article 8 Right to respect for private and family life and Article 2 Right to life

Government and the Care Inspectorate. At this time, this affected our previous excellent relationship. We were not being listened to and left to get on with the consequences.

Balhousie also spoke out publicly to highlight concerns surrounding the Scottish Government's significant relaxation of care home visits on 12 October, to up to four hours.
Balhousie successfully reintroduced outdoor visits from July and indoor visitation was phased in in December, with LFD visitor testing and, in some homes, the vaccine. However, the announcement of the new strain of COVID-19 on 19 December has resulted in a pause of all but window visitation until there is a better understanding of the impact of this new strain, in particular how it interacts with testing and the vaccine.

While we have received overwhelming support from family members on our visitation policy, there has understandably been an increased number of complaints from families, who appear to feel increasingly desperate after dealing with visiting restrictions for so long.

Impact on staff

We know staff anxiety is high and that many of our social care staff are feeling burnt out. They are under stress physically, from wearing PPE 12 hours a day, and emotionally, from caring for vulnerable residents most at risk from the virus. In addition, they are worried that they could put their families at risk and heightened media focus on the sector.

One of our carers, Fiona, shared her experience:

"We wanted to do our best to provide the best care to all residents, both those who are COVID-19 positive and non COVID-19 positive. My passion for my job kept me going, that and making sure residents were okay. It was so hot and tiring wearing aprons, masks and visors. The hardest thing was the decline in the residents after contracting the virus. It was like a domino effect. They all stopped speaking. So many had to be in self-isolation for two weeks. One gentleman was screaming with his eyes. Some residents struggled at the end.

I was scared for my family and felt I was putting them at risk being around them and working in the care home. I recently lost my mum, my dad was fighting for his life with sepsis and my son has a heart murmur. I always cared for my dad, took him to appointments and helped him with his washing. However, I had to make the very difficult decision not to visit my dad in his home because it would put him at too much risk. Since then, I have had to leave shopping at door and just do a window visit. I know it is for the best, but it has been such a difficult year.

We worked well as a team and pulled together to look after the residents and make sure their needs were seen to. The media focus on care homes made me feel anxious, particularly the newspapers. I am still on anti-depressants, not just because of the impact of working during the outbreak, but also losing my mum and my dad being in hospital.

Our manager did well letting us know about changings and briefings but I had to ask them about counselling. I think staff really need counselling. Our manager and operations manager kept talking to us; buying us cakes, little things like that helped h staff morale on the floor.

After being through it the first time, we are more educated about the virus. Everything is now in place. Balhousie did well, once we knew what was needed to fight the virus. I feel a bit better but still feel anxious. I am speaking with the mental health team now because I am suffering from night terrors and I already suffer with PTSD."

The long-term effect of the pandemic on social care workers is as yet unknown but they will undoubtedly require continuing support. The pressure of working under such challenging circumstances has led to a number of staff taking the decision to leave the sector. In April2020, Balhousie introduced an enhanced counselling service and a £200,000 hardship fund to support our colleagues during these difficult times. Communication and staff engagement has been a huge focus throughout the year, with regular letters from the Chairman and CEO, goody bags, videos and, most recently, the presentation of certificates and commemorative coins to staff.

There have been some delays from the Scottish Government in equalising their support to NHS and social care workers. One example of this was a delay in levelling up the death in service for NHS and social care staff in Scotland, some four weeks after the UK Government.

The announcement of a £500 bonus for NHS and social care staff is very welcome. However, the bureaucracy associated with claiming this for our staff means that, seven weeks on, we are no clearer on when they can expect to receive this. This appears to be an ill thought out and unfair way of rewarding staff.

To recruit and retain staff, we need government support to ensure that nursing and caring are seen as rewarding and attractive careers, by providing long-term investment in working conditions, pay and support both in the NHS and social care sector. We strive to be a fair employer. The lack of attention to the true cost of care means that until the government reflects this in The National Care Contract it has hard to make progress.

Since the beginning of the pandemic, 107 staff have tested positive at Balhousie in 16 care homes. Thankfully, all have recovered with the exceptions of those currently self-isolating in the most recent outbreaks. It has also been encouraging that many of these cases were identified through weekly staff testing and self-isolation, combined with infection control, prevented further transmission to residents.

Urgent action is required at government level to address workforce shortages in health and social care, and in particular nursing shortages. NHS Scotland recently reported c. 4000 nursing vacancies[12] and there are over 12,000 social care vacancies in Scotland[13]. We also know from the Royal College of Nursing that there has been a sharp increase in nurses thinking of leaving the profession since the COVID-19 pandemic. Reasons cited include pay and treatment during the pandemic.[14] This highlights the need for government support to ensure that nursing and caring are seen as a rewarding and attractive careers, by providing long-term investment in working conditions, pay and training in both in the NHS and social care sector.

Perception and the media

Social care has had huge profile in the media this year, both positive and negative.

Careless language relating to care homes and residents from the media and others in the public domain has been an issue throughout the pandemic. One example of this was Scottish Government

[12] Royal College of Nursing, NHS Scotland nursing vacancies reach all-time high, 3 September 2019 https://www.rcn.org.uk/news-and-events/news/isd-workforce-stats-3-sept-2019

[13] Skills Development Scotland, Social Care current and future skills demand https://www.skillsdevelopmentscotland.co.uk/media/46379/ssa-social-care.pdf

[14] Royal College of Nursing, Building a better future survey, 17 July 2020 https://www.rcn.org.uk/news-and-events/news/uk-members-have-spoken-survey-shows-increase-in-those-considering-leaving-the-profession-170720

National Clinical Director Jason Leitch who referred to care homes as “institutions” and said older people are "corralled" ’into care homes.

Such rhetoric has contributed to negative perceptions of care homes. It also affects how social care staff feel valued. The tone of the media reporting has at times not only been distasteful, but on many occasions inaccurate. Balhousie wrote formally to one publisher on four occasions for spurious and false reporting.

On 11 May there were stark announcements from the Cabinet Secretary for Health and Sport and the Procurator Fiscal that not only would the Scottish Government take failing »care homes under local authority control but that all care home deaths would be subject to investigation. The tragedy of deaths in care homes demands attention and investigation. However, these announcements were perceived by the sector as having an undertone of blame. There is no doubt the Government also unfairly differentiated between privately and publicly run care homes.

It is evident from the language used in the media, and by some government officials, that there is a lack of understanding of what social care is, and what it contributes to society.

We feel strongly that, just as the government has invested in a marketing and public relations campaign to promote the work of the NHS during the pandemic, so it should do the same for the care sector and care homes, both public- and privately-owned.

Relationships with regulatory bodies

Care homes have been subject to visits and regulation from Health & Social Care Partnership, the Care Inspectorate, Environmental Health, Public Health Scotland, Health and Safety Executive, Health Improvement Scotland during the pandemic. Providers are supportive of regulation; however, working with different groups with different requirements in a pandemic has at times been extremely and unnecessarily difficult. The challenges created by working remotely and the inability to meet face to face has undeniably had an impact on working partnerships.

The lack of consistency in approach across authorities has also made it difficult to implement changes and keep care home teams motivated when different groups have different views and requirements. Care homes feel there is a misunderstanding of the sector and sometimes an overly clinical approach, with limited understanding that a care home is an individual’s home, and that residents are not patients.

On 23 March 2020, the Care Inspectorate stopped making all routine visits to homes and redeployed their inspection teams to support services to manage the crisis, with regular checks matching the needs of the service, This was outlined in its report ‘The Care Inspectorate’s role, purpose and learning during the pandemic’[15]. Between 1 April and 26 July, inspectors made over 35,000 separate contacts with more than 6,700 individual services. While the relationship between providers and the Care Inspectorate has been positive overall, providers do feel that the sometimes punitive language does not support collaborative working to uplift the standards of care.

Care home managers have reported that interactions with some regulators have at times made them feel their professional experience has not been recognised or respected. This is another symptom of a lack of understanding of the sector. However, our home managers have also reported a notable

[15] Care Inspectorate, The Care Inspectorate’s Role, Purpose and Learning during the COVID-19 Pandemic, 21 August 2020 https://hub.careinspectorate.com/media/4167/ci-role-purpose-learning-during-covid-19.pdf

improvement in approach during the second wave of the pandemic, with more understanding and support from regulatory bodies.

PART 2 – REFORM

The tragedy of Coronavirus in care homes has highlighted the existing problems with the current social care model and the urgent need for reform.

On 1 September 2020, the First Minister announced there would be an Independent Review of Adult Social Care in Scotland. Derek Feeley, former Scottish Government Director of Health and Social Care and Chief Executive of NHS Scotland, is chairing the Review. The aim of the review is to recommend improvements to adult social care in Scotland, primarily in terms of outcomes achieved by and with people who use services, their carers and families, and the experience of people who work in adult social care[16]

In 2 November 2020, Balhousie asked several recognised experts in social care and policy to discuss our experiences and lessons learned from the pandemic in the sector from different perspectives. This report is an output of that discussion.

Their views are anonymised here and this report does not reflect a consensus of views from all contributors.

Lessons learned

The COVID-19 pandemic is an unprecedented situation, which has created many new challenges that nobody was properly prepared for. The impact of the pandemic on social care has been both an international and national issue and it is evident that there was a lack of consideration given to the impacts on the sector at the beginning of the pandemic. There is limited social care expertise on the Scientific Advisory Group for Emergencies (SAGE) and related sub groups[17].

While it was impossible for any government to predict the scale of the crisis, the crisis has shone a light on existing issues and stigmas surrounding the sector, particularly under-resourcing and proper recognition of social care workers.

The pandemic has also highlighted a lack of strategic planning at government level across primary and social care services. While care homes have been accustomed to managing outbreaks, such as influenza, they had never experienced such a high volume of elderly people transitioning from hospital in a pandemic situation.

An independent report by the Queen's Nursing Institute[18] reported that 1 in 10 care homes were asked to change resuscitation orders for residents by NHS Managers during the pandemic, without discussion with staff, families or the residents. This raises a number of ethical and practical questions around primary care support for care home residents.

[16] https://www.gov.scot/groups/independent-review-of-adult-social-care/

[17] Government Office for Science, List of participants of SAGE and related sub-groups https://www.gov.uk/government/publications/scientific-advisory-group-for-emergencies-sage-coronavirus-covid-19-response-membership/list-of-participants-of-sage-and-related-sub-groups

[18] The Queen's Nursing Institute, The Experience of Care Home Staff during COVID-19, A Survey Report by the QNI International Community Nursing Observatory, 24 Aug 2020 https://www.qni.org.uk/wp-content/uploads/2020/08/The-Experience-of-Care-Home-Staff-During-Covid-19-2.pdf

There is an immediate need for government and regulatory bodies to work more collaboratively with care homes. If social care representation were included in the decisionmaking process between Scottish Government and regulatory bodies, then this would have supported better implementation of changes.

It is evident that further discussion is required around the complex issues of social care and the role social care should play in society. We all grow older if we are lucky, yet there is still significant stigma surrounding the care sector. Education, messaging and marketing is required to present the sector as positive and engage people in how we move forward.

Financing Adult Social Care

An independent financial report, *Care Home Market Study,* commissioned by the Competitions and Markets Authority in September 2017, calls attention to the fact that the current National Care Home Contract is not reflective of the true cost to providing quality care to the people of Scotland[19]. While there is a divergence of opinion, there is broad agreement that the sector is under-resourced.

The pandemic has highlighted issues of underfunding and the sector is increasingly concerned about reaching agreement on the true costs of care. In recent years, negotiations between Scottish Care and COSLA on the National Care Home Contract have repeatedly broken down. The areas which remain disputed with the current model are[20]:

1) The model is based on 100% occupancy which is practically impossible to achieve
2) Excessive efficiencies applied to all direct costs including staff costs despite staffing levels being set by regulatory bodies
3) Lack of sufficiency for management support
4) Lack of provision for additional costs including holiday cover, building costs and activities
5) Return on capital
6) Provider's return

COVID-19 sustainability payments to the sector have gradually reduced throughout the year, without any corresponding improvement in occupancy. It also remains unclear whether all the additional costs incurred to make care homes safe will be reclaimable.

Additional costs combined with the reduction in occupancy, due to a downturn in public confidence in care homes, has put the sector under huge financial pressure. This an unacceptable level of financial unpredictability in the social care sector. Many providers, particularly smaller family providers, may not survive the Coronavirus Crisis, which will ultimately affect the access and choice of communities to vital care services.

Looking ahead, we need broad, honest dialogue about what we want our social care services to deliver and what the taxpayer is willing to pay for these services. Decisions driven entirely by fiscal

[19] Competition and Markets Authority, Care homes Market Study, 30 November 2017 https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf

[20] Donald Macaskill, Scottish Care update on the Care Home Cost Model (CHCM) and National Care Home Contract, 22 October 2019

considerations will continue to leave the sector starved of the resources it needs to deliver quality care.

Scotland is considered a leader in delivering a rights-based approach to care. We must look to other countries to deliver an ambitious plan for the future of social care, such as Sweden and the Netherlands[21], who have recently been commended for their resident-centric models.

Commissioning

The Ministerial Group for Health and Community care was established in 2008, with the role of decision taking in relation to transformational change in health and community care in Scotland. The Cabinet Secretary for Health and Sport chairs the group, alongside the COSLA Spokesperson for Health and Social Care[22]. There is a strategic opportunity for this group to examine the future residential and nursing care requirements of the population, and the aspirations for future care.

Currently decision making across local authorities operates in silos and is often based on the need for beds. Joined up, strategic direction is required across all local authorities in Scotland to uplift the standard of care across the sector. This includes regulation on location, care and standards.

The COVID-19 pandemic has had a huge impact on public policy function, including health. Everything has been paused to focus on fighting the virus, ironically at a time when the sector needs reform most.

Data and academia will play a critical role in assessing the current need of the sector and anticipating future needs for planning. There must be both a community and national agenda for change in social care.

Conclusion

There is still a long journey back to some 'normality 'from the COVID-19 pandemic. Even after the roll out of the vaccine, many questions remain. We know there have been fewer patients in hospitals and residents in care homes but we do not know what care, if any, they have been receiving.

Looking forward, we do not know if the pandemic will change adult social care completely but one thing is clear: the current model must urgently reform. The question of reform is not whether care should be delivered publicly or privately, but how can we best deliver quality care to the people of Scotland.

Recommendations

1. Commission an independent, strategic review of the role primary and social care services which also considers the future requirements of the population

2. National Care Home Contract and Care Home Cost Model to be reviewed as a priority, including engagement from the public on their expectations from social care sector

[21] https://www.heraldscotland.com/news/18970705.care-crisis-need-reform-care-sector-scotland--/
[22] Scottish Government, Ministerial Strategic Group for Health and Community Care, https://www.gov.scot/groups/ministerial-strategic-group-for-health-and-community-care/

3. Representation from Social Care to be included in key public health decision making bodies including Chief Medical Office and Government Office for Science

4. Additional government investment into NHS and social care staff pay, training and development to address immediate staff shortages

5. Future guidance from regulatory bodies to be supported with additional communication tools to support implementation, including tracked changes to guidance and frequently asked questions

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21 January 2020

Blackwood Homes and Care

Independent Review of Adult Social Care
Response to invitation for Submissions

Blackwood Homes and Care welcomes the opportunity to contribute to the Independent Review of Adult Social Care from the perspective of both a Registered Social Landlord and a registered provider of social care services. We operate three small care homes for people with complex need and provide in excess of 10,000 hours of care at home per week to around 550 customers across the Central Belt and North East of Scotland. As a landlord, we have over 1500 tenants in 28 local authority areas in Scotland, in small neighbourhood developments.
Our purpose is to help people to live as independently as possible so that they can live life to the full. For over 40 years we have done this through designing high quality homes and scare and support services, and by investing in innovation.

In the last few years, we set out to re-imagine our care services models using technology. We invested in innovation- and drew in funding from Scottish government and others to supplement our own investment - to develop our approach. This included engaging with customers and with HSCPs and government partners to bring our products, such as CleverCogs (our digital support offering), and our services such as the Night Support Service, to reality.

Our neighbourhood base has become increasingly important so that we can offer care and support across our own homes and to people in other tenures within a sustainable financial framework. We are currently preparing for Stage 2 of a 'trailblazer' Healthy Ageing programme with Innovate UK to establish whether we can support additional productive and healthy years. The programme will run in three neighbourhoods across Dundee, Glasgow, and Buckie, for the next three years, with University of Edinburgh and industry partners.

While we believe neighbourhoods and local communities are an ideal basis for delivery of social care, it is not systemically supported by the current approach across Scotland, with very fragmented commissioning, procurement and pricing models which mitigate against sustainable delivery and scaling up innovation.

Dimensions of high-quality social care

We believe that to design high quality social care Scotland needs a national policy focus on helping people to live independently, starting with prevention and moving through a spectrum of support and personal care, to supporting the shortest possible period of crisis care. This approach should focus on understanding and respecting the wishes of the individual, including enabling clearly understood acceptable risk levels.

We believe that clear standards of engagement, service delivery, and staff training are all dimensions of high-quality social care with an external validation of the outcomes to ensure Scotland nationally supports high quality social care as a fundamental right.

While there are major system issues where we would like to see radical reform, we strongly believe that the overall approach must facilitate high quality and trusted local delivery. The neighbourhood or place -based aspect is important and often misunderstood in its importance for social care and this could be strengthened.

Many of the aspects of the above points are well understood in Scotland and are in place to a good extent. We therefore think there is real scope to reform the system so that we have a more effective and efficient model of operation suitable to the geography and employment and economic circumstances in the country. Most importantly we believe it would be in line with values of community, helping each other, while respecting the dignity of people who wish to live independently and do things for themselves, all of which we believe are recognisable attributes in Scottish culture.

While we know it is a major undertaking to overhaul existing practices and institutional approaches, we are optimistic that a focus on high quality social care – particularly if it incorporates a much stronger focus on prevention – will be welcomed by many.

As our population ages, and as many more people live from a younger age with multiple morbidities and complex conditions the dimensions of high-quality care must be inextricably bound in with good housing, open space, opportunities for sport and other meaningful activity, and innovation in technology to support all of us as we age or live.

The ownership and use of data and information is another area where there is still major potential to change how we operate and we expect this to be a feature of any new system for a significant period in Scotland as we mature our understanding, embed a rights- based approach, and develop technology with industry partners to support new models of housing and care in local neighbourhoods and communities.

While the Review will consider a National Care Service, we want to ensure that this is not a medical model and instead is a whole population model with its roots in local communities and a variety of delivery models. Given technology is also evolving in many ways we want to avoid years spent on single big tech systems and instead focus on the interoperability of systems, and on the national quality approaches and policies which will underpin a wide variety of delivery.

Choice and Control - the needs, rights and preferences of people using social care services and supports - human rights and ethics in social care

Supporting people to exercise choice and control over their lives is fundamental to respecting and promoting their human rights. We aim to see each person as an individual with their own hopes and dreams and preferences as to how they want to live their life, including the way in which want their social care needs to be met.

Self-directed Support has not revolutionised adult social care in the way that many people hoped. The outcomes approach that was intended to put people's aspirations at the centre of the assessment and care planning processes focuses almost exclusively on care needs rather than the personal outcomes that the individual wants to see. In many cases choices around how care needs are met are limited to a narrow range of traditional care services, if there is any choice at all. We believe that this is because there is not a clear enough understanding of the delivery risks and market preparedness to sustainably deliver the right range of services. Blackwood's focus has been to embrace the use of technology to increase the choice, control and independence of both our tenants and the customers of our care services.

CleverCogs is our software system which has been developed through participation and with investment and evaluation support from Scottish Government. Our early stage in designing CleverCogs was based on small group participation with people in our care homes or in our tenancies. This enabled us to understand motivation for using CleverCogs, design services to assist with coaching, and led to CleverCogs being focused on a whole life set of interests – entertainment, hobbies, catching up with family and friends - as well as the service aspects such as home automation or care rotas. Permission to use data owned by individuals is an important component of how we designed the system and evolving further.

Living in an accessible home can significantly increase people's independence and quality of life and reduce the need for formal social care support. In 2017, we developed a new standard of highly accessible home now known as the Blackwood House - named in honour of our founder Margaret Blackwood who was herself a pioneer of design and technology in the 1960s and 70s. We felt that the current standard of 'Housing for Varying Needs' in Scotland needed complete overhaul and wasn't right for the 21st century with technology and construction which can aid design which greatly increases accessibility standards.

The Blackwood House, with its accompanying Design Guide, developed with architects Lewis and Hickey, is designed to be beautiful, affordable, highly accessible and connected. Key features are:

- An automatic door entry system that operates from a key card and has been fitted with an external camera for added security.

- A flexible floorplan with a core of internal kitchen and bathroom enabling services to be centralised and circulation space to be maximised

- Electric blinds that can be controlled from an app to suit a range of scenarios are installed in each room.

- Underfloor heating throughout and temperature control in each room gives maximum use of space without having radiators fixed to walls.

- Rise and fall surfaces and wall cupboards, and a rise and fall hob in the kitchen.

- A fully adapted bathroom with an adjustable rise and fall sink fits any height and equipment such as the grab rails that slide along the wall and lock wherever is comfortable. Also, in the bathroom is the Geberit toilet with remote control so the individual or a carer can operate from within the bathroom or a carer can wait outside and control the automatic cleaning system.

- Solar panels keep the home green and cost-effective ensuring temperatures which help residents to remain healthy.

To date 30 of these homes have been built in Dundee and Glasgow, with plans to build a further 100 in Dundee and Edinburgh. Helenvale, a development of 24 x 2-bedroom flats has just opened in Glasgow, built by Cruden Homes and with great support and engagement from the city council's DRS team and the Health and Social Care Partnership (HSCP). All tenants have been nominated through the HSCP. Whilst some tenants have moved to Helenvale from previous homes in the community others have from hospital and a range of residential accommodation including nursing and care homes and young persons' residential accommodation. In addition to the homes, we provide in the region of 1,000 hours care per week, a shared waking night service and all 23 tenants can access our 24/7 Responder Service.

