Independent Review of Adult Social Care in Scotland Evidence Submissions

Volume 2

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 D to H and the Appendix links directly to organisations' and representatives bodies' submissions where they were published on their own websites.

Deafblind Scotland

Subject: RE: Independent Review of Adult Social Care

Dear Ian,

I welcome the opportunity to attend the meeting next week and to look at what we might me able to do to make the open in-box accessible to our deafblind members to share experiences of social care. There are definitely some important experiences that I know members would want to share. I will work with our welfare rights team to see if we might find a way to provide some direct experiences from service users. We are also looking at what might be possible in terms of facilitating some roundtables to secure the input of deafblind people.

Meantime in relation to question/comments for Derek : our main area of concern regarding the current system and indeed the future challenge in securing a fairer system/reducing inequalities for deafblind people is:

There are currently around 1,000,000 people living with hearing loss in Scotland, 200,000 with sight loss and an estimated 31,000-34,000 people with dual sensory impairment (at a degree where one sense can no longer adequately compensate for the loss of another). Making sensory loss the most prevalent of conditions which disproportionately impacts on the lives of people as they age. Sensory loss therefore often sits alongside and compounds those other long term conditions and disabilities that can occur as people age (high levels of co-morbidity with conditions such as dementia where the association with hearing loss is increasingly understood and vision loss with causal links to conditions such as diabetes). To add to this picture older people are amongst those that are most often dependent on social care services and vulnerable when these services fail them. We are very aware of the impact that sensory loss has on an individuals ability to live an independent life if the right support is not made available but despite this the critical role of communication in supporting social connectedness and mental health and wellbeing is most often overlooked within the reality of current social care provision. At times this is due to the lack of skills of those assessing need for SDS but it is also a more systemic failure.

It is well rehearsed that preventing loneliness and mental health problems are an important endeavour in themselves. However, both loneliness and poor mental health and mental health problems impact on a whole range of other health and social outcomes. Without support to prevent loneliness and improve social connectedness we know that lives are shortened and that health outcomes are worsened (even within illnesses such as cancer). We also know the impact of poor mental health creates distress and real misery for people in the immediate term but that a failure to protect mental health and wellbeing upstream also has a longer term impact on demand for more specialist and critical services at a later point. The 'failure demand' described so well by the Christie report. However, the reality is that despite sensory loss posing one of the greatest risks to the social, emotional and psychological wellbeing of older people we currently have a social care system that focuses down on personal care and basic needs without due consideration of the central role that communication support plays in promoting that wellbeing for people. Over the years we have found more and more people in the position of having communication support reduced when they find themselves needing personal care or having to choose between communication support and personal care. Without communication support we find many people unable to maintain or establish even the most basic of human connections let alone be able to have meaningful relationships with others.

In a nation where we have a focus on reducing loneliness and improving mental health, it is vital to recognise that for a very significant number of our population this is only possible where communication support is made available. Having worked to embed a human rights approach into

the See Me Programme in my previous role I am delighted to see human rights at the centre of the social care review. However, will the social care review consider that access to emotional, social and psychological wellbeing as a priority and a human right at least equal to the meeting of personal care needs. We have many case studies to share that highlight the distress that people have experienced during Covid-19 where this lack of prioritising of the things that make life meaningful has played out as never before. We welcome the changes to care home visiting as an indication that this is now being understood and would welcome the opportunity to share some more of those case studies with the review if this was considered helpful.

A second area that we feel needs consideration is in relation to workforce development.

There are a number of social care areas that are more specialised. Sensory Impairment is one such area, alongside Autism, Learning Disability and Serious Mental Illness and Dementia. Deafblind Scotland's registered social care workforce are not only generically qualified as required by SSSC (through SVQ health and social care qualifications) but are also trained extensively as Guide Communicators through Signature registered qualifications (K202, T201 and T202) and in BSL Level 1 -7 and Deafblind Manual diploma. However, the current system often doesn't recognise this need for specialist training (or require it) and this plays out in a number of ways including the commissioning of services. There are some notable exceptions, where local authorities do require and acknowledge this specialist service but most often this is not the case. Will the review consider the need for a workforce framework that takes into account differing levels of specialism and payment rates as well as commissioning approaches that are accessible for more specialist services. The National Flexible Framework provides a useful example, where we are given daily information on a large numbers of service users requiring services but with no indication of whether any have a dual sensory impairment. Will the review consider the need now to create a workforce framework that recognises these highly specialist areas of Autism, Learning Disability etc and of course Sensory Impairment as 'allied social care professions' and build a workforce development framework around this that lifts this sector to the level we have in health over the past 30 years. I genuinely believe we can only realise ambitions around creating a person-centred, human rights based national social care service by strengthening the sector skill-base, creating career pathways and articulating the unique specialist contribution.

This is possibly more than you were requiring but I will stick to these two key areas in any discussion as they are really at the heart of the issues for the deafblind people we work with.

Thank you again for extending this invitation and the inclusion of deafblindness in this programme.

Kind regards

Isabella

deafscotland and Deafblind Scotland

Adult Social Care Review

Key messages from deafscotland and Deafblind Scotland

7 Nov 2020

Authors:
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Social Care Review
Deafblind Scotland and deafscotland Response

Context and Background

Deafblind Scotland (DbS) and deafscotland have worked on a number of joint initiatives and share a value base, a person-centred, rights based approach and support the social model of disability.

We also agree a broad definition of deafness which includes a spectrum and four key pillars: Deaf/BSL users; (12,500); Deafened (355,000); Deafblind/Dual Sensory (34,000); Hard of Hearing (700,000). We are working towards a more strategic approach; better evidence of issues - based on better quality data and research; improved awareness; and earlier, more informed interventions.

We seek to jointly address the communication poverty in Scotland and lobby for change through “Communication For All”. The response is lengthy but includes a number of case examples to illustrate points being made.

The Issues

1. Deafness/deafblindness

Deafness/deafblindness can lead to profound levels of isolation, loneliness, boredom, frustration, and depression. For example, a recent Deafblind UK study found that mental distress is three times more common among people with deafblindness than the general adult population. Within the study, 50% of people surveyed reported high levels of anxiety, depression, physical/somatic symptoms and/or social impairment. Respondents reported experiences of profound social isolation, a loss of independence, and the impact of other people's negative attitudes.

Similar data, from various sources, across the four pillars of deafness suggests rates of mental ill health are 3-5 times more than in the hearing population. British Sign Language users receive treatment for significantly longer than average.

Through our joint and ongoing consultation and Deafblind Scotland's vast service delivery experience in supporting people we know that being deaf or deafblind can be unusually isolating, even within more usual times, and can cause profound loneliness.

One of DbS member's described her life as "living in a cupboard with the door closed". During the pandemic these feelings obviously greatly increased. A recent public services survey evidenced that there is still limited confidence in communicating with someone who is deafblind. We see this daily with few people receiving adequate support provided in a way that they can engage with/understand.

A recent Sense report, highlighted grave health inequalities faced by deafblind people, stating that deafblind people are more reliant on the healthcare system and identifying inaccessible information and lack of communication support as key barriers

'*56% of deafblind people have left a GP appointment having not understood what had been discussed.'*

For those affected by deafness similar and other issues emerged:

- Lack of information, support and facilities in place for British Sign Language users;
- Lack of systematic access to hearing aid batteries, maintenance and user support;
- Little to no provision for access in English for those Deafened/Hard of Hearing. The Relay UK system is considered old fashioned and has low uptake in Scotland;
- General lack of staff awareness and reasonable adjustments, even in critical services like audiology;
- Need for adjustments to NHS 24, other services and Near Me online video-appointment support. This bridges to mental ill health and well-being; links to transport and community services and the broader social care system. The age related transitions phase is neither seamless nor well-resourced and challenging to manage too.

2. Deafness/deafblindness and Adult Social Care Needs

The numbers of people directly affected by deafness are around one million Scots. There is age related bias with 40% of the population aged 40; 60% aged 60; and 90% aged 75 plus.