The 24/7 Responder Service is the logical development of the Night Support Service we have been developing in partnership with Edinburgh Health and Social Care Partnership over the last four years. Initially funded through the Integrated Care Fund, the Night Support Service uses CleverCogs with video technology to provide support that might previously have been provided by a waking night service. Customers of this service can contact a specialist support team using video technology to request support and assistance. The Team assesses the situation and either provides virtual support via the video link or where necessary visits the customer. The service is valued by customers as they can access the service when they need it and do not need to have a worker staying in their home. From the HSCP's perspective, the service provides targeted and appropriate support and can

prevent things escalating unnecessarily, for example including reducing unnecessary calls to the ambulance service, and it represents better value for money, with significant savings to the HSCP.

We are moving from a Night Support Service to one that operates 24 hours a day and covers not only Edinburgh but is also operating in Glasgow and supports around 100 customers across the two areas. We are in discussion with other HSCPs about expanding the 24/7 service to other areas. We strongly believe that this is a service which would benefit from national support and has clear lessons which we are happy to share.

We encourage all our Care customers to make use of our Clever Cogs digital support system including providing them with a tablet, pc, or other suitable device. In addition to providing the platform for the 24/7 Service. CleverCogs is:

- integrated into the Blackwood House to allow tenants to control their environment

- Used to provide the alarm system within our care homes, so that a resident can use their mobile phone or tablet to make a video call for assistance and the nearest member of staff will respond

- used by our care at home customers to check their schedule and see which member of staff will be supporting them when. This function has been used over 1,000 times between 1st August and end of October 2020 as an example of potential

- a vital means of improving wellbeing and reducing social isolation as we work with customers to improve their digital skills, so that they can access social media to follow their interests, do their shopping online or communicate with friends and family via video link. The use of this functionality in CleverCogs has increased steadily during the current lockdown. The Friends and Family functionality which provides video calls has been used over 1,600 times since 1st April. There have been in excess of 8,500 hits on the entertainment function (music games etc). The data behind CleverCogs still hold enormous potential to increase knowledge and understanding of what matters to people who use it.

During lockdown many tenants who are vulnerable but do not use care services used CleverCogs. These tenants have been given support to develop their digital skills and use CleverCogs to reduce their social isolation and improve their wellbeing. We currently employ digital coaches to assist customers who need to increase their confidence in using the system.

We are keen to see this kind of preventative approach included within the Review of Adult Care. We believe that preventing or delaying the point at which a person's circumstances mean they need to access formal care services is critical to living independently and it can also help address current issues of high thresholds for assessment and delivery of personal social care.

The experience of staff working in the social care sector

The current pandemic has led to widespread recognition that housing, care and support staff are key workers, providing highly skilled, essential services which change people's lives, every day. However, the front-line support workers are also low-paid workers, usually on Scottish Living Wage and who can often earn more working in a supermarket. This may go some way to explain why many local authorities and other providers in the third and independent sector find it so difficult to recruit and retain care staff, resulting in insufficient services being available to meet identified levels of need.

It is also fair to say that with increasing requirements for training, registration, and focus on health and safety and PPE – which of course we fully support and invest in – many people find it more onerous than retail and hospitality sectors especially when allied with the daily responsibilities for delivering personal care in a wide variety of situations. As Scottish Care and CCPS point out the sector experiences high levels of turnover and Blackwood also experiences that despite offering good working conditions, paid travel, and so on. This is inefficient and militates against us building the commitment that many staff demonstrate in this sector on a consistent basis. The problems with agency care and agency spend are well documented and completely accord with Blackwood's experience especially in more pressured markets such as Edinburgh and Aberdeen. In several cases over the last few years we have reluctantly pulled out of some care at home services or reduced our exposure because of losing the fine margins on the business model.

We completely support the need for a fundamental review of the recognition and reward structure for social care workers that must lead to better reward, improved terms and conditions, high quality training and a recognised career structure.

In a separate issue on staffing, we notice a consistent difficulty in recruiting at team leader and manager level – we have successfully 'grown our own' staff to these roles but we believe it is worth considering the value and the competencies needed for these roles in the National Review. Team leaders and managers must manage systems, rotas, health and safety and facilities, and of course manage teams, with very different skills and attributes required than for personal care delivery which is the entry route.

Regulation, scrutiny and improvement of social care

We welcome the new Quality Frameworks introduced by the Care Inspectorate as the basis for the inspection of care services. Based upon the Health and Social Care Standards, the frameworks are person centred and place significant emphasis on the views and experience of customers and staff. The new Frameworks also encourage a more collaborative approach between inspectors and services focused on sharing and encouraging best practice and delivering improvement. However, the frameworks are designed to assess the quality of specific social care services e.g. care homes for older people, care homes for adults and we would welcome a more holistic approach that takes account of the whole range of service that allow people to live independently – care, technology and accessible housing. There are also clear opportunities for regulators and inspectors to make better use of video technology in particular, to engage more effectively with people who use care services.

Our experience during the Covid-19 pandemic has highlighted the tensions between scrutinising and supporting providers and creating additional burdens and costs. Our services have routinely been asked to provide similar data albeit in different formats to HSCPs, Health Protection Teams and the Care Inspectorate. They have also been asked to meet separately (virtually and in person) with representatives of all three organisations. There is clearly a need for a more coordinated approach across the various agencies with responsibility for the scrutiny of care services.

Commissioning and procurement

If we are to see the sort of integrated and holistic approach to the provision of support across care and support, accessible housing and technology that we have set out in this submission, an integrated approach to commissioning is vital. We would like to see all commissioners of support services for older people and younger adults with disabilities include housing and technology solutions in their market shaping statements. We also believe that there should be more joint commissioning across housing and social care.

We think there is scope to consider national approaches to commissioning so that each HSCP does not re-invent policy and we would like to see radically different thought given to how commissioning and procurement work. Significant amount of time and money goes into this both from providers like us and from the officers in HSCPs and local authorities. Currently we do not believe that this produces good value for the public pound or consistently better outcomes for people who use or need to use the services.

Whilst the focus of the Review is on Adult Social Care Support, there are significant numbers of people who are not currently eligible for formal social care support but

will become so if there is not more long-term sustainable investment in community based preventative approaches. The importance of prevention has been well recognised since the publication of the Christie report in 2011, yet there has been no significant shift of resources to allow real progress to be made. We believe that there is a real need for integrated commissioning of preventative services to target resources most effectively. For this approach to be most effective it will also need to involve real engagement and collaboration with people living in communities whose local knowledge can best inform the most effective approaches. Community and participatory budgeting offer real opportunities that should be fully exploited.

Currently we spend much of our time – and therefore money – on fulfilling tendering requirements and presenting this in multiple ways to renew our legitimacy to offer services. As we offer care in 13 HSCP areas it is a burden on our teams and reduces our fine margins even further, often adding to issues of sustainability. We would like to see exploration of simpler ways of ensuring cost and quality of providers such as a 'passport' potentially renewed at agreed intervals, along with a monitoring regime which focuses on reducing risk in services. In an ideal world this would also give providers a Quality mark and increase chances of a sustainable market, and in turn SDS customers could have more trust in how they proceed.

We have engaged in initiatives such as the Aberdeen Co-operative, and have worked with other housing associations to aim for neighbourhood offers but there is a need to have a much better overall framework on the procurement, commissioning and monitoring of service providers.

Finance

One of the perceived barriers to developing a truly integrated approach across social care, housing and technology is the fact that the planning and funding of these services remains siloed at a national and local level. At a governmental level housing and social care sit within different directorates and at a local level, planning and funding for social care sits with the Integration Joint Boards and Health and Social Care Partnerships, and local authorities, and housing is the responsibility of local authorities. Meanwhile the approach to technology remains patchy, dependent upon the level of interest and expertise within each local area.

Also, the enthusiasm at an organisational level for taking advantage of technology to give people more choice and control does not always filter down to staff on the frontline. Senior managers in Edinburgh gave excellent leadership in supporting us to establish our innovative Night Support Service. However, it required extensive engagement with HSCP frontline staff to convince them to make referrals to the service.

We believe there is value for Scotland in exploring modernised models of housing and care, especially with technology. We would like to see some cross- sector models from Health and Housing, with both Ministers 'owning' a pot of joint resources specifically designed to support prevention of needing to access hospital care, and to address the current issue of people stuck in hospital with no clinical need which the Health Cabinet Secretary asked to be addressed. This could be dedicated money in each HSCP area but with a shared system approach across Scotland.

Funding for more innovative cross cutting developments has tended to come from short term initiatives such as the Older People's Change Fund and Integrated Care Fund. Whilst this type of funding provides a welcome kickstart to get initiatives up and running, too often promising projects come to nothing because of a lack of mainstream funding once temporary resources come to an end. This start/stop approach is wasteful in terms of both resources and good ideas and needs to be addressed so that there is a sustainable pathway for mainstreaming innovation across care, housing and technology.

The role of adaptations within a strategic approach to help people live independently is important to consider in terms of funding. The same level of funding for adaptations has been in place for many years, always vastly outstripped by demand, with no recognition of the population changes and demand. While we recognise the pressure, it is critical in our view that the role is recognised, and the resources are adequate to meet demand which supports people to live independently.

Potential national aspects of a social care system

Our summary views on the national aspects of a social care systems are that we must base our system on supporting people to live independently, so that there is a strong policy driver. We strongly support the rights- based approach and the need for people to participate in designing the system and local delivery mechanisms. This could be backed up with a national system for 'passporting' providers so that HSCPs can draw down when needed.

We also believe a rights- based approach in care should recognise the fundamental requirement for people to have access to broadband or wifi and devices along with digital support so that this is not seen as optional.

The value of front- line support workers must be recognised and rewarded and a structure for appropriately trained and qualified team leaders/managers included. Much of the current role of SSSC and Care Inspectorate could be taken ahead and modified to fulfil a risk- based role.

The current digital focus within Health and Social Care should forge ahead and investment could be aligned with the 'passporting' of providers.

The role of Housing in Social Care should be recognised as the local preventative solution and models developed accordingly. This would update the old models of sheltered housing in many instances to a more targeted neighbourhood model with services which supply a range of tenures. If this is properly done it can also address the health inequalities in many instances which are still very prevalent among social tenants and poorer owners and private tenants.

Camphill Scotland

Camphill Scotland is the membership organisation for the 11 Camphill communities in Scotland. Together, our members support around 600 people with learning disabilities and other support needs, including children, young people, adults and older people. The communities are located in a variety of beautiful locations across Scotland, from Dumfries to Aberdeen. Each offers a supportive community life with personalised opportunities to find purpose and belonging through a wide range of social and cultural activities. Meaningful work and social enterprise play a key role within Camphill in Scotland.

1: Experience of staff working in social care sector

There is a general feeling across the wider social care sector that working in social care is not valued within our society. Reflecting this, the salary for working in a supermarket can often be equivalent to, or better than, that of a social care worker. This ignores the fact that the social care worker is expected to undertake professional training and to assume additional, high level duties and responsibilities, which can involve significant pressure and stress.

At the same time, however, there is also a feeling of a sense of vocation amongst staff working in social care, of forming genuine and caring relationships with people that use services, and that this sustains staff who otherwise might earn more money in an office or in a supermarket.

Within Camphill communities the experience of the staff, including international volunteer co-workers and foundation students, supporting other members of the communities with learning disabilities and other support needs, is generally very positive. In this respect, the Camphill communities in Scotland are fortunate to be in a position where they can, to a large extent, create the environment in which they work.

The Camphill communities in Scotland are also clearly operating in a very different environment from most other providers. Indeed, the experience of those living and working within Camphill communities in Scotland is, by comparison, unique. For the majority, this is an immersive experience in that the members of the 11 communities are living and working together in an intentional setting, in which few members of the community would define their experience as being ‘care staff’.

The positivity within Camphill communities is, in part, generated because people working in the individual communities feel that they are part of a mutually supportive organisation with a common ethos that aims to build authentic relationships with everyone including those, for example, who are in supported tenancies or day placements. This reciprocity creates a clear sense of meaning and value in what they are doing. It goes beyond being engaged to care for people to, instead, having a more holistic relationship.

2: Regulation, scrutiny and improvement of social care

Camphill Scotland supports the development of a regulatory regime, which is focused on improving care outcomes, rather than simply ticking boxes that, at best, will only give a false sense of reassurance to the public.

Against this background, Camphill Scotland believes that the Care Inspectorate methodology of continuous improvement, and of working in partnership with providers, is a positive aspiration. Our members’ experience of the Care Inspectorate, and of the latter’s inspections, are, however, mixed.

Reflecting this, some of our members reported that inspections tend to be based on dialogue, and on looking to help to improve services rather than on finding fault. These members highlighted that the experience of working with the Care Inspectorate feels like a partnership, which is particularly welcome, given that Camphill Scotland’s members are often significantly

different to other providers in terms of their approaches, and how they are staffed, managed and structured, and that their models of community living and shared life support may not easily fit generic registrations. By contrast, the experience of other members of Camphill Scotland of the Care Inspectorate was less positive. One member confirmed that, while it enjoyed an amicable relationship with the Care Inspectorate, there were too many examples where the Care Inspectorate reverts to 'type' as regulators. A recent example arose where the Care Inspectorate had a meeting with Camphill Scotland's members, and there was a discussion about success, including the sharing of positive feedback from Public Health Scotland's unannounced visits. The Care Inspectorate's representative's response was to highlight that the Care Inspectorate was increasing its regulatory activity in response to increased complaints, and that their follow up with Public Health Scotland visits showed that outcomes were not as initially reported by Public Health Scotland. Whilst the member acknowledged this may be correct, their concern was that the Care Inspectorate's response demonstrated more the hand of the regulator, than the actions of a partner body working with them, and understanding how Camphill was different from many other providers.

Regulation and standardisation of procedures, however, do not by themselves lead to good care. Camphill Scotland takes the view that good procedures should be based on best practice. "Good procedures" were, after all, put in place by Castlebeck, the company that ran Winterbourne View, a residential care home near Bristol where members of staff were sentenced for abusing people with learning disabilities.

The views of our members about relationships with the Commissioners of their services are mixed. Some of our members reported that such relationships, whilst generally amicable, do not involve the same level of meaningful dialogue, as they enjoy with the Care Inspectorate, and that the relationship with the Commissioners is much more transactional. By comparison, other members of Camphill Scotland reported that the Commissioners of their services are actively involved in working with them to review and to design services, and that they have a very good relationship with the Commissioners involving a higher level of meaningful dialogue than that enjoyed with the Care Inspectorate.

Camphill Scotland's members have also reported that there is a significant amount of duplication involved in the information requested by the Care Inspectorate, and by the Commissioners of their services. This can be very time consuming for our members.

Some of Camphill Scotland's members have confirmed that the direct involvement of social work support for them, and for the people that they support and their families, has reduced significantly. These members have reported that very few local authorities now pay even lip service to the notion of a statutory duty to be involved, to support and to review, and that their engagement with individual local authorities has been limited to the annual fee negotiation.

3: Human rights and ethics in social care

The human rights basis of the national care standards is welcome, and the need for a rights based approach has been underlined by the impact of Covid-19.

The pandemic has revealed (or confirmed) a major gap in how people who are receiving services are treated in comparison with members of the general public. The label "vulnerable" appears to have created a situation where basic human rights can simply be overridden under the banner of keeping people safe. In this respect, adults in residential care have been denied visits to them, and in many case been deprived the freedom of movement that was available to a much greater degree to the general population. They have been subject to the same measures applied to elder care and, as a result, have had restrictive and damaging limits placed upon them.

Many of Camphill Scotland's members are concerned that some local authorities seem to be using the public health crisis as a shield to cover cutbacks in services, particularly in the provision of day support and supported employment services. This trend has been accompanied by the spurious argument that people with learning disabilities and other support needs have coped well without these services throughout lock-down, and that these services are, therefore, not required going forward. Camphill Scotland believes that local authorities must consult the people who use and rely on these services, and their families, about any proposed cutbacks before making such potentially detrimental changes, which could have a major adverse impact upon the mental health and wellbeing of those requiring such services.

4: Commissioning and procurement

Camphill Scotland believes it is essential that procurement processes do not limit the possibilities for innovative or new ways of working to be supported and developed, particularly as our members' community models and staffing structures often cannot fit into current procurement frameworks.

Camphill Scotland takes the view that the focus of commissioning and procurement must be on what is right for the person requiring support and their needs, and not simply on the costs involved. We believe there is a need to encourage the development of a wide range of different services. Our concern is that, without addressing these issues, there is a real danger that procurement processes could lead to a situation where small local services are squeezed out, because on certain levels the latter might not have the infrastructure or resources to compete on price with larger, national providers.

5: National aspects of social care system

Camphill Scotland considers there is a need for a complete overhaul of our elder care provision. The deficiencies in elder care have been laid bare over the past few months and, as a society, we now have to give this the attention and resources it requires to bring about a radical change of approach.

Some of our members are also concerned that the creation of Health and Social Care Partnerships has left the smaller social care element very exposed in terms of the funding and resources, which will be required to address issues such as the future provision of elder care, and addressing the fall-out from Covid in terms of untreated health issues etc.

Camphill Scotland also believes that training in social care needs to be addressed. We take the view that the vocational model of SVQ's should be reviewed, and alternative models of training considered. This should include the models of training used in mainland Europe, where the approach to care training is far more rigorous, combining teaching and group led activities, and leading to a deeper understanding of the theory and practice required. Many of our members employ staff with European qualifications, based on a social pedagogical approach, and the difference in quality and relationship-based care that such training brings is significant, and merits further consideration.

6: Needs, rights and preferences of people using social care services and support

Grassroots organisations which remain small are more likely to remain close to the needs and preferences of people who use their services. Such organisations may have service users, and/or members of their families, on their Boards. Managers in such services are more likely to stay close to the work on the ground, and can be responsive when issues and challenges arise. By contrast, there is a risk that developing a national care service could result in a potential loss in quality from the loss of local diversity, which grows from local people getting together to form organisations. Quality comes through people. Putting in place national,

standardised systems would not guarantee a consistent approach to care provision, in which people receive care which meets their needs, and are kept safe.

7: Money and financing

Social care is in crisis. Camphill Scotland's members are involved, as providers in the third sector, in a constant battle to secure the funding necessary to ensure that they can continue to develop, and to improve, the care and support they provide for people with learning disabilities, and other support needs.

Camphill Scotland is aware that there are significant recruitment challenges across the social care sector. While the appreciation shown by the general public during the Lockdown was genuine and appreciated, we need to recognise that social care is not highly regarded as a profession, and that this has had an adverse effect upon recruitment.

There is also a risk that low pay and poor career progression across the social care sector will continue to undermine the possibility of improving care options for those requiring support. Camphill Scotland, therefore, believes it is vital that social care staff should be paid higher than the Scottish Living Wage, with salaries that reflect their professional skills and qualities. This would help to improve recruitment, and raise standards within the workforce. Goodwill, and a determination to do the best, can only be stretched so far!

Camphill Scotland's members have also expressed concern that the Scottish Government has not allocated any extra funding, unlike for supported living services, to ensure that there is parity for all staff in day services to ensure they are also paid the Living Wage. In addition, this is not reflected as an essential baseline cost when commissioning. Against this background, staff in day services can feel even more forgotten and undervalued as additional funding is directed at supported living services, but not in their service provision.

One member reported that, within their local authority area, the hourly rate for day services can be as low as £8.00 per hour. This means that there is absolutely no leeway to enable the development of services, and to access comprehensive training to support staff to gain formal qualifications, or to change the nature of the provision. The member also highlighted that the move towards outreach services would mean that individuals will not receive the same level of support, and would have very little choice in what options were available to meet their individual needs. Concern was also expressed that this development will have a significant, adverse impact upon the community links which are essential to their mental health and wellbeing.

Another factor which is creating uncertainty for Camphill Scotland's members is the potential impact of Brexit upon recruitment. Camphill has become a global movement, since the first Camphill community was set up in 1940 at Milltimber, Aberdeenshire by Austrian Jewish refugees from the Nazis. The Camphill movement is international in its outlook with more than 119 communities now established in 27 countries around the world. Camphill in Scotland has strong European roots, and citizens from other EU countries make a significant contribution to the work of the 11 Camphill communities, and to the care and support they provide for people with learning disabilities and other support needs. To put their contribution in perspective, a total of 170 (or 68%) of the 251 short-term co-workers currently living and working in Camphill communities in Scotland are from other EU countries, while 88 of the 165 (or 53%) of the long-term co-workers are from other EU countries. Camphill Scotland is concerned that Brexit, and the UK Government's introduction of the points based immigration system, could potentially have a significant, adverse impact upon our members' recruitment.

Capability Scotland

INDEPENDENT REVIEW OF ADULT SOCIAL CARE

SUBMISSION FROM CAPABILITY SCOTLAND

Thank you for the invitation to submit views & evidence to the review. We are pleased to offer you this paper as a contribution to your work.

About Capability Scotland

Capability Scotland delivers care, support and education for disabled children and adults across Scotland. Through our schools, and childcare services we support not only disabled children at crucial times in their life but their families and carers. We have many services which focus on giving disabled people the opportunity to live independent lives whether that is in their own homes, our residential services or participating in their local or wider community. We support more than 500 people and their families in Scotland, our total income for 2018/19 was £24.9m, of which 90% was from public funding.

We are a non-profit charity registered with the Office of the Scottish Charity Regulator (OSCR).

The third sector and "adult social care"

We would like to take the opportunity to set out what we believe "adult social care" is, and how we conceptualise it. We believe that this is important because the review comes at a time when "social care" is widely understood as relating principally to the personal care of older people, and even more specifically, those who live in care homes.

These people, and these homes, are extremely important and we recognise that what has happened since March has had a profound impact on them. We operate five care homes for adults with complex care needs. We also support people in their own homes and in the community.

Fundamentally, we see "social care" as a supportive relationship, in which we work alongside people who have significant challenges in their lives (disability; impairment; long-term condition; older age). We support them to retain or regain control of their own lives so that they can make their own decisions, live the life they choose and look forward to a better future. Where our system and our society make it very difficult for them to do that, then we work to ensure that the people we support are comfortable, cared for, enjoy greater peace of mind and still retain the ability to make as many of their own decisions as possible.

In this context, "social care" isn't a *service* (i.e. someone stepping in to do something that you can't do for yourself); rather it is a *vehicle* through which people can live their lives in a way that those of us without such challenges take for granted. In this sense, "social care" is not a

destination, end point or outcome in itself; it is the provision of support and assistance that allows people to achieve their own destination, end or outcome.

We see care & support as an investment in Scotland's people. We see it as a public good in & of itself, and as a means of preventing more acute stress & distress, or a deterioration in quality of life. In the public arena, it doesn't have a high profile: but when it is not available, lives are much the poorer for it: witness the huge levels of stress and distress experienced by people who have had their social care support removed or disrupted during the pandemic.

Good care & support can lead to reduced use of other, much more intensive and expensive public services. But that is not to say it's just a pressure valve for the NHS. It is a key public service in its own right.

The third sector has been providing good "social care" for decades, and certainly for much longer than the public sector. Capability Scotland have been in operation since 1946. Our mission and charitable objectives have been regularly reviewed and modernised, but they remain fundamentally unchanged.

The emergence of "adult social care"

Over time, this concept of a supportive relationship has been overlaid by a significant architecture of policy, legislation and regulation that has conferred important rights on people who need support and placed commensurate duties on public bodies.

This architecture has also had the effect of codifying care & support into:

- category definitions ('settings' – care homes, day centres, care at home)
- practitioner tasks ('personal care', 'housing support')
- organisational and practice standards
- service specifications
- contract conditions.

Some of this codification has been developed, we believe, primarily for budgetary and monitoring purposes.

The third sector strives to maintain its basic proposition of a supportive relationship within the confines of this architecture. Some of it is helpful (the conferring of rights, a shared understanding of quality), some of it less so (rigid service categories, time & task specifications, transfer of financial risk through contractual conditions).

But we have, arguably, reached a point where the codification has in effect become the service, now described as "adult social care". People are assessed as "needing" 20 hours of home care a week; "needing" four 15-minute visits a day; or "needing" a permanent care home place. This is what is meant by social care having become 'service-led': the system responds to need by deciding the quantity or volume of service that it will allocate to each person, from a range of services that it has decided to provide.

The development and introduction of self-directed support (SDS) was intended to change all this: assessment of need was to shift away from considerations of what people couldn't do (and therefore needed help with), towards a discussion about "outcomes", and the things that people would like to be supported to achieve. But self-directed support has not had the transformational impact that we had hoped for: that is partly the result of poor implementation, but we believe it is also because the system architecture that we have described above has remained largely unchanged, rendering SDS the proverbial square peg in a round hole.

So, our key interest, now, is in how we can **reset the system** so that it focuses on the following key dimensions of good care & support:

- "Care" as a supportive relationship and a vehicle to good lives, full citizenship and the exercise of human rights; **not** as a series of pre-determined tasks, or setting-based services
- Real choice & control for people in how their needs are met and how their support is delivered
- A rich diversity of support providers and approaches
- Robust & independent critical challenge applied to the whole system, not just to "services"
- Fair Work, and real professional autonomy, for people employed in care & support, whoever their employer
- Collaboration between agencies, not competition: partnerships of equals, sharing of risks, transparency of financial arrangements
- Investment in care & support as a public good.

This, in effect, represents our agenda for "adult social care". In this context, we note the **key areas being considered and explored by the review**, and we would comment briefly on each, as follows.

1. Needs, rights and preferences of people using social care services and supports

Assessment of "need", as noted above, is often service led, locking us into a cycle of commissioning (and re-commissioning) the same services again and again, because people "need" them. ***We would encourage the review to consider how to break this cycle.***

Service-led assessments, coupled with the application of eligibility criteria based on urgency or criticality of need, undermine the agenda for prevention & early intervention, since the focus is often purely on "personal care". Social care is, or should be, about whole lives, but other types of support can remain excluded (and unfunded). ***We would encourage the review to consider how to expand the scope of funded social care to include less "formal", currently non-commissioned support.***

The rights conferred on people with care & support needs are scattered across various legislative instruments. ***We would encourage the review to consider bringing them together in a single "Bill of Rights", at a national level.***

Self-directed support (SDS), and its focus on people's needs, rights and preferences, should be the foundation of any changes to the social care system in Scotland. SDS remains largely misunderstood and poorly implemented; other parts of the system have not been adjusted in order to support it (especially procurement) and the shift of power required to make it work has not happened. ***We would encourage the review to consider how best to 'turbo-charge' the adoption and implementation of SDS.***

There is insufficient critical challenge applied to systems and decisions that (appear to) undermine the rights of individuals, and the principles of SDS, including many procurement decisions. ***We would encourage the review to consider how to strengthen our collective ability to challenge poor decision-making without recourse to the courts, particularly where people's rights are concerned.***

Linked to the above, independent advocacy is essential in ensuring that people's rights are respected. ***We would encourage the review to consider how best to support, expand and strengthen it.***

2. The experience of staff working in the social care sector

Evidence shows that most people working in third sector care & support enjoy their work and are committed to it. ***We would encourage the review to avoid being drawn into a narrative that characterises care & support workers as dissatisfied and unfulfilled; at the same time it should consider how best to support the good employers in our sector to continue nurturing and developing their staff.***

Third sector staff and employers are generally supportive of the aims of professional registration and regulation, but our collective aspirations for a competent, confident & qualified workforce are undermined both by the characterisation of care work as 'low-skilled', and the associated trend towards low pay. This is not unrelated, in our view, to the workforce being composed predominantly of women. We are also aware that in the context of health & social care integration, some NHS colleagues remain unaware that care & support is regulated, with a qualifications-based registration process. ***We would encourage the review to consider how best to ensure that our professional aspirations are reflected in awareness, status, esteem and reward.***

The codification of social care into a set of tasks, categories and standards, combined with high levels of monitoring, compliance and regulation, has served to undermine the autonomy of care & support workers; this has contributed to the perception of social care as low-skilled. We support the conclusions of the Fair Work Convention's report into social care in this regard, and its recommendations. ***We would encourage the review to examine the report's findings in this area, and to consider ways in which greater professional autonomy can be restored to care & support work.***

Training, development, supervision, and support are critically important but are often under significant financial pressure. The original National Workforce Strategy for care & support recommended 5% of service costs as a benchmark for investment in training & development, but this has rarely been recognised in funding arrangements. ***We would encourage the review to consider how to support wider recognition of the need for investment in these areas.***

Competitive tendering for social care contracts led to a significant 'casualisation' of the workforce, as staff were transferred from employer to employer under TUPE. This type of mass staff transfer has become less common since the introduction of framework contracts, however the risk remains, and framework contracts can lead to major problems of workforce planning & stability since they offer no guarantee of volume of business. ***We would encourage the review to consider the impact of competitive tendering, and of framework contracts, on the workforce, and examine alternative ways of commissioning care & support (see below).***

Health & social care partnerships and local authorities rarely support the third sector to implement all the dimensions of Fair Work – particularly pay, terms & conditions – that they implement themselves, as employers of their own staff. This is unjust, inequitable and in our view, indefensible in the context of a national approach to Fair Work and to professional registration, qualifications, standards and conduct. ***We would encourage the review to seek to dismantle the "two-tier" workforce and ensure parity of status, esteem and reward across all sectors.***

3. Regulation, scrutiny and improvement of social care

Whilst there are excellent (and poor) providers in every sector, third sector care & support overall is consistently awarded the highest proportion of "very good" and "excellent" Care Inspectorate gradings in all "adult social care" categories compared to its public and private sector counterparts. ***We would encourage the review to consider how best to capture learning from the third sector's record of high quality and use it to inform improvement initiatives across all sectors.***

A joint approach to health & social care regulation, scrutiny and improvement can prove valuable (for example, ongoing joint HIS and Care Inspectorate inspections in key areas). However, we strongly support the continuation of a discrete regulatory system that focuses on social care specifically, given the important distinction between health care (in particular, acute health care) and social care support. ***We would encourage the review to ensure that a focus on social care support remains in any future system, and that it is not subsumed by more clinical interpretations of safety, assurance and quality.***

The third sector supports the ongoing shift away from 'tick-box' regulation & inspection towards self-evaluation and improvement. We do not believe that quality can be "inspected in", although we are mindful of the regulator's role in protecting individuals and providing public assurance. ***We would encourage the review to ensure that scrutiny continues to***

develop its focus on self-evaluation & improvement and improves, in turn, its own ability to measure performance & quality on the basis of experiences and outcomes for people, rather than provider compliance with policy and process.

The regulatory system and its powers of enforcement focus almost exclusively on "services" rather than on the system more broadly: there should be much more robust critical challenge in other areas including assessment processes, resource allocation and commissioning & procurement. ***We would encourage the review to revisit, extend and strengthen both the scope and the powers of scrutiny bodies along these lines.***

4. Human rights and ethics in social care

Social care support is a human rights issue: without social care, people with support needs may be unable to access or exercise their human rights (e.g. to work, to family life, to freedom of movement, to democracy). ***We would encourage the review to ensure that any future social care system is aligned with relevant UN Conventions (including UNCRC and UNCRPD).***

There are long-standing concerns about the extent to which people's human rights in the context of social care support may be re-interpreted in the light of budgetary considerations. Probably the most stark example of this was played out in the case of R vs. Royal Borough of Kensington & Chelsea (we understand that there have been similar instances in Scotland). ***We would encourage the review to consider this case, and others like it, and to clarify where it believes a Scottish future social care system should stand, in particular on the question of how far the human rights of individuals should be considered subordinate to the needs of a population to have basic social care needs met, within a limited budget.***

Social care support itself must adhere to high ethical standards and human rights principles. In this context, we are concerned by the issues that arose in relation to Covid-19 including, for example, access to hospital care for older people receiving social care support; application of 'DNR' orders for disabled people using social care services, without consultation; restrictions on family contact for care home residents; lifting of assessment requirements under emergency legislation, and so on. As noted in (1.) and (3.) above, there is little critical challenge to these decisions and practices, and insufficient access to independent advocacy in relation to them. Added to this, successive reports on human rights breaches in the context of social care (the most recent being the SHRC report on social care during Covid19, published in October 2020) tend not to be followed up by any significant change. We believe that without enforcement, a human rights position is ultimately meaningless; yet court action is out of reach for many. ***We would encourage the review to consider how best to introduce greater, rights-based critical challenge with "teeth", beyond court proceedings.***

Considerations of ethics in care & support commissioning & procurement have been usefully addressed in Unison's "ethical care charter". Whilst we are generally supportive of the charter, it does not address head-on the need for commissioning authorities to pay a competent rate for care, particularly if providers are to implement better pay & conditions,

and Fair Work. ***We would encourage the review to establish a clear line of sight between high ethical standards and the level of budget required to underpin them.***

5. Commissioning and procurement

We are a member of CCPS who have researched & written extensively about the negative impact and consequences of current approaches to procurement – in particular, routine & cyclical competitive tendering and re-tendering – for the workforce, for our sector, for the market, and for the people we support. ***We support their recommendation to encourage the review to consider carefully their work in this area, and to consider, equally, the absence of any comparable body of work that points to the beneficial outcomes of tendering for care.***

Most approaches to procurement, as currently conducted, are antithetical to the principles of self-directed support, since they position care services primarily as business opportunities for providers, not as a means to good lives for people; and they place decision-making capability squarely in the hands of public authorities, not the people we support. CCPS have produced briefings on this. ***We would encourage the review to interrogate procurement policy & practice, and those who advocate for their application to care & support, with respect to the suitability of these processes to care & support as we have conceptualised it.***

In the context of the dominance of competitive tendering as the primary means of arranging care & support provision, we have adopted two responses: first, to ensure that if competitive tendering is the approach taken, then at the very least it must be conducted in accordance with guidance (guidance that CCPS instigated, and continue to promote); and second, to explore the potential of alternative, more collaborative approaches

In the context of commissioning & procurement and proposals for reform, there are a number of myths about providers that we are keen to dispel, including for example that there are "too many providers", or that providers are incapable of collaborating with each other. In our experience, the "too many providers" narrative is most frequently adopted by authorities whose primary concern is to reduce their transaction costs, rather than to offer choice & diversity to people; whilst the record of collaboration among providers, considering that they are encouraged to compete against each other, is very strong (see for example CCPS work to support collaborative providers). ***We would encourage the review to interrogate and challenge these and other myths, should they be encountered in the course of your work.***

In order to shift commissioning practice & culture away from competitive tendering and towards more collaborative approaches, we believe that it will take a major change programme: well-funded, well-led, with buy-in from all stakeholders. ***We would encourage the review to recommend the establishment of such a programme as a key plank of reform of the Scottish social care system.***

6. Finance

Capability Scotland has no fixed organisational view about how any additional investment in care & support should be financed, be it through higher tax rates, altered priorities, the

introduction of specific insurance schemes, and so on. We believe that this is a question to be addressed by political leaders in full consultation with the public. ***We would encourage the review to approach this question from the perspective of a renewal or renegotiation of the 'social contract' between the state and citizens.***

Third sector providers like ourselves are rarely in a position whereby the funding they receive (under contract or other arrangement) covers their full costs. Research findings over many years have consistently indicated that third sector organisations either run a fair proportion of services at a deficit, and/or subsidise them from other income sources, including reserves. From our perspective then, there is not enough money in the system – at least, not enough of it is coming our way. What we cannot say with any confidence is that resources are always applied efficiently throughout the system: we are aware, for example, that many services provided by local authorities directly are vastly more expensive than comparable services we provide ourselves, with no commensurate increase in quality. Similarly, we know that our sector provides a much greater proportion of care & support in some areas (for example, learning disability) than the proportion of the overall budget that it receives. ***We would encourage the review to seek analysis of spend in terms of volume, efficiency and outcomes achieved, by sector, as well as addressing the matter of overall funding levels.***

Accountability, transparency and equity are key financial issues for our sector. As noted, we see significant problems with the current 'two-tier' system in which 'in-house' care & support is routinely funded more generously than commissioned support; and we experience major problems with the absence of any effective ring-fencing of resources or monitoring of spend. This is very starkly revealed by the huge difficulties that third sector organisations have experienced in accessing the multi-millions allocated to public bodies to support additional social care spend arising from Covid-19. In general, third sector finances are minutely scrutinised whilst comparatively little independent scrutiny is applied to public expenditure on social care. ***We would encourage the review to address these issues as a matter of urgency: every citizen, regardless of who provides their care & support, ought to be confident that the same financial rules and standards apply to all organisations in all sectors.***

7. Potential national aspects of a social care system

A number of figures and organisations have proposed the establishment of a National Care Service. We are cautious about these proposals, both because they appear to lack any substantive detail about how such a service might operate in practice, and because they appear to over-simplify either the problem (for example, private care being inherently 'wrong') or the solution (for example, that social care should in effect be 'nationalised' and delivered by the public sector alone). ***We would encourage the review to resist 'pre-cooked' solutions that do not address, in detail, long-standing flaws in the existing system, and that run counter to agreed principles (most prominently, the availability of choice & control for people over their support).***

A further narrative surrounding proposals for a National Care Service relates to the perceived fragmentation of the social care system, containing as it does several hundred separate providers and employers, each one accountable to its own governance structure rather than a national structure as for the NHS. We hear that it was this fragmentation that led, for example, to problems of PPE distribution, and the introduction of effective infection prevention & control measures. We strongly reject this narrative: rather, from our perspective, we understand these problems to have arisen from an almost complete failure to treat third sector providers as part of the existing system, and as equal partners within it. Again, this is not new. Addressing this, we believe, would be a far better way of streamlining the system than the introduction of a top-down, command-and-control model of governance. ***We would encourage the review to interrogate such proposals rigorously and test their ability to solve the problems to which they present themselves as the answer.***

A key strength of the current social care system in Scotland is that the third sector can be mobilised to deliver high quality, localised support that people need & want in order to live good lives. In that sense there already is a National Care Service, or at least the framework for one, and a significant development in this regard would be to seek to standardise provision and quality of support to the level provided by our sector, and/or to support our sector to take on a greater role than its current one-third 'market share'. ***We would encourage the review to build on success and explore how the system might support & enable providers of high quality care to do more.***

Registration & regulation of care was put on a national footing for the first time in 2001; since then, all providers – public, private and third sector – have been subject to the same regime of independent regulation and inspection against the same national standards. Prior to that, arrangements were largely local. There may be other areas of care & support where a move from a local to a national approach, with appropriate standards across the board, may be beneficial, for example: the application of eligibility criteria; availability of, and access to, specific types of support; implementation and operation of SDS; and approaches to charging for care. ***We would encourage the review to consider these areas.***

One of the most significant shortcomings in our existing system, exposed by the experience of Covid-19 but pre-existing it, is the failure to deliver Fair Work to all care & support staff, and in particular, the poor terms and conditions available to staff predominantly in the private sector (Statutory Sick Pay being a particular feature highlighted during the ongoing crisis). There are mixed views in our sector about the wisdom of standardising terms & conditions across the board at a national level – simply because of the risk of thereby compromising the diversity of support available to people – however there is a strong view that the current two-tier system cannot be allowed to continue (see (2.) above). As above, then, ***we would encourage the review to seek to dismantle the "two-tier" workforce and ensure parity of status, esteem and reward across all sectors.***

Also, as above, in section (1.), we would note again that the rights conferred on people with care & support needs are scattered across various legislative instruments. ***We would***

encourage the review to consider bringing them together in a single "Bill of Rights", at a national level.

In the ongoing debate about what is best decided or organised nationally, rather than locally, we would want to question the extent to which local government or health & social care partnership boundaries are themselves an appropriate reflection of what people understand to be 'local'. This has been a subject of debate since health & social care integration policy required the identification of 'localities' for planning purposes, and that debate remains live. ***We would encourage the review not to limit itself by considering 'local' decision making or discretion to be entirely synonymous with local authority decision making, but to consider further dimensions of locality.***

Carers of East Lothian

Independent Review of Adult Social Care

Carers of East Lothian Response

Carers of East Lothian exists to support all adults in a caring situation in East Lothian to get information and services to help their individual caring role, enhance their own wellbeing, and strengthen their collective voice to improve services.

We welcome this opportunity to contribute to such a significant Review of Adult Social Care in Scotland, ensuring that the voice of carers, and their organisations, are part of this important process.

This Review comes at a difficult time for carers, who are reporting increased stress and pressure, both locally and through national research (*Carers Week 2020 Research Report, Carers UK*). We have seen increased demand for our Counselling Service and all our workers report carers needing significantly more emotional support in recent times. It is more important than ever to ensure that our social care system properly supports, and involves, everyone who needs it, including unpaid carers.

Valuing Care

Unpaid carers throughout Scotland provide significantly more care than the health and social care workforce combined. When supported well, carers make a hugely positive contribution to the lives of those they care for and society as a whole. A successful social care system must recognise the value of carers by investing in them directly, as well as in the services that support them, with long-term funding that can be used in a preventative way.

Paid care work must also be properly valued to support a more effective social care system. This means better pay for these important roles as well as a proper career structure that encourages talent to join and progress in this field. Without a robust social care workforce, many unpaid carers have to reduce their own working hours, or give up work altogether, in order to fill the gaps in available support, with wider economic implications, including in terms of tax revenue. We know that women are more likely to take on caring roles than men, and research from Carers UK shows that women aged 45 - 54 are more than twice as likely to have reduced their working hours as a result of their caring responsibilities (*Facts About Carers, 2015, Carers UK*). Women will therefore suffer a disproportionate economic impact from a system that lacks adequate capacity.

Supporting Choice and Control

Despite the Social Care (Self-directed Support) (Scotland) Act (SDS Act), there is still a lack of creative and flexible approaches to care, with many care packages still being set up to fit around service providers rather than around service users and carers. Many people still do not have the choice and control envisioned by the Act, with difficulties in accessing respite, day care services or home care agency support limiting meaningful choice. Locally, we know that agencies can struggle to recruit and retain workers, connected to the limited pay and career progression opportunities associated with this type of work.

Consistency

Carers not only tell us about difficulties in accessing respite, day care services or home care agency support, some also report a lack of involvement in hospital discharge and many say they find the systems and processes involved in accessing social care complicated and hard to navigate. These difficulties are compounded by a lack of consistency across Scotland, making it harder for people to understand and realise their rights under the relevant legislation.

The opportunity for the Review to consider a National Care Service is exciting. We recognise the implementation gap around recent key legislation relating to social care (particularly the SDS Act, the Carers (Scotland) Act and the Public Bodies (Joint Working) Act) and would support any activity that will give rise to a greater level of consistency for carers, and service users, throughout Scotland. However, that is not to say that a one-size fits all model would be appropriate. We have seen some excellent joint working and quick action locally, for example in ensuring access to PPE and flexibility of direct financial support for carers through individual grant schemes, and note the value of local support and provision in working responsively with carers. Ultimately, we believe that all carers, and service users, should be able to expect the same high-quality, person-centred, preventative support no matter where they live in Scotland.

Funding

Adequate funding for a successful social care system is essential. To be most effective, investment needs to be long-term and focused on prevention. We believe that to achieve this the Review should consider taking a human rights based approach towards budgeting for the cost of social care in Scotland, and certainly must ensure that any recommendations are fully costed with adequate additional funding made available.

Continuous Improvement

We believe that the involvement of carers, and service users, is crucial to continuous improvement within social care. Systems like *Care Opinion* support greater accountability of providers, including HSCPs, but rely on them engaging with this process. An agreed, Scotland-wide, approach to this type of direct engagement with those who use social care services would support greater transparency, accountability, and continuous improvement. In addition, carers' voices must be heard more strongly at every level in planning and decision-making on social care to ensure that services evolve to be fit for purpose in the future.

As a member of the Coalition of Carers in Scotland, Carers Scotland, and Shared Care Scotland, we fully support the response to this Independent Review from the National Carer Organisations, in particular the key principles and features they outline that should underpin any social care system.

Carers of East Lothian note the detailed response to this Independent Review from East Lothian Integration Joint Board (IJB) and support their call for national action to maintain and where required, increase, capacity across social care. We agree that the opportunity for a greater focus on individual outcomes could be one benefit from such increased capacity, and that any recommendations from the Review should be fully costed and supported with adequate additional funding. We recognise the challenges the IJB acknowledge in ensuring local people's voices are heard as part of strategic decision-making. Carers of East Lothian are equally committed to advancement in this area, to ensure that the starting point for the development of social care services is to listen to the voices of those who use them, their families and carers, as it must also be at national level.

CCPS - Coalition of Care and support Providers in Scotland

The independent review of adult social care in Scotland
Commissioning and procurement submission from CCPS

2nd October 2020

The current context

The architecture of social care commissioning and procurement is 'perfectly designed to get the results it gets'[1]. The problem, as we see it, is that the results we are getting aren't working for supported people, providers or statutory partners. As commissioning and procurement processes underpin how social care operates in practice they are foundational to a system that works well for people.

Introduced in 2006 [2], procurement practice was intended to bring increased transparency, fairness and 'best value' to the way that social care and support was funded. Procurement legislation and practice then created a monopsony – a form of quasi- market where the contracting authority is the primary purchaser. As monopsonies allow the purchaser to control both price and specification this is an initially attractive solution for financially pressured public sector organisations.

However longer term monopsonies actually destabilise markets and make them fragile. [3]This is particularly acute where price is a determining factor and margins are tight as all but the largest providers exit the market.[4]leads both to increased financial risk for contracting authorities and crucially a reduction in the range and diversity of care and support for people as well as the loss of specialist supports and a drive towards genericism.

Self- directed Support (SDS) was brought into legislation in 2013[5] with the intention of increasing choice and control for supported people. The legislation set out four options for how much control a person wanted to have over the money for their support as well as a duty on local authorities to promote a 'range of providers and types of support' in order to ensure meaningful choice for service users. Fully and properly implemented SDS has the

[1]Edward Deming (attrib) https://deming.org

[2]The Public Contracts (Scotland) Regulations, 2006 https://www.legislation.gov.uk/ssi/2006/1/contents now superseded by The Procurement Reform (Scotland) Act, 2014 and associated 2015 and 2016 guidance https://www.legislation.gov.uk/asp/2014/12/contents

[3] Evans, K (2016) "*Public markets aren't working for the public good, or as markets" in* "Kittens are Evil: Little Heresies in Public Policy: https://www.childrenengland.org.uk/Handlers/Download.ashx?IDMF=b32ab2da-5662-44ad-885b-f5d334d31f23

[4] Cunningham et al (2019) *Handing Back Contracts: exploring the rising trend in third sector provider withdrawal from the social care market*" http://www.ccpscotland.org/resources/handing-back-contracts-exploring-the-rising-trend-in-third-sector-provider-withdrawal-from-the-social-care-market/

[5] Social Care (Self-directed Support) (Scotland) Act, 2015 https://www.legislation.gov.uk/asp/2013/1/contents/enacted

potential to move social care to a far more stable market form where the individual becomes, in effect their own commissioner; financial risk is spread across multiple providers and people have choice.

It is argued that, applied correctly our legislative framework allows for flexible collaborative choice- promoting procurement[6] arguing that the source of the problem is poor implementation and risk adverse practice.[7]

However no matter the skill of the procurement officer, commissioner and provider the system is based on competition, not collaboration. This raises the fundamental question- are we simply going to 'do the wrong thing righter' or reform our current system that places business before relationships and price and process before people?

The possible futures

Over the last three months CCPS members have worked together to produce a set of 'Big Ideas' . These are not blue-prints, silver bullets or off the shelf solutions but rather practical thought- through approaches to resetting the system that are grounded both in the research and first- hand provider experience.

Selected research and resources

"Nice People; Terrible System" (2017) surveyed over sixty providers to understand their experience of commissioning and procurement. Respondents noted:

- That competitive tendering destroys the very relationships that are crucial to success in social care.
- That collaboration is poorly understood and there is a significant lack of skills and experience in collaborative working in the system.
- Process and requirements in procurement and contract monitoring are disproportionate and burdensome.
- Skilful commissioning supports relationships and innovation but is often derailed by competitive tendering.

Fraser, D (2017) " Nice People; Terrible System: provider experiences of procurement and commissioning", CCPS

Handing Back Contracts: exploring the rising trend in third sector provider withdrawal from the social care market" (2019)

[6]Fallas, R (2019) Self- directed Support and Procurement Practice: Key Points and Mythbusting Social Work Scotland: Macroberts LLP https://socialworkscotland.org/wp-content/uploads/2018/09/Self-directed-Support-and-Prcocurement-Best-Practice.pdf

[7] Dickinson, H (2020) "The Elephant in the Room: Public Servants and Implementation" in The Palgrave Handbook of the Public Servant https://link.springer.com/referenceworkentry/10.1007%2F978-3-030-03008-7_107-1

This piece of University of Strathclyde research explores the rising trend of provider withdrawal from the market. Key findings include:

- The majority of respondents reported withdrawing from more than one contract- most of these relating to care at home services.
- Prior to handing back services, organisations could run significant annual deficits on individual contracts that ranged from £20K to £100,000. For some organisations, cumulative deficits over a number of services could reach over £1m.
- The financial viability of individual contracts and the implications of persistent deficits on the overall financial wellbeing of provider organisations, especially the draining of reserves, was often seen as the key reason behind management's decision to withdraw.
- Uncertainty caused by a lack of critical mass and fluctuations in volume of delivered services also contributed to the financial pressures faced by providers, and their decisions to withdraw.

Cunningham et al (2019) Handing Back Contracts: exploring the rising trend in third sector provider withdrawal from the social care market"

Commissioning and Funding in complexity (2017 and 2019)

Research that sets out a potential radical shift in the commissioning and procurement function from control of resources to 'systems stewardship'. This research is supported by a practice network facilitated by Dr Lowe for live learning about this approach in practice.

Davidson Knight, A; Lowe, T; Brossard, M and Wilson , J (2017) *"A Whole New World: Funding and Commissioning in Complexity"* Collaborate: Univ of Newcastle

Lowe,T and Plimmer, D (2019) Exploring the new world: "*Practical insights for funding, commissioning and managing in complexity."* Collaborate: Univ, of Newcastle.

All together: A new future for commissioning human services in New South Wales (2020)

An example of provider led commissioning reform in collaboration with the Sydney Policy Lab. This thorough piece explores what commissioning should be; how it can be done well and what reform in NSW could look like.

Goodwin, S.; Stears, M; Riboldi, M.; Fishwick, E.; Fennis, L. "All together: A new future for commissioning human services in New South Wales," Sydney Policy Lab, University of Sydney (April 2020)

About the programme

The Commissioning & Procurement programme is hosted by CCPS and works with organisations across the sectors to improve the way that care and support is planned, purchased and paid for.

Information – Research - Workshops - Action Learning- Policy – Facilitation – Development

The programme is funded by the Mental Health and Social Care Directorate Scottish Government.

About CCPS

CCPS' membership comprises over eighty of the most substantial not for profit care and support providers. Our member provide high quality support for adults with disabilities, people with learning disabilities older people; community and criminal justice; children and families those experiencing homelessness and those with problematic drug or alcohol use.

CCPS works to champion the quality support provided by not for profit providers. Challenge and improve the policy and practice environment to allow the sector to flourish. Prepare providers for current and future challenges and opportunities and support providers' understanding and ability negotiate and influence their complex operating environment.

CCPS is a registered charity (SCO 29199).

www.ccpscotland.org

Close the Gap

Close the Gap submission to the Independent Review of Adult Social Care

November 2020

Close the Gap is Scotland's policy advocacy organisation working on women's labour market participation. We have been working with policymakers, employers and employees since 2001 to influence and enable action that will address the causes of women's labour market inequality.

1. Introduction

Care is profoundly gendered. Women do the bulk of unpaid and informal care and comprise 85% of the social care workforce in Scotland.[1] Social care is vital to women's lives, as workers and as service users, and to the functioning of Scotland's economy. Investment in the workforce is core to providing high quality personalised care. Despite this, the social care workforce is underpaid, undervalued and under-protected.[2]

Early in the pandemic social care workers were designated key workers by Scottish Government, reflecting their essential role in society and in the response to the COVID-19 crisis. The pandemic rendered social care work more visible and a marked shift in societal attitudes around the low pay and poor terms and conditions associated with this work. While this recognition is welcome, it is not enough. It is crucial that investment in social care, with particular interventions to address the undervaluation of the workforce, are core to economic recovery.

Care is as essential to our economy as bricks, steel, and fibre optic cable.[3] Research by the Women's Budget Group also found that investment in care is an effective way to stimulate employment, reduce the gender employment gap and to counter economic recession.[4] This research found that investment in care in the UK would produce 2.7 times as many jobs as an equivalent investment in construction. Furthermore investment in care is greener than investment in construction and more

[1] Scottish Social Services Council (2019) *Scottish Social Service Sector: Report on 2018 Workforce Data*
[2] Close the Gap and Engender (2020) *Gender and Economic Recovery*
[3] Ibid
[4] Women's Budget Group (2020) *A Care-led Recovery from Coronavirus: The case for investment in care as a better post-pandemic economic stimulus than investment in construction* https://wbg.org.uk/wp-content/uploads/2020/06/Care-led-recovery-final.pdf

of its costs would be recouped in increased income tax and National Insurance contributions.

The need for social care reform is a longstanding issue, reflected by a range of commitments that long pre-date the COVID-19 crisis. The Scottish Government commenced its programme of reform of adult social care in 2016, explicitly recognising social care as an "investment in Scotland's people, society and economy".[5] The Report of the Fair Work Convention's Social Care Inquiry acknowledged that the undervaluation of social care work is "to a significant extent, linked to the predominance of women workers in the sector"[6] and made recommendations to tackle the low pay and poor terms and conditions of this work. A Fairer Scotland for Women, Scotland's gender pay gap action plan commits to "[d]evelop an approach to treat investment in childcare and social care as economic infrastructure" and to work with the Fair Work Convention on implementing its recommendations on social care.[7]

The Independent Review of Adult Social Care (IRASC) must recognise that many of the challenges identified with the system, and particularly the workforce challenges, are a cause and consequence of gender inequality. It is pivotal that the Review makes recommendations that address the undervaluation of care workers as a central aim of reform.

Close the Gap welcomes the opportunity to contribute evidence to the IRASC. As Close the Gap's area of expertise is gender and the labour market, our submission focuses on addressing the gendered undervaluation of the social care workforce and the importance of delivering fair work for women in the sector. We welcome the inclusion of the experiences of the social care workforce in the Review, but this must include their employment conditions if the Review is to address the social care system and the necessary reforms in its entirety. In doing so, we urge the Review to apply a gendered lens when considering evidence and making recommendations.

2. Care work and COVID-19

The ongoing COVID-19 crisis has further highlighted pre-existing issues in social care provision, including the undervaluation of the predominantly female social care workforce. However, from the outset, and prior to, the pandemic, government responses failed to adequately respond to the clear risks in the sector and effectively deprioritised the safety of social care staff in relation to NHS staff.

[5] https://www.gov.scot/policies/social-care/reforming-adult-social-care/
[6] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[7] Scottish Government (2019) *A Fairer Scotland for Women: Scotland's gender pay gap action plan*

Over the course of the crisis, there have been widely reported concerns around PPE for social care staff. The Royal College of Nursing have raised particular concerns around access to PPE for staff working outside of a hospital environment, including care home staff,[8] and an analysis by National Records of Scotland identified that social care workers are more than twice as likely to die from COVID-19 as colleagues on the NHS frontline.[9] UK-level data revealed that 76% of all worker COVID-19 reports made by employers to the Health and Safety Executive and local authorities were in the Human Health and Social Work activities sector, with 34% of all reports located in Residential Care Activities.[10] Sectoral data is not available at a Scotland-level. Taken alongside the fact that women were 77% of all worker COVID-19 reports in the UK and 75% of reports in Scotland[11], and women are the majority of the social care workforce, it is highly likely that women's concentration in social care work placed them at greater risk of the virus.

Exercise Cygnus, the 2016 cross-government exercise to test the UK's response to a serious influenza pandemic highlighted the potential for a devastating impact on social care. The report made recommendations including an audit of care home capacity, "ring-fenced" funds, provision of PPE and active engagement with providers on the vital issue of "surge capacity".[12] Despite this, no action was taken in response to the recommendations, with the report noting that "little attention paid to this sector by ministers during the [Cygnus] Cobra meetings".[13] Social care providers have stated that they were not contacted about pandemic planning.[14] The sector was therefore unprepared and its service users and workforce underprotected. For some time following the outbreak of COVID-19 hundreds of patients were moved from hospitals into care homes, including patients who had not been tested and those who had tested positive prior to transfer[15]. This ultimately resulted in rapid spreading of the virus in the sector and many residents dying from COVID-19, along with social care staff.

3. The gendered undervaluation of social care work

[8] Royal College of Nursing (2020) 'Nurse leader calls on First Minister to intervene on protective equipment supply' available at https://www.rcn.org.uk/news-and-events/news/rcn-writes-to-fm-re-ppe-23-mar-2020
[9] McArdle, Helen (2020) 'Social care workers twice as likely to die from Covid as colleagues on NHS frontline', *The Herald,* 18th June 2020, available at https://www.heraldscotland.com/news/18524205.coronavirus-social-care-workers-twice-likely- ovid-colleagues-nhs-frontline/
[10] https://www.hse.gov.uk/statistics/coronavirus/april-to-july-2020-technical-summary-of-data.htm
[11] Ibid
[12] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/927770/exercise-cygnus-report.pdf
[13] Ibid
[14] Ibid
[15] https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/discharges-from-nhsscotland-hospitals-to-care-homes/

The concept of undervaluation underpins gendered experiences of low pay, occupational segregation and the gender pay gap.[16] In economics, the undervaluation of "women's work" means that there is evidence of lower returns to women's productive characteristics.[17] Practically, this means that women will receive lower pay from investing in education or from their own work experience. The undervaluing of "women's work" contributes to women's higher levels of in-work poverty; two-thirds of workers earning below the Real Living Wage are women.[18]

The undervaluation of the social care workforce is sustained by stereotypes around gender roles and assumptions and women's and men's capabilities and interests. There is a widespread assumption that caring and other unpaid work done in the home is better suited to women because historically it has been their role. This drives the undervaluation of this work when it is done in the labour market, with jobs such as cleaning, catering, childcare and social care paid at, or close to, the minimum wage as a result. In addition, the idea that women are intrinsically more caring is used to justify the low pay attached to care work in the labour market, with perceived job satisfaction a substitute for fair pay.[19] The designation of care as low-skilled contributes to the economy-wide undervaluation of care work more broadly. **Close the Gap urges the Review to ensure that tackling the undervaluation of the workforce is at the heart of its recommendation on social care reform in Scotland.**

4. The link between the pay and conditions of social care work and the crisis in service delivery

The social care sector has faced significant challenges for some time. Rising demand due to changing demographics and difficulty recruiting and retaining workers have combined with funding pressures to create a crisis in social care delivery. The sector faces challenges around recruitment and retention of staff and delivering a high standard of care. This crisis has clear implications for quality of care both now and in the future and is sustained by the gendered undervaluation of social care work.

Rising demand requires expanded provision, which can only be delivered with an expanded workforce. Many employers in the care sector are already reporting high vacancy rates, a shortage of good quality applicants and high staff turnover. The overall vacancy rate in social care is already almost twice the Scottish average.[20] Care providers say that they struggle to fill these posts and foresee this getting worse.[21] One in five care workers were born outside the UK[22] which is likely to compound

[16] Grimshaw, Damien and Jill Rubery (2007) *Undervaluing Women's Work*, Equal Opportunities Commission
[17] Ibid.
[18] Scottish Parliament Information Centre (2017) *The Living Wage: Facts and Figures 2017*
[19] Folbre, N (2012) *Should Women Care Less? Intrinsic Motivation and Gender Inequality*
[20] NHS Scotland and COSLA (2019) *An Integrated health and social care workforce plan for Scotland*
[21] Ekosgen (2019) *The Implications of National and Local Labour Markets for the Social Care Workforce: Final Report for Scottish Government and COSLA*
[22] Engender (2020) *Women and COVID-19*

staffing pressures as the wage threshold set in the UK Government's immigration bill excludes the majority of social care workers.

The recruitment and retention challenges in the sector are primarily driven by the pay and conditions of social care work. **Care workers cite the low pay and poor conditions of the work as a primary reason for leaving their jobs.**[23] The average hourly pay in the wider social care sector is just £9.79[24], with 43% of the Scottish social care workforce being paid less than the Real Living Wage.[25] Many social care workers report not being paid for travel time between appointments or for overnight stays[26], effectively reducing their hourly pay rate, alongside highly compressed appointment times.[27] Evidence shows that social care workers frequently do not have enough time to deliver high quality care to service users.[28] This has a detrimental impact on service users, but also on workers' mental health and wellbeing because they cannot deliver the standard of dignified and compassionate care they would wish to. This is a significant issue in homecare settings but is also evident in care homes due to understaffing.[29]

These are further significant drivers of social care workers leaving the sector, but also of the standards of care it is possible to deliver within the current system. Practices such as not paying for travel time and insufficient appointment times are a major barrier to quality of care.[30] Evidence shows that pay is the primary determinant of care quality[31]. **Delivering quality social care requires delivering high quality pay and conditions to the social care workforce.** It is impossible to resolve these issues while maintaining low pay in the sector.

Additionally, if more men are to work in the care sector, which is necessary to meet staffing requirements, reduce occupational segregation and close the gender pay gap, there needs to be an economic imperative to do so, with appropriately remunerated jobs and clear progression pathways as evidence that it is a good career

[23] Implementing the Scottish Living Wage in adult social care: An evaluation of the experiences of social care partners, and usefulness of Joint Guidance – CCPS and University of Strathclyde (2018) http://www.ccpscotland.org/wpcontent/uploads/2018/11/Univ-of-Strathclyde-Living-Wage-implementation-research-November-2018.pdf **and** Ekosgen (2019) *The Implications of National and Local Labour Markets for the Social Care Workforce: Final Report for Scottish Government and COSLA*

[24] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*

[25] Williams, Martin (2010) 'Half of Scotland's care workers paid less than Real Living Wage', *The Herald,* 2 May 2020, available at https://www.heraldscotland.com/news/18421934.half-scotlands-care-workers-paid-less-real-living-wage/

[26] Briefing for care and support providers: Holiday Pay and Overtime Sleepovers and National Minimum Wage – CCPS (2015) http://www.ccpscotland.org/wpcontent/uploads/2015/03/CCPSsleepoverbriefing.pdf

[27] Rubery, J. et al (2011) *The Recruitment and Retention of a Care Workforce for Older People*

[28] GMB Scotland (2020) Show You Care: Voices from the Frontline of Scotland's Broken Social Care Sector

[29] Ibid

[30] Rubery, J. et al (2011) *The Recruitment and Retention of a Care Workforce for Older People*

[31] Rubery, J. and Urwin, P. (2011) *Bringing the employer back in: why social care needs a standard employment relationship*

choice. Without action to tackle undervaluation and investment in care work, any future gaps in social care provision are likely to lead to increased pressure on women to fulfil these roles on an unpaid basis, potentially driving them out of the workforce and into greater poverty.[32] **It is critical that the Review recognises that investing in the pay and conditions of the social care workforce is central to a sustainable and high quality social care system.**

5. Fair work for Scotland's social care workforce

The Fair Work in Scotland's Social Care Sector report[33] concluded that fair work is not being delivered in the social care sector and highlights the undervaluation of women's work as a key theme. Indeed, in addition to low pay, employment in the social care sector is also characterised by a range of other features including:

- Increasingly precarious forms of employment, such zero hours contracts, which negatively impact predictability of shifts, regular income, household budget management, women's in-work poverty and children's poverty.
- A rise in self-employment, with women losing critical employment rights such as sick pay, holiday pay, maternity leave and pay, and the right to request flexible working.
- Increasing time constraints on service delivery which detrimentally affects quality of care, results in many workers doing unpaid overtime, which in turn affects women's physical and mental health. One in six social care workers do unpaid overtime each week.[34]
- Some workers not being reimbursed for mileage, or not being paid for travel time between visits to service users. Homecare employers across the UK have acknowledged that 19% of workers recorded working time is unpaid spent travelling between visits. [35]
- Limited progression opportunities caused by the largely flat staffing structures, with little differentiation in pay between levels of seniority, which makes working in the sector less attractive to potential new recruits.
- A lack of access to training and development opportunities.[36]
- Problems with recruitment and retention, with the sector exhibiting the highest sectoral staff turnover rate in the labour market[37], and more than a

[32] Close the Gap (2020) *Disproportionate disruption: The impact of COVID-19 on women's labour market equality*
[33] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[34] Office for National Statistics (2017) Labour Force Survey 2017
[35] Hayes, L.B.J. (2017) *Stories of Care: A labour of law – gender and class at work*, Palgrave: London
[36] Scottish Government (2019) *Social Care Support Reform: Summary of discussion paper responses*
[37] Hayes, L.B.J. (2017) *Stories of Care: A labour of law – gender and class at work*, Palgrave: London

third of social care services reporting that they have had unfilled vacancies in the past 18 months.[38]

Valuing women's skills

Women's work in social care is often seen as unskilled, despite increasing professionalisation and responsibility for complex and skilled tasks. For example, social care staff are increasingly being expected to dispense medication, with no corresponding uplift in pay or status.[39] The invisibility of women's skills is a major cause of undervaluation[40] and this is particularly the case for homecare workers, whose work is carried out in the service users' homes rather than in a workplace, and often alone rather than in front of or while working with colleagues. The emotional labour required of care work is especially undervalued, and rarely is it adequately captured in pay and grading systems, where these exist.

The Fair Work Convention's report into social care highlighted that while the skills and qualifications necessary for social care work have increased, this has not resulted in a pay rise to reflect these additional requirements of the job. The report noted that "unlike social work or health, social care staff have limited access to adequate training and support, placing a predominantly female workforce under pressure in a sector which requires formal qualifications with little or no central funding for training." This has led to a situation where many care staff are required to cover their own training costs and undertake training in their own time, as a result of work pressures.

This is especially problematic in light of the well-established gendered barriers to training and development. Women are less likely to receive employer training than men, in particular training that will enable them to progress or secure a pay rise.[41] This is reflected in gender differences in outcomes; with men more likely to have received a pay rise as a result of receiving training, and full-time workers, the majority of whom are men, are more likely than part-time workers to see improvements in the pay and promotion prospects.[42] Low paid, part-time women workers are the least likely to receive any type of training.[43] Across the labour market, more women than men contributed towards the cost of their training, and full-time workers are more likely than part-time workers to have had the total costs of their learning paid for by their employer.[44] Women's caring responsibilities also

[38] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[39] Hayes, L.B.J. (2017) *Stories of Care: A labour of law – gender and class at work*, Palgrave: London
[40] Grimshaw, Damien and Jill Rubery (2007) *Undervaluing Women's Work*, Equal Opportunities Commission
[41] Aldrige, Fiona and Corin Egglestone, (2015) *Learning, Skills and Progression at Work: Analysis from the 2015 adult participation in learning survey*, UK Commission for Employment and Skills
[42] Ibid.
[43] House of Commons Women and Equalities Committee (2016) *Inquiry into the gender pay gap*
[44] Aldrige, Fiona and Corin Egglestone, (2015) *Learning, Skills and Progression at Work: Analysis from the 2015 adult participation in learning survey*, UK Commission for Employment and Skills

represent a barrier to access training and development, as time spent doing this unpaid work extends into all aspects of women's lives making it more difficult to undertake training or education outwith working hours. Finally, budgetary constraints and financial pressures experienced by social care providers, particularly in light of increasing demand during COVID-19, can be expected to result in freezes on non-essential training, further reducing opportunities for progression.

A critical tool to make women's skills valued and visible is job evaluation. Analytical job evaluation free of sex bias ensures that pay is determined by objective factors such as the skills, knowledge, effort and responsibility associated with the job. However, not all job evaluation systems are analytical and free of sex bias, with many characterised by in-built assumptions around the value of one job relative to another based on gender stereotypes and norms.

Pay modernisation programmes in the public sector, including Single Status in local government and Agenda for Change in the NHS, were intended to address pay discrimination, but have largely failed to tackle the undervaluation of 'women's work', with many stereotypically female jobs remaining low-paid and low-status. During and after the implementation of Single Status local authorities received tens of thousands of equal pay claims by female workers, including homecare workers. There were many reasons for these including claims against pay and bonus protection given to predominantly male workers and discrimination in job evaluation schemes.[45] Some of the approaches taken by local authorities when implementing Single Status failed to prioritise pay equality and were later found to be discriminatory.[46] Importantly Single Status has not addressed the systemic undervaluation of homecare work, or other types of 'women's work' in local government.

The Fair Work Convention noted in its inquiry report into social care that no mechanism has been devised for undertaking job evaluation in the sector and for upgrading the pay of those with greater skills and experience.[47] This has resulted in challenges recruiting and retaining senior posts and managers, with existing workers reluctant to take on additional responsibility for a limited financial reward. **Establishing robust mechanisms for analytical free from sex bias job evaluation is therefore a critical aspect of action to address the sector-wide economic undervaluation.[48]**

<u>Increasing collective bargaining in the social care sector</u>

[45] Accounts Commission (2017) *Equal Pay in Scottish Councils*
[46] Ibid.
[47] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[48] Close the Gap response to Scottish Labour's consultation on the National Care Service available at https://www.closethegap.org.uk/content/resources/Close-the-Gap-response-to-Scottish-Labour---National-Care-Service-August-2020.pdf

Trade union coverage in the social care sector is limited. The nature of work in the sector, which occurs outside of conventional workplaces, can make social care a challenging environment for unions to operate in and for workers to engage collectively.[49] Currently, only 19% of social care workers have their pay and conditions affected by agreements between employers and trade unions. The Scottish Government and local government directly fund social care, either through direct provision or through commissioning. The STUC asserts that this should make it easier to ensure social care employers recognise trade unions for collective bargaining purposes or to agree sectoral bargaining arrangements so that all workers in the sector are raised up to a certain standard.[50]

Collective pay bargaining is often weaker in sectors where women's work is concentrated, resulting in less associated protections for women's pay compared to men's. The Fair Work Action Plan commits the Scottish Government to increasing collective bargaining in social care. In addition, the Advisory Group on Economic Recovery recommended the implementation of extended collective bargaining in the social care sector as an aspect of work to strengthen the capacity and sustainability of the care sector.[51] This work is a clear opportunity for work focused on addressing undervaluation, but gender expertise is required to ensure this is achieved in implementation. The design of this work will be the key determinant as to whether it has a positive impact on women's socio-economic equality.

While increasing collective bargaining would assist in improving terms and conditions, collective bargaining in individual workplaces alone will not guarantee the necessary coverage across the sector making it insufficient to tackle sector-wide undervaluation. It is therefore necessary to explore options for sectoral bargaining.[52] Unison Scotland have advocated that a timetable for the introduction of a Social Care Sectoral Bargaining arrangement should be established as a priority, with such an agreement covering wage rates, and terms and conditions across the sector.[53] Close the Gap is supportive of Unison's proposed approach. While a starting point for the agreement should be the consolidation of the real Living Wage, a timetable should be developed to raise levels of pay to the equivalent in health and local government.[54]

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[49] Ibid.
[50] STUC (2019) *Scotland's Social Care Crisis* available at http://www.stuc.org.uk/files/Policy/Reasearch_Briefings/Scotland%27s%20Care%20Crisis.pdf
[51] Ibid.
[52] STUC (2019) *Scotland's Social Care Crisis* available at http://www.stuc.org.uk/files/Policy/Reasearch_Briefings/Scotland%27s%20Care%20Crisis.pdf
[53] Unison Scotland (2020) Care After Covid: A UNISON vision for social care available at https://www.unison-scotland.org/wp-content/uploads/Care-After-Covid.pdf
[54] Close the Gap response to Scottish Labour's consultation on the National Care Service available at https://www.closethegap.org.uk/content/resources/Close-the-Gap-response-to-Scottish-Labour---National-Care-Service-August-2020.pdf

6. The delivery model: sustaining low pay and poor conditions

A sustainable delivery, funding and governance model is crucial to the functioning of the social care system. The Scottish Government has made a number of commitments to review the current system of delivery and investment in social care in its social care reform programme[55], its acceptance of the recommendations of the Fair Work in Social Care report[56] and in A Fairer Scotland for Women.[57] These commitments reflect that the current system is simply not delivering for service users, their families and carers, or the social care workforce.

Outsourcing and the mixed market economy

The mixed market economy of social care has created inequality in workers' terms and conditions, and service provision. By 2009, over two thirds of adult social care jobs had moved to the independent sector, with a significant percentage of council provision being delivered by arm's length bodies. This withdrawal from service provision means that the market and providers have been left to manage the workforce, with little support from national Government. This has ultimately intensified the division between health and social care, and weakened the state's responsibility to the social care worker.[58] In addition, price has been viewed as the dominant factor in commissioning and procurement processes,[59] leading to a 'race to the bottom' culture.[60] These changes have had implications for the value afforded to the workforce. For example, Grimshaw and Rubery concluded that the outsourcing of work previously done in-house creates new risks around undervaluation, as outsourcing can reduce collective representation, and worsen employment policy and practice.[61] Indeed, wage variation across the public, private and third sectors would support this view. If the commissioning and procurement model is to be maintained, there is a need for the introduction of more ethical commissioning models that take into account factors beyond price, including fair work, terms and conditions and trade union recognition.

Personalised support and workers' rights

[55] https://www.gov.scot/policies/social-care/reforming-adult-social-care/
[56] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[57] Scottish Government (2019) *A Fairer Scotland for Women: Scotland's gender pay gap action plan*
[58] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[59] Unison Scotland (2020) Care After Covid: A UNISON vision for social care available at https://www.unison-scotland.org/wp-content/uploads/Care-After-Covid.pdf
[60] Penrose Care (2015) *Written submission from Penrose Care* available at http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Women%20and%20Equalities/Gender%20Pay%20Gap/written/29587.html
[61] Grimshaw, Damien and Rubery, Jill (2007) *Undervaluing Women's Work, Equal Opportunities Commission*

Access to high quality social care which centres choice, power and control with service users is critical to ensuring that people in need of care are treated with dignity and respect. Ensuring that people can access the care they need is also a vital step in advancing women's equality. However, there is a clear tension between the implementation of self-directed support and the working conditions of the workforce, and this tension is underpinned by the marketisation of social care.[62] The introduction of self-directed support has thus contributed to the increasing precarity of work in the sector.

The Fair Work Convention notes that the current method of competitive tendering based on non-committal framework agreements has created a model of employment that transfers the burden of risk of unpredictable social care demand and cost almost entirely onto the workforce.[63] Public sector commissioners offer very low price to multiple providers resulting in competition on costs that drives low pay and a need for hyper flexibility from workers but not employers. [64] The one-sided flexibility makes it particularly difficult for women workers to combine work with their own unpaid caring roles. This "race to the bottom" drives down pay, terms and conditions for the women care workers, entrenching their inequality in the labour market and sustaining Scotland's gender pay gap. Human rights outcomes cannot be realised for service users at the expense of the rights and dignity of the majority female social care workforce.

Tackling precarious work

Almost a fifth of social care workers are on non-permanent contracts and 11% of the workforce are on zero-hour contracts.[65] Three-quarter of third sector providers use zero hours contracts, and four-fifths report using agency staff to cover shifts of support workers.[66] Self-employment is becoming increasingly common in the social care sector, with many women in the sector accessing work through online platforms and apps.[67] It is clear that casualised and precarious work is becoming increasingly common in the social care sector.

Women on these types of contracts lose out on maternity and parental rights and face difficulties reconciling variable hours or job insecurity with caring

[62] Close the Gap (2020) Submission to the Health and Sport Committee inquiry into social care https://www.closethegap.org.uk/content/resources/Close-the-Gap-submission-Health-and-Sport-Committee-inquiry-into-social-care.pdf
[63] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[64] Ibid.
[65] Ibid.
[66] Coalition of Care and Support Providers (2019) *2018 Benchmarking Report for Voluntary Sector HR Network and CCPS – Executive summary*
[67] Close the Gap (2020) Submission to the Health and Sport Committee inquiry into social care https://www.closethegap.org.uk/content/resources/Close-the-Gap-submission-Health-and-Sport-Committee-inquiry-into-social-care.pdf

responsibilities. Agency/casual workers may be required to work a variety of different shifts at short notice, which presents a particular problem for parents and carers as childcare is not flexible enough to support irregular patterns of work, and alternative care is difficult to arrange. Variation in income also makes it harder to afford or retain childcare, makes it more difficult to manage household budgets for which women usually have control, and can also result in disruption to social security payments.

The use of technology and the changing labour market

As agency work in the female-dominated social care sector has increased in recent years, a range of online platforms and apps have emerged which provide an agency function to match self-employed care workers with clients. Providers argue that this enables greater flexibility and reliability for both the worker and the client. However, this flexibility is often one-sided, resulting in greater pressures on workers, including those who are self-employed or on an insecure contract.

This one-sided flexibility in the sector is amplified by use of technology by some providers. For instance, some local commissioners use electronic homecare monitoring, whereby payment from the local authority is based on exact time when a social care worker "checks in" or "checks out" of a support session via a phone call from the house of the service user.[68] Any time programmed not spent with the service user is deducted from payments to the provider. As a result, there is increased pressure on already overworked workers to arrive and leave at exact time, rather than being able to respond flexibly.[69] This prevents any autonomy of engagement between the worker and the individual[70] while also fostering a culture of surveillance which can ultimately erode trust and lower morale. As it is likely that platform working will become increasing common, the Review should be cognisant of this in its consideration of workforce and commissioning issues.

A national care service: the potential for change

Establishing a national care service provides an important opportunity to improve the quality of care in Scotland, while also improving job quality and raising the status of paid care work. However, without transformational changes to the current model of delivery these outcomes are not a given. Outsourcing and the mixed market of delivery has entrenched undervaluation and women's inequality in the social care workforce, with commissioning processes that prioritise cost over good quality employment. A national care service that simply 'shuffles the deckchairs' is unlikely to have any real impact on the low pay and poor conditions that characterise the

[68] Dalrymple, J., D. Macaskill and H. Simmons (2017) *Self-directed Support: Your right, your choice*
[69] Fair Work Convention (2019) *Fair Work in Scotland's Social Care Sector 2019*
[70] Dalrymple, J., D. Macaskill and H. Simmons (2017) *Self-directed Support: Your right, your choice*

sector and therefore is unlikely to deliver the changes necessary to tackle the crisis in social care.

The social care workforce is the foundation of the social care system. A high-quality social care service is predicated on improving outcomes for its workforce. A fairly remunerated workforce is motivated and supported to both enter and stay in the sector and enabled to deliver quality, person-centred care. This must be a priority for any recommendations made by the Review in relation to developing a national care service.

7. Recognising women's unpaid caring roles

Care, both paid and unpaid, is a gendered issue. There are now 1.1 million unpaid carers in Scotland, 61% of whom are women. This is an increase of 392,000 since the start of the crisis with 78% of carers having to provide more care than they were prior to the coronavirus outbreak.[71] This issue predates the pandemic, with reducing provision and tighter eligibility rules driving an increased reliance on unpaid carers. Women provide the vast majority of unpaid care, often having multiple unpaid caring roles for children and other relatives who are older or require support.[72] Unpaid care is foundational to the economy and yet is missing from mainstream economic models. This sustains the undervaluing of care and of unpaid carers.

Women's disproportionate responsibility for care and other domestic labour affects their ability to enter and progress equally in the labour market. Women are four times more likely to leave their job because of multiple caring responsibilities and are more likely to be in low-paid, part-time employment as this is often the only option that will enable them to balance earning with caring.[73] Providing unpaid care also has a significant impact on carers' health and wellbeing, with one in four unpaid carers reporting that they have not had a break from caring in five years.[74] Women's disproportionate responsibility for unpaid care, along with their over-representation in paid care work, is sustained by persistent gender norms.

In the context of COVID-19, work by Glasgow Disability Alliance, Inclusion Scotland and the ALLIANCE has found that social care packages have been reduced during the crisis, with some Health and Social Care Partnerships increasing their eligibility criteria which has made it more difficult to access care, displacing responsibility for

[71] Engender (2020) *Gender and Unpaid Work: The Impact of COVID-19 on Women's caring roles*
[72] Carers UK and Employers for Carers (2012) *Sandwich Caring: Combining childcare with caring for older or disabled relatives*
[73] Ibid
[74] https://www.carersuk.org/news-and-campaigns/news/one-in-four-unpaid-carers-have-not-had-a-day-off-in-five-years

care onto female family members.[75] Without action to tackle undervaluation and to invest in care work, any future gaps in social care provision are likely to lead to increased pressure on women to fulfil these roles on an unpaid basis, potentially driving them out of the workforce and into greater poverty.[76]

Close the Gap calls on the Review to respond to the gendered nature of unpaid care in its recommendations. Recognising the intersecting rights of service users, the social care workforce and unpaid carers is essential in order to ensure the social care system is able to deliver positive outcomes for all stakeholders.

8. Investment in care economy: recognising care as infrastructure

Evidence from Scotland[77] and internationally[78] finds that investment in care infrastructure, including investment in high quality childcare and social care, stimulates job creation, community regeneration, and increased opportunities for under-employed women.[79] As mentioned previously in this submission, research by the Women's Budget Group found that investment in care in the UK would produce 2.7 times as many jobs as an equivalent investment in construction. Investment in care is greener than investment in construction and more of its costs would be recouped in increased income tax and National Insurance contributions.[80] Care contributes an estimated £3.4bn to the Scottish economy, with a GVA greater than that of agriculture or the arts.[81] Despite this, care is commonly framed as current consumption rather than capital investment.[82]

It has been a long-standing call of Close the Gap to designate care, including both social care and childcare, a key growth sector. This has been reiterated in Close the Gap and Engender's joint paper, *Gender and Economic Recovery*, which sets out nine principles for a gender-sensitive economic recovery.[83] The Scottish Government's response to the Advisory Group on Economic Recovery affirms their commitment to develop an approach that will treat investment in childcare and social care as

[75] The ALLIANCE (2020) *Response to the Equalities and Human Rights Committee inquiry on the impact of Covid-19 pandemic on equalities and human rights*
[76] Close the Gap (2020) *Disproportionate disruption: The impact of COVID-19 on women's labour market equality*
[77] Lapniewska, Zofia (2016) *Growth, Equality and Employment: Investing in Childcare in Scotland*, WiSE Research Centre
[78] De Henau, Jerome, Sue Himmelweit, Zofia Lapniewska and Diane Perrons (2016) *Investing the Care Economy: A gender analysis of employment stimulus in seven OECD countrie*s, ITUC Research Centre
[79] Lapniewska, Zofia (2016) *Growth, Equality and Employment: Investing in Childcare in Scotland*, WiSE Research Centre
[80] Women's Budget Group (2020) *A Care-led Recovery from Coronavirus: The case for investment in care as a better post-pandemic economic stimulus than investment in construction* https://wbg.org.uk/wp-content/uploads/2020/06/Care-led-recovery-final.pdf
[81] The ALLIANCE (2020) *Response to the IJB Executive Group's questionnaire on adult social care*
[82] Close the Gap and Engender (2020) *Gender and Economic Recovery*
[83] Close the Gap and Engender (2020) *Gender and Economic Recovery*

infrastructure.[84] However, it remains a commitment to 'explore options' in this area, rather than to implement changes in the categorisation of spending on social care investment.[85] While this rhetorical commitment is welcome, there must be clear action if ambitions on developing this approach are to be realised.

Recognising care as infrastructure is critical to realising gender equality, not only for those accessing services but also for the predominantly female workforces. This would drive the policy focus and allocation of resources necessary to grow the sectors, and address the systemic undervaluation of 'women's work'. Social care, along with childcare, is critical infrastructure which enables women's labour market participation, and is a necessary step in realising women's wider economic equality. Inclusive growth must mean investing in a care economy, with investment in childcare and care for disabled people and older people considered as necessary infrastructure for a sustainable wellbeing economy and a good society.[86]

9. A human rights-based approach

Close the Gap welcomes the Review's commitment to taking a human rights-based approach. This should also integrate gender equality ambitions. As outlined in this response, a social care system that delivers fair pay and conditions to social care workers and values and supports unpaid carers has the potential to contribute to a reduction in women's labour market inequality and wider gender inequality.

Women's human rights are specifically set out in the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which was adopted by the UN General Assembly in 1979. The Convention "establishes not only an international bill of rights for women, but also an agenda for action by countries to guarantee the enjoyment of those rights".[87] Article 11 of CEDAW includes "(d) The right to equal remuneration, including benefits, and to equal treatment in respect of work of equal value, as well as equality of treatment in the evaluation of the quality of work[.]" Tackling the gendered undervaluation of social care work would support progress towards the realisation of this right for women in Scotland.

High quality social care is also essential to realising the rights of disabled women. Women are more likely to be disabled or have long-term health conditions than men and are less likely to be able to afford private care.[88] As detailed earlier, the

[84] Scottish Government (2019) *A Fairer Scotland for Women: Scotland's gender pay gap action plan*
[85] Scottish Government (2020) *Economic Recovery Implementation Plan*
[86] Ibid.
[87] https://www.ohchr.org/en/professionalinterest/pages/cedaw.aspx
[88] Engender (2020) *Response to the Commission on Social Justice and Fairness consultation on Discussion Paper 2: Reform of Social Care*

pandemic has driven a reduction in social care packages.[89] This sits alongside an increase in eligibility criteria has erected significant barriers in accessing care and a challenge maintaining quality and provision with changing demographics and funding constraints. These issues are likely to have a greater impact on disabled women potentially denying their rights to dignified care and support services.

The rights of social care workers are not in conflict with the rights of service users; indeed, they are mutually reinforcing. The ALLIANCE states that "a rights based approach can be applied across all parts of the system: incorporated into law and guidance; embedded in financial, regulatory and commissioning frameworks; mainstreamed into employment conditions and workforce development; and service design and delivery".[90] Human rights outcomes cannot be delivered to the service users at the expense of the rights and dignity of the majority female social care workforce. **Close the Gap urges the Review to recognise the human rights issues inherent in the gendered undervaluation of social care work in its recommendations.**

10. Conclusion

COVID-19 has illuminated the importance of social care work in Scotland's economy. Workers in social care have been rendered more visible and recognised as key workers, accompanied by a societal shift in views on the perceived value of social care. The Review is an opportunity to translate this into meaningful change by recommending improved pay, terms and conditions for social care workers. Investment in social care and addressing the gendered undervaluation of the workforce should be core to the recommendations of the Review.

Care is profoundly gendered, and COVID-19 has exacerbated the gendered patterns of care. Women are the vast majority of the social care workforce and the majority of unpaid carers and both of these groups have borne the brunt of the increase in care needs during the pandemic. Social care reform has clear implications for the predominantly female workforce, through enabling better pay and conditions, but also for unpaid carers through improvements in provision and wider support. As set out in this submission, a good quality social care system is therefore an important enabling factor to closing the gender pay gap as it allows women to participate in the labour market. It also has the potential to tackle women's low pay and in-work poverty in social care itself.

[89] The ALLIANCE (2020) *Response to the Equalities and Human Rights Committee inquiry on the impact of Covid-19 pandemic on equalities and human rights.* Available at: https://yourviews.parliament.scot/health/social-care-inquiry/consultation/view_respondent?show_all_questions=0&sort=submitted&order=ascending&_q__text=ALLIANCE&uuId=828970470

[90] The ALLIANCE (2020) *Response to the IJB Executive Group's questionnaire on adult social care*

There is abundant evidence that the pay and conditions of social care work are the primary determinants of standards in social care delivery. The social care workforce is the foundation of the social care system. Without tackling the chronic low pay and gendered undervaluation of social care work itself it will not be possible to attract and retain a quality workforce or to deliver substantive improvements in the quality and provision of care.

In order to create the transformational change needed the Review must tackle the failings of the current social care model. Outsourcing and the mixed market of delivery has entrenched undervaluation and women's inequality in the social care workforce, with commissioning processes that prioritise cost over good quality employment.

The Independent Review of Adult Social Care is a critical and timely intervention. The expectation of stakeholders of the Review to deliver real change is clear. The Review has the opportunity to help accelerate the implementation of existing Scottish Government commitments on social care, building the foundation for a social care system that works for service users, their carers and families, and the social care workforce. The vision for social care reform however must recognise that many of the challenges identified with the system, and particularly the workforce challenges, are a cause and consequence of gender inequality. Close the Gap calls on the Review to take a gendered approach to developing its recommendations.

Close the Gap - Supplementary submission

Close the Gap

Supplementary submission to the Independent Review of Adult Social Care

Introduction

Variable and very often poor terms and conditions has been identified as a key workforce challenge for the social care sector. In particular, low pay driven by the undervaluation of the predominantly female workforce is a defining characteristic of social care work and a central cause of the sector's retention problem. Close the Gap is supportive of the development of minimum standards of employment which aim to improve the terms and conditions across the sector. Integrating minimum standards of employment into the adult social care commissioning process is necessary to lever employer action and realise Scottish Government's ambitions on fair work[1] and gender equality at work[2].

Including a minimum standard on pay would be a step towards addressing undervaluation but tackling this requires a longer-term sectoral approach. Close the Gap therefore calls on the review to recommend that a taskforce be established to address the gendered undervaluation of social care work. The taskforce should include gender experts, and its work should be informed by international learning on tackling undervaluation and using state wage-setting power to address low-pay.

Developing gender competent minimum standards of employment

The minimum standards of employment must be gender competent if they are to address the most pressing issues in the social care workforce and drive the system-wide reform that is desperately needed. This means they must respond to women's and men's differential engagement with the labour market and their different experiences of employment, unpaid caring, education and skills acquisition. These are clearly evidenced in social care work, which is economically undervalued precisely because it is overwhelmingly done by women.

Providers in receipt of public funding should be required to meet the minimum standards of employment. The standards should include:

[1] https://economicactionplan.mygov.scot/fair-work/

[2] Scottish Government (2019) *A Fairer Scotland for Women: Scotland's gender pay gap action plan*

- Pay;
- Job security;
- Training and development;
- Progression pathways; and
- Flexible working.

Meeting these standards will not only deliver for the workforce, it will have a multiplier effect through improving care standards and increasing recruitment and retention of skilled and experienced workers (thus reducing the associated recruitment and retraining costs associated with current vacancy and attrition rates). The minimum standards will benefit all social care workers however, as the majority of social care workers, women will be the biggest beneficiaries.

Gender competent minimum standards

1. Pay

Close the Gap calls for the following minimum standards on pay:

- Social care workers in all settings should be paid at least the Real Living Wage (RLW). This should be reflected in an increase to Personal Budget payments to enable payment of this rate for self-directed support.
- Social care workers should be entitled to occupational sick pay from day one of employment.
- Home care workers should be paid for travel time. This should include mandatory reimbursement for mileage incurred in travel to and from appointments.
- Providers should meet the costs of uniforms and any other necessary items e.g. mobile phones.

Why tackling low pay is important for women's equality in social care

Gender stereotypes and norms drive both women's concentration in low-paid work such as social care and the low pay associated with such work. Gender norms funnel women into feminised occupations and sectors and are then financially penalised for "choosing" low-paid work.

Scottish Government introduced the RLW for early learning and childcare (ELC) workers, however only for the delivery of the funded entitlement. This has not driven an across-the-board increase in hourly pay, with ELC workers paid the RLW for only the hours in which they are delivering the funded entitlement. In fact, most ELC workers do not receive the RLW. The piecemeal introduction of the RLW has not resulted in a sector-wide uplift in pay. It is estimated that around 80% of

practitioners and 50% of supervisors in private and third sector partner settings are paid below the Real Living Wage[3].

Similarly, the introduction of the RLW for adult social care workers in the public sector has not had a knock-on effect on pay rates in private and third sector providers. Payment of the RLW for all social care workers would be a step towards addressing the low pay in social care, but it does not address the undervaluation of the work.

Why ending the non-payment of travel time is important for women's equality in social care

Many social care workers report not being paid for mileage and/or not being paid for travel time between appointments or for overnight stays[4], effectively reducing their hourly pay rate, alongside highly compressed appointment times.[5] Homecare employers across the UK have acknowledged that 19% of workers recorded working time is unpaid spent travelling between visits which translates to a potential 19% cut to hourly pay[6]. This exploitative practice can be linked to the undervaluation of social care work. If social care work is not valued, the workers are not valued, which increases the risk that women are exploited by poor employment practice, entrenching their labour market inequality.

Women are more likely to be dependent on public transport to get to work. They are also more likely to take multiple short trips in order to deal with school and childcare drop-offs, known as "trip-chaining". This means women will take longer getting to and from appointments, an issue compounded by the highly compressed appointment times mentioned above. Travel on public transport may also incur higher costs, further eating into social care workers' already small pay packets. This will impact on women's in-work poverty.

The evaluation of Unison's Ethical Care Charter[7] notes that all but one of the providers signed up to the charter paid travel time. Providers used one of two methods: paying an additional sum on top of the hourly rate or absorbing it into the hourly rate. This report noted that payment for travel time is more transparent where it is added to the hourly rate and not absorbed within it. Close the Gap would

[3] Skills Development Scotland (2018) *Skills investment plan for Scotland's early learning and childcare sector*
[4] Briefing for care and support providers: Holiday Pay and Overtime Sleepovers and National Minimum Wage – CCPS (2015) http://www.ccpscotland.org/wpcontent/uploads/2015/03/CCPSsleepoverbriefing.pdf
[5] Rubery, J. et al (2011) *The Recruitment and Retention of a Care Workforce for Older People*
[6] Hayes, L.B.J. (2017) *Stories of Care: A labour of law – gender and class at work*, Palgrave: London
[7] Moore, S. (2017) *An evaluation of Unison's Ethical Care Charter,* Work, Employment & Research Unit, University of Greenwich

recommend ensuring payment of travel time is transparent in order to limit opportunities for evasion or erosion of payment.

Why tackling low pay in social care is important for addressing women's in-work poverty

Poverty in Scotland is gendered. Women are more likely to be living in poverty than men. Women also find it harder to escape poverty and are more likely to experience persistent poverty than men. In line with the multiple labour market barriers experienced by different groups of women, there is a particularly high risk of poverty among black and minority ethnic women, disabled women and refugee and asylum-seeking women.

The undervaluing of "women's work" contributes to women's higher levels of in-work poverty; two-thirds of workers earning below the RLW are women.[8] The social care sector is marked by increasingly precarious forms of employment, such zero hours contracts, which negatively impact predictability of shifts, regular income, household budget management, women's in-work poverty and children's poverty. The link between women's poverty and child poverty is well-established: the Scottish Government's Child Poverty Delivery Plan recognises that there is "conclusive evidence that poverty and gender are inextricably linked".[9]

2. Job security

Close the Gap calls for a minimum standard on job security as follows:

- An end to bogus self-employment so that women have access to employment rights, for example sick pay, maternity pay and the right to request flexible working.

Why ending insecure employment is important for women's equality in social care

As noted in the previous section, the social care sector is marked by increasing precarity of employment. Those on zero-hours contracts often are not entitled to basic employment rights, including the right to return to their job after maternity, paternity or adoption leave, access to maternity/paternity pay and sick pay, and the right to request flexible working. Workers on these types of contracts find that flexibility is demanded of them by their employer, but there is no reciprocity; a lack of employment rights makes it difficult for worker to request a change in hours or working pattern, or to resist an imposed change. Workers who are unable to accept

[8] Scottish Parliament Information Centre (2017) *The Living Wage: Facts and Figures 2017*
[9] Scottish Government (2018) *Every Child, Every Chance: The Tackling Child Poverty Delivery Plan* available at https://www.gov.scot/Resource/0053/00533606.pdf Accessed August 2018

shifts because of a clash with caring responsibilities report finding that they are not offered as many, or indeed any, shifts in future.[10]

Agency/casual workers may be required to work a variety of different shifts at short notice, which presents a particular problem for parents and carers as childcare is not flexible enough to support irregular patterns of work, and alternative care is difficult to arrange. Variation in income also makes it harder to afford or retain childcare, makes it more difficult to manage household budgets for which women usually have control, and can also result in disruption to social security payments. This contributes to women's higher levels of poverty, and as women are more likely to be responsible for household budgets, children's poverty.

These poor conditions of employment also have implications for the standard of care that is achievable, due to the associated recruitment and retention challenges[11]. High staff turnover and high vacancy levels inhibit the delivery of person-centred care[12]. Lack of continuity of staff means care recipients are met with a succession of different staff which not only impedes the standard of care, but the ability of care recipients to build secure relationships with their carers. The relationship aspect of social care is critical to the wellbeing of care recipients. This is being severely disrupted by staffing challenges driven by precarious work and low pay.

3. <u>Training and development</u>

Close the Gap calls for the following minimum standards on employee training and development:

- Employees should be paid the normal hourly rate to attend induction training.
- Providers should meet the costs of mandatory training requirements, including those for employee SSSC registration.
- Training and development opportunities should be accessible within working hours and on a flexible and part-time basis to enable women with caring responsibilities to participate.
- Employees should not be expected to attend training and development in their own time.

Why tackling the barriers to training and development is important for women's equality in social care

Across the labour market, women are less likely to receive employer training than men and more likely to have contributed towards the cost of their training[13]. The

[10] Working Families (2015) Rigid flexibility: the work of the Working Families Legal Advice Service in 2014
[11] Close the Gap (2020) Submission to the Independent Review of Adult Social Care
[12] The ALLIANCE Scotland (2020) *Social Care Review Engagement Activity- Carers: People at the Centre*
[13] Close the Gap (2020) Submission to the Independent Review of Adult Social Care

gender pay gap, women's concentration in low-paid work, and women's higher levels of in-work poverty means that women are far less likely to be able to afford to pay towards the cost of training.

Because of women's greater propensity to have caring responsibilities they are less able to undertake training or education outwith working hours. Research has also identified gender differences in training outcomes; men are more likely to have received a pay rise as a result of receiving training, and full-time workers, the majority of whom are men, are more likely than part-time workers to see improvements in pay and promotion prospects.[14]

Budgetary constraints and financial pressures experienced by social care providers, particularly in light of increasing demand during COVID-19, are likely to mean that there will be freezes on non-essential training, which may further reduce opportunities for progression.

There is also evidence of new workers in the social care sector being required to attend unpaid induction training for up to two weeks, pay for their uniform and own disclosure checks before starting in the role.[15] The Fair Work in Social Care report also noted that many care staff are required to cover their own training costs. As social care work is low paid there is a clear financial barrier to accessing training and development when workers are required to meet the costs.

4. Progression pathways

Close the Gap calls for the following minimum standards on progression:

- Providers should develop progression pathways for employees.
- Promoted posts should be available on a part-time and/or flexible basis.

Why tackling barriers to women's progression is important for women's equality in social care

The Fair Work Convention's report into social care highlighted that there has been no mechanism devised to undertake proper job evaluation to enable the upgrading of pay for those with greater experience and skills, including for supervisory and managerial roles. Measures to value women's skills and addressing the largely flat staffing structures to provide for progression opportunities are critical in supporting social care as a profession. There must be financial incentives for progression and a clear career path.

Women face a number of gendered barriers to progression. Gendered assumptions about women's capabilities and preferences prevent them from progressing into

[14] Ibid.
[15] Ibid.

more senior roles. This is particularly the case for women who have had children and need to work flexibly to accommodate childcare. However, discriminatory attitudes about their suitability for management and other senior roles exist for all women, irrespective of whether they have children, or even want to have children. A study of UK employers found that nearly one in three employers admits they have or would reject a female job applicant because they suspect she "might start a family soon". A further 29% said they have discounted or would discount a woman for a job role because she had young children and 28% said they have or would because she was recently engaged or married[16].

Women are not only under-represented in senior grades in male-dominated sectors and professions. Men who are employed in female-dominated occupations, are more likely to progress to management and supervisory positions, thereby entrenching the gender pay gap. For example, men are over-represented in senior nursing grades despite being a minority in the workforce, benefiting from a "glass elevator" effect[17]. Many promoted posts are not advertised or available on a part-time or flexible basis, creating a further barrier to women's progression.

Women's lack of progression in social care is likely to stem from the different barriers listed here, but the general lack of meaningful progression opportunities in the sector indicates a lack of investment in developing these. Progression opportunities in social care should not solely be about workers moving from frontline care work into, for example, supervisory or managerial office-based roles. Instead, progression opportunities should also be about providing progression within frontline jobs.[18] For example, Penrose Care offer additional front-line training to care workers, enabling care workers to specialise in specific areas of social care provision.[19]

5. <u>Flexible working</u>

Close the Gap calls for a minimum standard on flexible working as follows:

- Flexible working should be available to all workers in social care from day one.

Why enabling access to flexible working is important for women's equality in social care

[16] Slater and Gordon (2018, July 15) *Bosses are not hiring women in case they might start a family soon* available at: https://www.slatergordon.co.uk/media-centre/press-releases/2018/07/bosses-are-not-hiring-women-because-they-might-start-a-family-soon/

[17] Royal College of Nursing (2020) *Gender and Nursing as a Profession*

[18] Women and Equalities Committee (2016) *Gender Pay Gap: Second report of session 2015-16*

[19] Penrose Care (2015) *Written submission from Penrose Care* available at http://data.parliament.uk/WrittenEvidence/CommitteeEvidence.svc/EvidenceDocument/Women%20and%20Equalities/Gender%20Pay%20Gap/written/29587.html

Women are disproportionately responsible for care for children, sick people, older people and disabled people, and a lack quality part-time and other types of flexible working makes it difficult for them to balance work with family life. Part-time jobs are more likely to be found in the lower grades of all organisations, and concentrated in undervalued work such as care, admin and cleaning. Three-quarters of part-time workers are women, and disabled women are significantly more likely to work part-time compared with disabled men, and non-disabled men and women.[20]

Only 6% of jobs paid £20,000[21] or more are advertised as being available on a flexible basis.[22] While all employees have the right to request flexible working, research by Close the Gap has found that there is no evidence of an increase in the use of formal flexible working in Scotland since 2010.[23] Pervasive presenteeism[24] in many workplaces, and a cultural presumption against flexible working creates a significant barrier to women's progression and labour market equality.

Recent developments in social care delivery, including online platforms and apps, are heralded as delivering greater flexibility and reliability for both the worker and the client. In practice, this flexibility is often one-sided, resulting in greater pressures on workers, including those who are self-employed or on an insecure contract. While agency working can potentially offer a degree of flexibility, it comes with a loss of employment rights such as sick pay, maternity leave or pay, holiday pay, employer pension contributions and the right to request flexible working. This should not be the cost to access flexible working.

Monitoring and evaluating the minimum standards

To ensure the minimum standards of employment are gender competent, the development process must be informed by gender-expertise. Additionally, it is necessary to ensure that **a gender competent monitoring framework is produced to ensure provider accountability.** The monitoring and evaluation process must use gender-sensitive sex-disaggregated data to identify whether the minimum standards are advancing women's workplace equality in the social care sector.

Addressing gendered undervaluation in the social care workforce

[20] Close the Gap (2018) *Response to the Scottish Government consultation on increasing the employment of disabled people in the public sector*

[21] £20,000 full-time equivalent or more.

[22] Family Friendly Working Scotland (2017) *The Timewise Flexible Jobs Index Scotland*

[23] Close the Gap (Forthcoming 2018) *Flexible Working for All? The impact of the right to request regulations on women in Scotland*

[24] Presenteeism is the practice of being present at work outwith one's normal hours, and for more hours than is required. Cultures of presenteeism negatively impact women because of their disproportionate caring responsibilities outwith work which makes it more difficult to be at work outside their normal hours.

Gender stereotypes and norms drive both women's concentration in low-paid work such as social care and the low pay associated with such work[25]. A critical tool to make women's skills valued and visible is to establish job evaluation mechanisms. The Fair Work Convention noted in its inquiry report into social care that no mechanism has been devised for undertaking job evaluation in the sector and for upgrading the pay of those with greater skills and experience.[26] This has resulted in challenges recruiting and retaining senior posts and managers, with existing workers reluctant to take on additional responsibility for a limited financial reward. Establishing robust mechanisms for job evaluation is therefore a critical aspect of action to address the sector-wide economic undervaluation.

Tackling the economic undervaluation is not a small undertaking as it is a structural problem with roots across all aspects of gender inequality. It requires a strategic response at the sectoral level, including a sectoral job evaluation process. The minimum standards on pay would provide an interim response to low pay in the sector, facilitating a longer-term response to be developed and implemented within a timeframe sufficient for work of such scale.

Close the Gap therefore calls on the review to recommend that a taskforce be established to address the gendered undervaluation of social care work. The taskforce should include gender experts, and its work should be informed by international learning on undervaluation and using state wage-setting power to tackle low-pay. The taskforce should also examine the potential for a collective bargaining agreement covering wage rates and terms and conditions across the sector[27]. This would include tackling gendered undervaluation as a core aim.

Establishing a taskforce on undervaluation not only has the potential to advance equality for women working in social care. The work of the taskforce would generate critical learning that could be applied to other jobs and sectors in which women's work is undervalued. Such action would also identify Scotland as a world leader on tackling gendered undervaluation and realising women's equality and rights in the labour market.

[25] Close the Gap (2020) Submission to the Independent Review of Adult Social Care
[26] Ibid.
[27] Unison Scotland (2020) Care After Covid: A UNISON vision for social care available at https://www.unison-scotland.org/wp-content/uploads/Care-After-Covid.pdf

Coalition of Carers in Scotland

The Coalition of Carers in Scotland

Carers as Equal Partners in Care

Submission to the Review of Adult Social Care

> "Nothing is going to change radically until there is far more provision, and that will not happen until caring (both paid and unpaid) is valued in a very real, financial sense"[1]

We welcome this opportunity to respond to the review of adult social care. We hope that the review will deliver radical change by creating a social care system which is progressive, ambitious and will ultimately improve the lives of supported people and unpaid carers.

As a country we need to be clear about how we define social care, recognising its value and purpose. Social care should not be viewed as a 'service', but as an investment in supported people and unpaid carers. We believe that a broader definition should be taken of what it means to be a successful country, looking not just at economic growth but at the collective wellbeing of citizens. The value of unpaid care and the contribution carers make to the economy must be viewed through this lens.

We wholeheartedly agree with the comment Derek Feeley made at our recent meeting

'One of the challenges we have around funding is that social care is looked at through a lens of crisis and burden, it's time to change the conversation. An investment in social care is a good investment. It makes sense in economic development terms, in citizenship terms.'

We hope this signals a new approach to how social care will be designed, delivered and funded in the future. We are committed to supporting and contributing this ongoing process and would value future involvement in the implementation of recommendations leading from the review.

Section One: Engaging with carers and emerging themes

Throughout October and November we facilitated the following engagement events with carers and other key stakeholders. Over 100 carers participated in our discussions, each meeting was attended by Derek Feeley.

1. Our member meeting, which included carers and carer support staff from across Scotland
2. The Carers Collaborative Forum for carer representatives on IJBs

[1] All quotes are from carers and carer support staff who attended our engagement events

3. The Carers Centres Managers Network Meeting
4. The Carers Collective, a group of carers engaged in local campaigning

Some of the key themes that emerged from the participants were:

- Several people stated that they felt the 'system is broken' Inequalities which were in evidence before have been further exacerbated by Covid-19. (More information on how carers have been impacted by their caring role both pre-Covid and during the pandemic is included in Section Three)
- Carers highlighted the lack of consistency within the current social care system, both between areas and also within areas. Participants felt the system was unfair as it was a 'postcode lottery' with support depending on where you live, what services you require and how much your care manager is able to advocate on your behalf.
- The social care system is massively complex. Both process and provision vary considerably between areas and data collection is inconsistent. It is therefore difficult to identify where the deficits and inefficiencies are. For example, there is no way to calculate how much is spent on carer support in Scotland, as the information typically sits across several workstreams and is calculated differently in each area.
- The system is hugely bureaucratic. Carers reported that dealing with statutory services has a greater impact on their health and wellbeing than their caring role. This is also a deterrent to some carers accessing support
- Because of the inconsistencies within the system, the lack of portability and the bureaucratic process required to access support, people feel unable to move between local authority areas and fear transitions.
- When carers have been unable to access their rights, including their right through the Carers Act to have their eligible needs met, they are unable to challenge effectively. The complaints system is inadequate and legal recourse is not a viable option for most people.
- Caring can impact on all areas of a person's life. This has been amplified by the current pandemic. Several carers said they felt 'broken' or 'worn down' and worried how they will make it through the Winter. Covid-19 will leave a legacy of diminished physical and mental health for many carers, which will need to be addressed.

Section Two: Key Asks

As part of our engagement meetings we asked people what they wanted to come out of the review and what their 'Key Asks' were, these included the following:

- The review needs to take a radical approach, several people used the phrase 'there is no point in moving deckchairs around on the titanic' as an analogy to the need to re-think both the current system and how it is resourced
- Participants welcomed the reviews focus on human rights. In developing its recommendations carers expressed the need to adopt a rights based approach and consider the need for additional rights, including the right to short breaks for carers.

- Social care requires significant investment, but it is essential that both existing and additional funding is maximised to achieve the best outcomes for supported people and carers. Several participants talked about how funding allocated to implement the Carers Act has been used for other purposes to the detriment of carers. **We need to move towards targeted investment so that commitments made nationally are properly funded.**
- Social care cannot be viewed in isolation, it needs to interface with other services, including housing, education, and employment support. For example, parent carers talked about the impact of education on their caring role and carers of disabled people talked about the need for accessible housing.
- Power must shift to communities, supported people and unpaid carers. Carers must be viewed as equal partners in care. There has been significant disappointment at the lack of carer representation on advisory boards across all social care review/renewal programmes. Despite carers providing the majority of care in Scotland they are still not included at the highest levels of decision making.

> "Right now it comes to value and how we choose not to value disabled people and unpaid Carers. We've made choices as a country pre and post covid which have made our lives smaller, harder and more difficult. Until our families are at the heart of shaping these policies, nothing will change"

- The needs of all caring communities must be addressed in the review. There are already pockets of good practice across Scotland, but often groups which are considered 'hard to reach' experience barriers to accessing support. Social care must be accessible to all (In Section Six we look at specific groups of carers who require additional consideration)
- Transitions continue to be a very difficult and stressful process for many people, particularly for parent carers when their son or daughter transitions from children's services to adult services. In their submission COSLA identified funding as a specific issue: '*This is due, in part, to how parts of the system work together, and how the associated funding streams are provided. This makes it difficult to enact transition planning meaningfully and the variation in budgets that will be available for people can change drastically almost overnight*' Although this review focuses on adult social care, it should also consider the transitions from childrens services and the need for greater consistency and clarity in the level of support between the two services.

Section Three: The impacts of caring

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

The impacts of caring have been well researched, most notably by Carers UK annual State of Caring research.[2] The 2019 survey, pre-Covid, evidenced the following impacts on carers:

Finances

37% of carers said they were struggling to make ends this rose to 53% of carers receiving Carers Allowance. 79% of carers regularly use their own income or savings to pay for support, equipment or products for the person they care for. 54% said they were not able to plan for their retirement

Carer Support

90% of carers worry that the support they receive might be reduced. 12% reported that their support had reduced in the last year. 21% of carers thought an emergency hospital admission could have been avoided if more support had been provided

Health and Wellbeing

90% of carers said they are not able to do as much physical exercise as they'd like. 93% of carers reported feeling lonely and isolated because of their caring role. 29% of carers reported 'bad' or 'very bad' mental health

The current pandemic has had a disproportionate impact on unpaid carers. Many social care services have ceased or been reduced during this period, meaning carers have not had access to the support they generally rely on. Carers UK have undertaken two surveys during this time, the most recent one in October 2020[3], found that carers had been affected in the following ways:

Increase in unpaid care provided

As a result of the pandemic there are an additional 392,000 new carers bringing the number of carers in Scotland to 1.1million. 87% of carers are providing more care now than they did before the pandemic and 92% of BAME carers are providing more care.

Carer Support

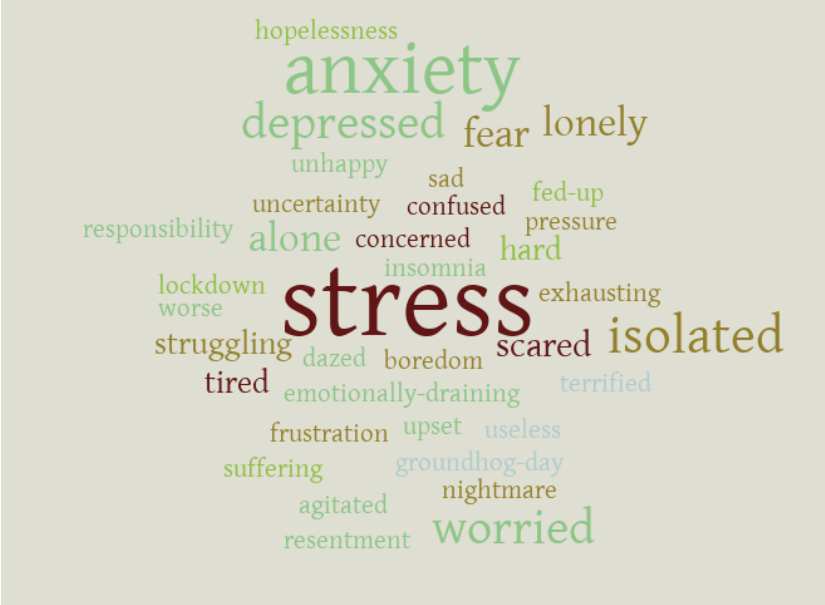
65% of carers have not had a break during the pandemic. 77% reported feeling exhausted and worn out

Carers Health and Wellbeing

63% of carers are feeling more stressed and 55% said it has had an impact on their health and wellbeing. 72% of BAME carers are worried about how they will manage this winter.

[2] State of Caring, Carers UK, 2019
[3] Caring behind closed doors: 6 months on, Carers UK, October 2020

Angus Carers Centre undertook a survey of local carers in October 2020. The Wordcloud below provides a visual description of how respondents reported feeling during the pandemic



Section Four: The arguments for supporting carers

> "For me the biggest issue is the expectation that I will sort everything. I've recently had several minor operations, but no time for me to be unwell, recover, hard enough to find time to go to hospital appointments. My daughter is 28 so this has been for years and will be for the rest of my life"

The contribution carers make is incontrovertible. Their contribution has long been recognised in national and local policy, but recognition has only recently led to legal rights for carers and services leading from those rights have been slow to materialise.

On an individual level, having a family member who is perceived as being available to provide care means that supported people are considered a lower priority and are therefore less likely to meet local eligibility criteria for support.

Human Rights

Carer support is a human rights issue in the same way that support for disabled people is. As the table below shows, lack of support often means carers are unable to access their human rights.

Participation	• Carers are on IJB Boards – but are non-voting members and often feel ignored

	• Without replacement care and short breaks carers cannot participate fully in society and often cannot maintain employment
Accountability	• The Carers Act and SDS Legislation have not been fully or consistently implemented. Funding allocated to implement the Carers Act has been re-directed elsewhere
Non-discrimination	• Carers from rural and BAME communities struggle to be heard and get support • Caring disproportionately affects women • 1 in 10 carers are older people • Carers are not routinely included in EQIAs, despite facing discrimination by association
Empowerment	• In our 2019 survey 46% of carers did not know about The Carers Act or their rights in it • Carers are not yet equal partners in care
Legality	• Carers have rights on paper – but they are a postcode lottery • There is very little right to redress for people who have not been able to access their rights

"To date we've been very focused on the people who use services and their human rights and perhaps not so much on the human rights of carers" (Derek Feeley)

Carers Economic Contribution

The value of unpaid care in Scotland is estimated at over £36billion a year (The NHS cost £13.4billion in 2019)

Carers Health and safety

We have already outlined the impact of caring on people's health and wellbeing in Section Three. However carers' safety is rarely acknowledged or accounted for, unlike the paid work force who have substantial legal protection. In our discussions we heard from several carers who were expected to use equipment such as hoists with no training and without support. In comparison, following risk assessments, paid care workers would only use equipment with two or three workers present. **Unpaid carers must have similar protections to the paid care workforce.**

"The rights of unpaid carers should be aligned to the rights the PAID workforce, NOT to those of people requiring care. If a carer requires care, they will have those rights, but they need the rights of PROVIDERS, not of USERS of services"

Breaks from caring

Carers currently do not have a right to breaks from caring. While some short breaks are available, there is no minimum entitlement and carers struggle to access regular breaks. We held a poll at our member meeting asking people if they felt carers should have a right to short breaks and replacement care, 100% of participants agreed that they should.

> "Not only are carers indispensable, they are also human beings and need time off like the rest of us. That's an investment I think we ought to make" (Derek Feeley)

Employment

1 in 5 carers give up work to care, meaning they are no longer economically active. In many cases this is because they are not able to access replacement care to enable them to combine caring with employment. During the pandemic the employment status of carers has been particularly vulnerable. Research from Citizens Advice found that 2 in 5 people with caring responsibilities were facing redundancy, more than double that of the average working population[4]. The government has invested in childcare to enable parents to remain economically active. The same economic arguments apply to enabling carers to remain in employment through investment in replacement care services.

> "Access to replacement care for carers in employment should also be viewed in the same way as childcare - with the same investment"

Section Five: The System – A National Care Service?

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

At all our engagement meetings there were discussions on the value of a National Care Service. We introduced a poll at our member meeting and 38% of respondents thought it was a good idea, 56% said they 'don't know' and 7% were not in support of it.

In general, the majority of people were cautiously positive, but this was dependent on what model the National Care Service would take. There was some hesitation around the cost in establishing and running the service, with concerns that it would result in less investment going directly to social care provision and individual support. There was also a concern that rather than supporting the integration agenda it would result in a silo effect between the National Health Service and the National Care Service.

Some of the pitfalls of the NHS would need to be avoided, such as being too bureaucratic and rigid, making it unable to evolve rapidly to changing needs. A National Care Service must not

[4] An unequal crisis, Citizens Advice, August 2020

stifle innovation or lead to resources being directed to large national organisations, rather than smaller grass-roots organisations. Overall, there was agreement that in order for it to be effective it would need to come under the jurisdiction of elected members of parliament, in the same way the NHS does.

> "Social care should stand alone, it is such a huge piece of work. Any new National approach to care should not be management top heavy, I would like to see majority of money going to services for the people we care for"

For it to address some of the deficits and inadequacies of the current social care system it would need to centre people with lived experience of social care, along with unpaid carers and understand and value the role of the third sector in the design and delivery of social care. Below we have set out the key principles and features that we believe must be an intrinsic part of any National Care Service, whatever shape it might take.

Human rights approach

Social care must be framed in the principles of human rights, with tangible and enforceable rights enshrined in statute. Individuals should have redress when their rights are not met, beyond what is seen by many as a toothless complaints system or complex and expensive legal action. Particular attention should be given to how access to social care will meet the needs of those with protected characteristics.

To support people in accessing their rights **unpaid carers should have a right to advocacy in the same way as people under The Mental Health Act have a right to advocacy**

National Oversight and Consistency of standards

Across Scotland people with social care needs must experience equality of entitlement and rights. There should be consistency of provision across Scotland with support not determined by local authority resources, but by people's needs. This does not mean that exactly the same services should be provided everywhere, but that people should have an equal entitlement. For example, a carer should know that they have a right to a break or a right to services to support them to remain in employment. It is essential that regardless of where in Scotland someone lives, they are confident they will be able to make choices about how their support is delivered, and that their needs will be met.

A National Care Service should establish the framework for consistency by providing

- national standards
- national improvement programmes
- national eligibility standards
- national contracts for the workforce – pay conditions and training

"You can have all the national standards you want - we have these in the existing legislation but we have local culture which often blatantly ignores these standards and expectations. How do we challenge/change this?"

Sufficient Funding, Preventative Support & Choice

Social care must be funded sufficiently. It must have equal parity with health provision and be funded accordingly. Resourcing should also recognise the additional costs faced by remote, rural and island communities and in meeting the needs of diverse communities. Without additional investment, real change cannot be delivered.

The current framework for funding social care has created a system fraught with inequalities, and the rationing of services through eligibility criteria consistently set to meet only the highest or critical level of need. There is an opportunity to expand the role of social care as a key part of reducing both health and income inequalities and, as such, should be seen in the same way as corresponding policies to increase investment in targeted areas such as early years. This is as an investment in Scotland's people.

"Eligibility criteria is used to set the bar high in order to reduce the spend on SDS. Officers also do not fully understand the legislation. Risk also supersedes outcomes where it should be the other way around"

We need to see a shift from financial responsibility being placed on families, through charging and the provision of unpaid care, to a more equal division, with an end to social care charging and the financial burden of ill-health and disability being equally shared by the whole of society.

"Fair and equitable funding does not place the burden on individuals through charging"

Choice is one of the central tenets of Self-Directed Support. Both supported people and carers should be able to exercise choice in the type of support they access and its delivery mechanism. This means delivering SDS in a more flexible way, allowing people greater autonomy in setting their personal outcomes and deciding what support options will help them achieve them. In the case of carers this may often mean purchasing an alternative to traditional models of support, such as gym membership or a break with the person they care for.

Carers also need to be able to choose how much care they are 'willing and able' to provide. Pressure should not be placed on them to provide more care and assumptions should not be made about their availability, or the other responsibilities or ambitions that they are juggling alongside their caring responsibilities

"Carers aren't able to specify what care they are able and willing to provide. This has been highlighted even more so during Covid with even more expectations put on the carer"

Inclusivity – Carers as equal partners

Despite the duties relating to carer involvement in The Carers (Scotland) Act 2016 and carers previously being recognised as ' Partners in Care' in the Community Care and Health (Scotland) Act 2002, carers are not yet treated as equal partners in care.

In 2018/19, two reviews of Health and Social Integration took place, one carried out by Audit Scotland and one by the Ministerial Strategic Group for Health and Community Care. Both noted the importance of involvement and collaboration for effective health and social care integration and made recommendations or proposals for improvement.

However, the Carers Collaborative, established in 2016 by the Coalition of Carers to support, evaluate and improve carer representation on Integration Joint Boards (IJBs) noted in its 2019 scoping report that there are still areas for improvement in relation to carer involvement in strategic planning. In particular:

- Recruiting and retaining new carers who are willing to undertake representative roles has become a challenge
- Most IJBs continue to require Carer Reps to subsidise their public duties, with expenses not being provided and expenses policies not being in place.
- Involvement in agenda-setting has improved in some areas, but Carer Reps are still excluded in many others.

As equal partners in care, carers must be included in the governance arrangements of any future National Care Service, as full voting members.

"Carers are meant to be equal partners. However, the reality so often is that we are given all the responsibility without the support, resources or recognition. It's so often far from being a real partnership"

Changing Lives and reducing bureaucracy

Change must be focused on making a real difference to the lives of disabled people, older people and carers and not on lengthy (and often costly) structural change and process. We also emphasise that changing the structure of how social care is delivered must not be framed by the reaction to the COVID-19 pandemic, but must be focused upon the whole person, providing choice over what services and support will meet their outcomes and their aspirations. It is not enough to only offer services that meet, for example, personal care needs. We must seek to develop an approach that enables people to fulfil their potential, and to be part of their communities: to work, volunteer and study if they wish and to have strong community, family and social connections.

People should be able to move with ease through the system supported by navigators, rather than gatekeepers. People should not have to 'battle' or 'fight' to access support

> "The level of bureaucracy carers are facing in order to access support or to access their rights in relation to ACSPs is diabolical. They are creating barriers rather than seeking solutions. The number of carers facing extreme mental health concerns is growing every week"

Full implementation

Any changes arising from the review must be fully implemented and the organisations responsible for implementing changes must be held accountable for doing so. There are many examples of good legislation and policy that are simply not implemented consistently across Scotland. There must be oversight and the ability for the Scottish Government to intervene where required

This graphic was developed by the Coalition of Carers in Scotland to illustrate the implementation gap, which cannot be bridged without a commitment from all partners

> "We need some accountabilities in our system for how the money is spent…we need transparency about how much we are spending and simplification of some of the flows of how money is allocated. Clear accountability for every pound for social care, what are we spending that on and what's the thought process that led us to invest in X rather than Y" (Derek Feeley)

Investment in carers

Many people have rightly drawn attention to the need to invest in the paid care workforce. But we cannot discuss investment in paid care work without also underlining the crucial need to invest in unpaid carers as equal partners in care. The value of care provided by unpaid carers in Scotland is greater than that of the health and social care workforce combined. Investing properly in our unpaid carers is an essential part of preventative support. This ranges from a Carers benefit that properly compensates carers financially for their contribution and loss of earnings, to support services that enable carers to work, study, access leisure opportunities and maintain social connections alongside their caring role. Caring should not drive carers into poverty and poor health.

> "Carers have to fight for everything, or they just give up and think it's easier just to get up in the morning, do what I have to do and then go back to bed. 100 reasons why you can't get something rather than 1 reason why you can"

Investment in the paid work force

Investment in social care staff is also critical. The value Scotland places on social care must be reflected not only in the quality of services it provides to carers and those they care for, but also in the employment conditions of staff that support the delivery of care. Whilst work has been undertaken with SSSC to enhance the professional standing of social care workers, this is not yet reflected consistently in wages, terms and conditions or career development. Poor pay and conditions has an impact on the ability to recruit and retain staff, with staff turnover meaning the loss of valued relationships that are important to people receiving care.

> "In our area there are not enough paid carers, even for personal care packages. Social care is not paid adequately and there is a really high turnover of staff, Covid has exposed these gaps"

Valuing Community and Third Sector Organisations

Many unpaid carers rely heavily on the services they receive from third sector organisations, such as carers centres. This has never been illustrated so starkly as during the pandemic where community and third sector groups rallied across Scotland to meet the needs of disabled people, older people and carers, while the public sector stepped back services, or could not respond and innovate quickly enough.

Throughout the pandemic carers centres have provided continuous, unbroken service provision. They have delivered practical and emotional support to carers, ensuring people have access to food and medication, organising PPE deliveries and keeping in regular contact by phone and online platforms to ensure carers feel safe and supported. They have also been able to support carers to access alternative forms of breaks where traditional services have been suspended.

> "What we've learned absolutely from the pandemic is the significantly quicker response/adjustments possible from the third sector."

Any review of social care must place equal value on our voluntary organisations and community groups as public sector partners. Giving people choice and control within a social care system also means having a sustainable market available that can deliver on the choices that they make. **The role of the third sector in delivering services is critical and must not be secondary to the statutory sector**.

For a level playing field and a relationship of equals, the statutory sector must be subjected to the same scrutiny and accountability as the voluntary sector. Current commissioning practice must be reformed and power must shift from the statutory services to community provision, ensuring that third sector organisations receive adequate, long-term, sustainable funding.

In order to achieve this we need to move from a market economy to a community economy. This requires a paradigm shift from investment in the profit making private sector to resources being directed to the third sector and community organisations, led by supported people and carers. With an emphasis on local community solutions to social care

Collaborative commissioning needs to be the standard model, creating the conditions to allow innovation and collaboration to flourish

This requires a turnaround to traditional commissioning relationships and a shift in the balance of power and responsibility between agencies, supported people and unpaid carers

> "Carers centres should not be put out for sale. We are here to do a fundamental job to support carers in our community. We can only do the best we can if we have stability of funding. Third sector organisations should not be traded this way. The government has said often that we need to be seen on the same level as statutory partners, we are not"

Use of technology

Throughout the pandemic the prodigious use of technology has enabled people to stay connected. For many carers, particularly those in rural areas, or with very isolating caring roles, it provided them with greater opportunities to engage than they had before Covid-19. Technology has the ability to extend and customise choice and promoting and facilitating digital inclusion must be a recommendation for the review. However, digital connectivity must never be viewed as an alternative to personal, face-to-face support, but rather as an enhancement to this.

Section Six: Specific Groups that require additional consideration

BAME carers

We must acknowledge the unequal impact that some communities experience when accessing social care, particularly in relation to the current pandemic.

BAME communities have suffered more through COVID-19 than other communities. Those who were already disadvantaged are now even more marginalised because of a lack of tailored support to meet their specific needs, including the need for community languages and culturally responsive services. (Section Three provides further information on how BAME carers have been disproportionately affected by Covid-19)

We cannot ignore this and the review must make some recommendations regarding this. For example, where carers centres have specific BAME carer support posts, there is much greater uptake of services from minority ethnic communities.

Caring as a gender issue

Around the world, women spend two to ten times more time on unpaid care work than men[5] and in Scotland twice as many female carers rely on benefits than male carers. We cannot talk about unpaid care without acknowledging the specific impact it has on women.

This unequal distribution of caring responsibilities is linked to discriminatory social institutions and stereotypes on gender roles. Gender inequality in unpaid and paid care work is the missing link in the analysis of gender gaps in labour outcomes, such a wages and job quality.

> "The capitalist patriarchal system has found a great care solution - make the women do it for nothing. Care crisis is as much to do with women asking for more as about the ageing population"

Carers from rural and island communities

The Coalition of Carers has facilitated a working group for rural and island carers for the last 10 years. This group has consistently highlighted how carers from rural and island communities face additional challenges, including a lack of public and community transport, increased levels of poverty, additional isolation, challenges with the recruitment and retention of the social care workforce and less choice and availability of social care provision and carer support. We recommend that targeted resources are directed to rural and island communities to help address these additional challenges.

Young carers

Young carers have specific needs and challenges that require their own solutions. As an organisation. we only engage with adult carers, however our colleagues at the Scottish Young Carers Services Alliance are an excellent source of expertise on the needs of young carers.

Section Seven: Supporting Carers – Models of Support

> "We need to move away from only providing support to those in critical need. We need to invest in preventative support. This is a priority to enable a healthier fairer Scotland"

In principle we believe that models of social care provision should be co-produced locally through engagement with local communities, supported people and carers. However, as part of our discussions with carers they have recommended three models of support, which if applied nationally would contribute to a preventative approach and greater consistency for carers in accessing support.

[5] Unpaid Work, the Missing Link, OECD Development Centre, December 2014

In illustrating these models we have used a human rights approach, based on the PANEL principles.

Preventative Support Budgets for Carers Centres

In 2018 The Carers Act brought in new rights for carers, including the right to support for carers who meet local eligibility criteria. However, the majority of carers still rely on local community and third sector organisations for support. We propose that local carers centres should hold a preventative budget in order to respond to the needs of carers identified through Adult Carer Support Plans in a flexible way, allowing carers to choose what support best meets their outcomes and preventing them from reaching crisis point.

Participation	This model will allow carers to choose the right support for them. It would build on the principles of SDS, extending choice and control to carers who do not meet local eligibility criteria
Accountability	Carers centres are trusted organisations with expertise in supporting carers. They already manage Time to Live which provides one-off interventions for carers and which is highly evaluated by carers
Non-Discrimination	Carers centres support carers from all caring communities, including carers with protected characteristics
Empowerment	Carers centres are carer-led orgs who involve carers at all levels of decision making and recognise carers as equal and expert partners in care. On an individual level, carers will be supported to identify the best options to meet their personal outcomes
Legality	This proposal supports the duties in The Carers (Scotland) Act 2016 and the Social Care (Self-directed Support) (Scotland) Act 2013

"Local authority bureaucracy is a huge barrier to the delivery of social care. Third Sector needs to be an equal partner in the delivery of social care and it needs to be recognised that Carers Centre are well placed to allocate budgets and access respite options for carers"

Minimum Entitlement to Short Breaks, including a right to replacement care for carers in employment

Although the Carers Act introduced new rights to carers in 2018, it did not include the right to a break from caring. Short breaks are critical to the health and wellbeing of carers and their ability to maintain a life alongside caring and remain active citizens.

In addition, investing in replacement care for carers looking after disabled people and older people should be viewed in the same way as investment in childcare. Replacement care is essential to enable carers to remain and return to employment.

Participation	This model would allow carers greater access to short breaks, choice in the type of provision they access and would enable them to participate in the workplace and in their local communities
Accountability	There are already measures in place in relation to the inspection and monitoring of short break providers. Most short break provision is carer-led and carers are involved in the design and delivery of services
Non-Discrimination	This model would be available to all carers, including those with protected characteristics. A range of providers would be required to ensure services were available to meet individuals needs and to ensure there were no barriers to people accessing support
Empowerment	Rather than relying on local provision and local eligibility criteria, all carers would have an equal entitlement to short breaks and replacement care, allowing people greater rights and autonomy
Legality	This proposal supports the duties in The Carers (Scotland) Act 2016 and the Social Care (Self-directed Support) (Scotland) Act 2013

More Choice & Control through Self-directed Support

As a response to Covid-19, the Scottish Government issued temporary guidance in July 2020 to reduce bureaucratic processes and enable Direct Payments to be used more flexibly, including for the employment of relatives. We believe this guidance should be made permanent and work should be undertaken to increase the take-up of direct payments by unpaid carers

Participation	This model would allow carers greater Choice and Control in line with the principles of SDS.
Accountability	There are already measures in place in relation to the monitoring of direct payments. This approach of reducing bureaucracy would reduce the barriers to people accessing support
Non-Discrimination	By introducing greater flexibility in the support people can access, this would enable carer from all communities to have their needs met.
Empowerment	As part of this approach carers would be supported to identify support solutions to best meet their personal outcomes
Legality	This proposal supports the duties in The Carers (Scotland) Act 2016 and the Social Care (Self-directed Support) (Scotland) Act 2013

"Simplify the SDS process and allow carers to be the commissioners of their own support

One of the outputs from the survey about changing SDS options during lockdown was 'if we can fast track it now, why not all the time?"

Section Eight – The three tests

Finally, we believe that as a measure of success, any new system or models for delivering social care, must pass the following three tests:

1. **Is it person centred?** Are the people who use services and their carers at the heart of decisions about social care and are their views paramount, strategically and in their day-to-day lives?
2. **Is it adequately resourced?** Is our 21st Century social care system funded to a level that will truly improve the lives of people who use services and their carers? Will it meet not only their daily needs but also their ambitions and aspirations and will it reduce the inequalities they experience.
3. **Does it deliver choice to supported people and carers?** The choice to be independent, to choose how much care they are willing and able to provide, to have services that fit around their lives not around time slots, contracts and tasks? Does it place individuals and their carers in the driving seat rather than as passengers in an unresponsive system?

About the Coalition of Carers in Scotland

The Coalition of Carers in Scotland exists to advance the voice of carers by facilitating carer engagement and bringing carers and local carer organisations together with decision makers at a national and local level.

Since its inception in 1998 the Coalition has played a fundamental role in advancing carer recognition and support and more recently in establishing a Carers Rights agenda in Scotland.

It is our vision that carers in Scotland will achieve full recognition as equal partners in care. Carers will have the right to quality services and access to personalised support at every stage in their caring role to ensure they enjoy good health and a life outside of caring.

Through our membership we connect with carers and carer-led organisations from all local authority areas, from urban, rural and island regions and many individual carer members, ensuring that carers from the Borders to the Shetlands have the opportunity to have their views heard.

Further information

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Community Hospitals Association

COMMUNITY HOSPITALS – THE NEXT 50 YEARS MATTER!
Dr Alastair Noble – A Personal Reflection

Scotland is a visionary country

If we really want to give the highest quality of care, we need to deliver the right structures and organisations. All patients must have access to the full range of options.

This means a Community Hospital bed in all localities.

Why? Because it allows the complex team working to allocate the patient to the correct level of care for them at all times. It provides the level playing field that allows both Generalist and Specialist to fulfil their best roles and target optimum care.

Last but not least we must look at educating a suitably trained work force in all professions for the future. Most care will be in a community setting. We must make sure most education is in that community setting. The Generalists in all professions must do the bulk of training and this is where the Community Hospital with the extended Community Teams comes into its own. Specialists have undermined the quality of Generalist training and we must put it back at the top of the agenda.

I hope this strategic paper will give the necessary impetus to restore the Generalist role to its essential core building block in both Education and service delivery. It also allows the Specialist in all Professions to concentrate and deliver their care where it is appropriate, but above all to allow them to stop doing what is not in our Patients best interest-over treating, over diagnosing and above all delivering no continuity of care. Patients and their relatives value continuity of care. The cradle to death aspect of General Practice immersed in its own rich locality is fundamental to that trust and human relationships which makes General Practice so fulfilling as a profession.

We have the right model available and now is the best opportunity ever to deliver the highest quality Health and Social Care for Scotland. This must also be linked to the correct Education and Training for all Professions.

In summary, I believe that General Practice provides real Professional satisfaction for Generalists, like myself, and if we get it right it allows people with Specialist minds to deliver their skill and input. Above all we need a balanced system and that means for next few years we concentrate on General Practice and train our next workforce to be both Generalists for the majority and fewer Specialist where we need them.

Well done to the Community Hospitals Association for reaching 50.

It would be a nice present if we can deliver a Community Hospital for all our patients.

Why General Practice Teams including Community Hospitals are an essential part of Patient Care in the future.

This paper is written to celebrate the 50th anniversary of the Community Hospital Association in England. I have been asked to write the Scottish View. I have chosen not to do a historical review and would recommend Sir Lewis Ritchie's Community Hospitals in Scotland paper from 1996 (1) along with the output from the SACH Alumni last conference in 2016 (2) as essential reading.

We have inherited an ageing model of care which is no longer fit for purpose. We must deliver an integrated, locality-based health and care service to meet the real needs of our population going forward in all localities in Scotland

We have over-concentrated on Specialist Big Hospital Medicine and almost totally disregarded the essential role of Generalist Community Care. We have increased Consultant numbers in Highland for example from 160 in 2005 to 242 in 2016 whilst the GP count went from 300 to 305.The ratio being 0.7 Consultant per GP in Highland. Tayside historically is 1.6 Consultant and Glasgow 1.9 Consultant per GP.

A recent BMJ paper (3) shows the same pattern in prescribing in England, the total rising from £13 bn in 2010-11 to £17.4 in 2016-17. The GP prescribing rising slightly from £8.8 bn to £9.1 bn while hospital spend went up from £4.2 to nearly double at £8.3 bn.

The health and social care models have delivered massive benefits since their inception. We have the fittest, healthiest population ever. Yet all we hear are complaints! People are still dying. It must be stopped - everybody must live forever. Well my outcomes are the same as every other Doctor, 100% of my patients have been born and 100% of my patients will die.

The Covid-19 saga has been highly informative. Big hospitals with ventilators and renal dialysis have not cured frailty. How much has been wasted on kit/toys for boys for no return? The patients in nursing homes are frail and do not overcome terminal illness. It awaits us all.

We have been seduced by research. It is a massive growth industry. The answer is always more research and we waste billions on repeating the same sort of investigation to learn nothing new. Why do we not use research properly as an essential component of development?

Why do we not deliver the best systems to ensure maximum gains for our population and that they are as cost effective as they can be. High quality community care is the essential building block for all care systems. If it is performing to its optimum, we can deliver the highest quality secondary care where appropriate. The evaluations of the Total Purchasing sites (4) showed clearly that those GPs with extended Community teams delivered the best community care outcomes. They were also the best commissioners of secondary care as they knew what their teams can do and what they cannot. The best commissioning is when the GP and Consultants agree what needs to be done in Consultant Care and as importantly what does not and when to transfer the patient back to the integrated locality-based Community Team. This clinical decision-making treats both Consultant Care and General Practice Care as equals.

The clear outcome of the Multi Agency Inspection Team's work (5) is that high quality Community Care can and should deliver over 99% of the occupied bed days for our over 75 population (our biggest spend). Put simply most elderly people are in their own homes living independently and enjoying life.

Background DATA Scotland

Data (6) Total occupied bed days (OBD)

- 6.4 million OBD
- 0.8 m scheduled/planned
- 5.6 m unscheduled/unplanned
- 600,000 DELAYED DISCHARGES = 50-55 wards full of delayed discharges=2 DGHs full
- Nearly 4m OBD are occupied by patients over 65
- 2% of patients occupy 79% of OBD
- 2.5 % of total population =50% of spend on hospitals and prescribing

It is understood that of the frail elderly patients who were unscheduled admission who are in hospital today it is estimated that one third up to will be dead within 1 year and 1 in 10 will die in this hospital admission.

Can we save the Titanic? Do we even want to?

Francis/Mid Staffordshire Report (7) showed how dangerous it can be in an acute hospital if you do not need to be there and 20% were discharged straight to a Nursing Home. The coronavirus death rates again show how dangerous institutional care can be. Both hospitals and nursing homes clearly show this. Can we improve on this?

The Perth & Kinross Perfect equation work shows the realistic alternative, and sets standards which improve both quality of care, but also quality of life. Which bed did you sleep in last night? A great question for the over 75s!

- 95% OBD - they are getting on with enjoying life with only GP & General medical services input
- 3% OBD - they are at home with complex care health and social care package-under regular review
- 0.8% OBD - they are in nursing homes with average length of stay 1 year
- 0.5% OBD - they are in Community Hospital (including Hospice care) average length of stay2-3 weeks
- 0.7% OBD - they should be in Consultant bed and average stay should be about 1 week

This is being delivered in the best areas in Scotland where we still have extended Community Teams with GP-led Community Hospitals. This would give Scotland a quite different pattern of care.

5.6 m OBD would be reduced by 600,000 OBD of delayed discharges being eliminated. The variations would reduce another 2m OBD to reach our perfect equation standard of quality care. Again, the evidence is overwhelming. The proximity of a big hospital drives admissions and worried well/social class use more OBD in hospital and Nursing Homes. This is not clinically appropriate

A realistic outcome total of 3.8 m OBD in all Scottish hospitals. There is also a 3-4 times variation in Nursing Home rates and in >10.5 hours of home care. The patterns are clearly historical rather than clinical. It is aye been that way!

Our Elderly and Infirm deserve a 'Gold Standard' of care

I firmly believe that having 60% of all OBD in hospital being in GP-Led Community Hospital Beds, as in Aberdeenshire, is the gold standard of care for our frail elderly/near to death patients. Aberdeenshire also has the lowest hospital OBD rate and again I believe this is because the GPs, their community teams and above all their local communities and individuals all know this is the optimum quality of care.

Patients, relatives and communities all value continuity of care. There is no alternative to the GP and the community teams in delivering that quality of care. The Covid-19 experience has again shown the fundamental weakness of the disease specific specialist model. Most people have more than one condition and most need health and social care.

The role of the disease-specific specialist is to help the patient get optimum treatment for that specific condition. All my discussions with the best of Consultants and General practitioners have agreed on this fundamental point. This is why we pay the Consultants and General Practitioners to take responsibility and accountability for the clinical care.

Scotland's 2020 vision

I have some thoughts on the benefits of bringing back of Kerr (8) and reflecting on the lack of progress to the "2020 Vision." There are some difficult questions with some obvious answers.

** Why have we bought the Specialist model?*

Common conditions are Common. The commonest is old age/frailty and closeness to death. None of these is a Specialist condition. It just needs honesty, integrity, and good generalist clinical skills to help our patient and their relatives/friends /carers see what they already know.

Every report I have read says we need more Generalists/more community care/more integrated health and social care-yet we keep not doing this.

** Why are GP s not being valued?*

Some of this is our own failing. "Everybody "can do what the GP can do? Absolute rubbish-the most difficult skill in medicine is getting the diagnosis right. This is especially true when diagnosing nothing wrong with the patient and being right! The next most difficult is in diagnosing where therapeutic (curative) treatment is no longer in the patient's interest and supporting palliative care.

We must cherish and support the excellent GPs we have now and promote them as the model for teaching our young Doctors to be Proud to be a GP.

** Why Independent Contractor Status?*

Simple answer to the GPs who do not want to be partners. Would you prefer to be managed by a fellow GP (who knows what it is like) or by a non-medical low to middle grade manager? I always think of Bob Liddell (9) explaining to me why the individual clinician is always responsible for their own clinical decision-making and how as a manager he could not and would not take that responsibility away from them (polite version).

** Why localities must take 24/7 accountability and responsibility?*

We take 100 bright young doctors. 50 become Consultants and continue to do nights and weekends, 40 become GPs and will never do another night or weekend and 10 will do all the GP. Out of hours work. I cannot think of a dafter contact decision. It must be changed. It can be changed.

Nairn still has our own Nurses triaging our Out of Hours (O-O-H) calls and our own GPs on call. It is a great source of local knowledge and again a massive benefit to our patients. It allows for example remarkably close co-operation and liaison between our mental health Team and the O-O-H care which benefits some of our most vulnerable patients with mental health conditions. It reinforces our continuity of care with shared access to our medical records. Again, particularly essential in end of life care where we consistently see over 75% of our deaths taking place in our own community.

** Why Localities and Integrated Care*

All the team working evidence is around stable settled teams who are confident and trust each other. This must be locality based and involve all health and social care. This also gives maximum confidence to the Consultant Team.

** Why has the situation not improved for GPs and Community Integrated Care?*

The clinical decision has and always will be the purchasing decision. We have always ducked the value for money debate and discussion. There will always be a top line budget. My recent experiences in Tayside and Highland have just confirmed that without clinical change overspends and write off from debts will just roll on.

Therefore, the Integrated Resource Framework (IRF) Fair Share Integrated Locality based Budget (10) is essential and the GP leadership in each Locality becomes accountable and responsible for staying within that agreed Fair Share budget.

However, and this is vital the clinical decision-making and therefore accountability and responsibility is shared with and accepted by Consultants and GPs together. This equally applies to all the teams-community/social and hospital. Probably and this is most important the individuals in each locality share/understand and can contribute to improving their health and social care outcomes. It also allows us to target the variation we accept in Fair Share allocation and see if the extra allocation is working or not.

The future?

General Practice Teams, including Community Hospitals, are an essential part of Patient Care in the future.

Dr Alastair L Noble MBE

Community Hospitals Association Committee and Lead for Scotland
Chair of Scottish Association of Community Hospitals Alumni

September 2020

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Community Integrated Care

Hi,

Whilst we will be submitting a review that includes accounts from our supported people, family and colleagues, I wanted to note some additional thoughts from our organisation on this review.

We support over 300 people in Scotland and the vast majority are commissioned for are through SDS Option 3. We would like to work in partnership with the HSCP's to increase uptake on the other options of SDS. Since the introduction of the SDS Act 2013 there continues to be confusion over how people can access social care and how they receive funding. There is a real lack of understanding of SDS and what this means across some social care teams. People in need of support very often are not aware of what they are entitled to.

Commissioning and procurement vary across the HSCP's and there is no consistent approach. We welcome market position statements and strategic commissioning plans to help us plan for the future, however traditional tendering and competition amongst providers continues to be the main route for commissioned services. Further exploration of alliancing and more modern approaches that are not restricted by contract and price/quality reviews would be welcomed.

Our income is mostly received through contracts with Local Authorities/HSCP's. Over the past decade we have witnessed a clear reduction in funding revenue in the sector. It has been reported that even whilst the demand is increasing, spend per head will not. The independent review of social care should identify and correlate need versus the spend in the sector.

Innovation in care is part of our ethos and continued aims and we welcome efficiency in support delivery whether that be through technology or a change in practice. Furthermore, we welcome the attainment of living wage in Scotland for all frontline workers. However, this has created an annual rate review process that is time consuming leading to hourly rates being assessed at a granular level with ongoing dialogue and negotiation to finally agree. The timeline of living wage being announced (November) and applied (May) to the agreement with the HSCP of the annual 'rate' can take over a year to agree in some cases. Care providers, such as we, are front loading the costs to then reclaim back dated payments throughout the year. This, for many providers, is unsustainable, but furthermore unethical and would not be accepted in the public or private sector.

From a national context, implementation of the IJB and HSCP's has not had the desired effect in terms of blending care provision with NHS Care setting such as step-down hospital care, or clinical care within a social care environment. Budgets and financing of Health and Social Care are not integrated. HSCP's continue to have separate social care and NHS budgets, however if blended and working together, clinicians could work with social care provider to offer a lean service, costing less and meeting the needs of the individual receiving care.

Finally, we would add that the idea of a National Care Service is not something that we would welcome. Care providers tend to work in an agile approach in a fast-paced environment. Delays in change tend to be driven by the public sector due to the level bureaucracy. For example, changes need to go through IJB who only meet four times per year. Social care needs to be dynamic and a national approach would not allow for this; thus only adding more layers of decision making to confuse the people in need of care. A nationalised service would only result in a higher social care spend focussed in bed rates and hourly rates and potentially a movement from outcome led supports. The very nature of the charity or independent social care provider allows for added value that would not be viable in a national service.

A fuller response has been provided to the ALLIANCE that details feedback from people who use care services, family members and colleagues.

We would welcome further participation as the review moves through to phase 2 and 3 and if we can be further involved please do get in touch with me.

Kind regards

Leanne

Community Integrated Care

www.c-i-c.co.uk

People Passion Potential

Competition and Markets Authority

Classification: **Official**

Dear whom it may concern

I am writing from the Competition and Markets Authority, an independent non-ministerial UK government department and the UK's primary consumer and competition authority. We work to promote competition for the benefit of consumers across the UK. Competitive markets and an effective competition policy can play a major role in delivering productivity and growth in the economy. In well-functioning, competitive markets, businesses innovate and compete vigorously to attract customers' business. Customers make informed choices between suppliers on price, quality, innovation and service.

While I understand that the Review is not explicitly considering the competition and consumer aspects of social care provision in Scotland, some of our recommendations may be worth bearing in mind. Unfortunately, we are not able to make a formal submission to the Review, but I thought it might be useful for you to be aware of some previous work that we have done on social care.

In 2017, the CMA conducted a UK market study into care homes for older people, to review how well the market worked and if people are treated fairly. It also included consideration of how Scottish policy and regulation affected the experience of elderly consumers, particularly those who privately fund the costs of their residential care. The short Scottish summary of the study can be found using this link - https://assets.publishing.service.gov.uk/media/5a201ae7ed915d458b922ec6/scotland-short-summary-care-homes-market-study.pdf

The market study outlined concerns in the care sector that those requiring care need greater support in choosing a care home and greater protections when they are residents. We found that the current model of service provision could not be sustained without additional public funding; the parts of the industry that supply primarily local authority funded residents were unlikely to be sustainable at the current rates Local Authorities paid.

We found that significant reforms are needed to enable the sector to grow to meet the expected substantial increase in care needs. We highlighted numerous recommendations on how the sector could be reformed covering three key areas:

- Capacity recommendations, such as early action to encourage investment;
- Consumer protection recommendations, such as the requirement to provide better information to prospective care home residents, and
- Consumer decision-making recommendations, such as supported decision making to help people understand their care options.

We also proposed that Scottish regulatory rules should more effectively embed consumer protection principles and be monitored through inspections by the Care Inspectorate.

Following the study, in November 2018, the CMA also undertook the following, which included engagement with relevant stakeholders in Scotland:

- progressing enforcement action against firms infringing consumer law
- issuing detailed guidance on consumer law for care home providers
- issuing a short guide to consumer rights for residents
- issuing consumer law advice on charging of fees after death
- publishing an open letter to care homes, reminding them of their responsibilities under consumer law and urging them to review the advice immediately.

I hope this information is useful. I would be more than happy to provide additional information to you should you wish.

http://www.gov.uk/cma | @CMAgovUK

Crossroads North Argyll

Crossroads North Argyll are a third sector organisation providing respite for unpaid carers in Oban, Lorn and Isles.

For the Kind and Personal Attention of Derek Feeley

Dear Derek,

To support the Coalition of Carers response to your review of adult social care, please could Crossroads North Argyll's Board request a recommendation be added when you report to Government in January 2021 that there will be an intention to '**Fund the Budget' of Carer Centres/Services** on a full cost recovery basis.

We would also like to recommend the following in support of the Coalition of Carers response:

1. All Carers Act funding should be ring-fenced and used to support unpaid carers, if full cost recovery is not an option.
2. All unpaid carers should have the right for replacement care in conjunction with the right for regular breaks. Short breaks are crucial to the health and wellbeing of unpaid carers and their ability to maintain a life alongside caring and remain active citizens.
3. Unpaid Carers should be involved in the decision-making process when providing care. They are not treated as equal partners in the provision of care.
4. Investing properly in our unpaid carers is an essential part of preventative support.
5. The third sector rose to the challenge of COVID and quickly made adjustments to provide continued support to unpaid carers. The role of the third sector in delivering services is critical and must not be secondary to the statutory service.
6. Current commissioning practice must be reformed, ensuring that third sector organisations receive adequate, long-term, sustainable funding, possibly looking at full service recovery.
7. We would like to see targeted resources directed to rural and island communities to help address these additional challenges.

Thank you and I hope the review is going well.

Joan Best
Manager
Crossroads North Argyll
c/o North Argyll Carers Centre

Appendix

Appendix

Direct links to organisations' and representatives bodies' submissions to the Independent Review of Adult Social Care in Scotland as published on their own websites

ARC Scotland - "We're all in this together" The impact of Covid-19 on the future of social care in Scotland: a view from the workforce

Carr Gomm - Submission to the Independent Review of Adult Social Care

CCPS - Submission to the Independent Review of Adult Social Care

CCPS - Big Ideas

Common Weal - Submission to the Independent Review of Adult Social Care

Cosgrove Care - Submission to the Independent Review of Adult Social Care

COSLA - Submission to the Independent Review of Adult Social Care