Specific issues:
Children and families require specific attention to ensure significant input to early years that supports communication, language and skills development. The historic pattern leaves a significant number of adults with disproportionate needs to their potential and ability struggling to live independently.

Transitions into adulthood and from adulthood to older people's services are poorly managed. Levels of support diminish rapidly, awareness and use of equipment and aids is poor and support available does not keep up with changes in society. It is particularly challenging when people's hearing ability changes and goes unrecognised in casework, care planning and delivery.

Older Adults
Today, there are an estimated 34,000 people with significant dual sensory impairment in Scotland with varying degrees of substantive sight and hearing loss. There are many ways to develop a dual sensory loss, therefore deafblind people adopt a diverse range of communication methods making use of their residual sight and/or hearing. Deafblind people and Sign Language users are amongst the least visible in society and can face multiple, intersecting layers of discrimination - being older, living with other long-term conditions or disabilities, and in some cases, coming from an ethnic minority background where there is a higher rate of visual loss.

There are practical barriers to achieving good health, such as not understanding rights to 50+ cancer screening, access to dental care and being unable to adopt healthy lifestyle behaviours because the person cannot shop and/or for themselves inability or carry out the recommended weekly exercise.

A high percentage (around 65%) of Deafblind Scotland members are aged 70+ and overall, in Scotland it is estimated that around

75% of deafblind people are aged 65 years plus. Deafblind people are often in need of high levels of social care support and are arguable amongst those with most at stake within this Inquiry into Social Care.

The numbers with mild to moderate dual sensory loss are huge but unknown as the data is not collected (there is a need for more accurate data collection in arenas such as the Census and health). It must be remembered that even mild hearing loss causes significant communication breakdowns and has a significant impact on well-being and loneliness. Links between deafness and dementia are well evidenced.

Sensory services deliver different standards across Scotland and there is a postcode lottery to investment, the adjustments available and what is seen as acceptable levels of communication and language support, directly within the system and the associated welfare support.

The levels of challenge can be better quantified with the gaps: under use of current accessible systems, and under-representation in consultation and participatory processes leading to chronic silence from those who should be involved in the design of service delivery. The work done on co-production of services is failing those who most need to be given their voice.

We believe the range of interventions increased with some significance when the See Hear strategy was prioritised at local levels and that investment would serve to produce positive returns. We seek to see a socio-economic and cultural change, so the Duty Bearers understand, engage and involve all rights holders in the design and delivery of services that impact their lives.

Recommendations:

- Link the See Hear Strategy to adult social care developments.
- Make inclusive communication explicit in strategy, plans and guidance.
- Review processes to ensure consistent and improved data is gathered.

3. The Role of Communication and Language Support professionals including Guide/Communicators within the Social Care Workforce

Communication poverty is in part driven by a national systemic undervaluing of communication and language access as a mediator to wider positive social and health outcomes. This indirect and, often, unconscious bias supports a need for culture and attitudinal change, as well as spending and programme development to redress the imbalance. Through further omission, there will be significantly exacerbated communication poverty with an increasingly aging population.

Casework requirements:
Deafblind Scotland has created a highly skilled bespoke Guide/Communicator workforce through accredited Guide/Communicator training, SVQs related to Health and Social Care and Registered Management duties and SQA accredited BSL, Tactile BSL training and Deafblind Manual and Deafblind diplomas. These specialists have been a lifeline to many deafblind people, especially for the large number that are living alone without family support. Guide/Communicators are able to help with practical tasks such as shopping, picking up prescriptions or attending hospital appointments. However, much more importantly they help the deafblind person gain an understanding of the world around them, communicating information in a way that they can understand – often described as ‘the eyes and ears’ of a deafblind person.

Many deafblind people have great difficulty accessing the usual sources of information – general conversation around them, the press, TV, internet and social media - and therefore suffer an information deficit when it comes to making informed decisions. They find it difficult to sift through the information they do get for accurate data. Guide/Communicators also have a health improvement role where they not only assist in helping deafblind people to understand health advice and guidance but work alongside them to support them to shop and cook healthier meals and to get out of the house to take exercise. Covid-19 shone a spotlight on health inequalities sharply where, as an organisation we had to fundraise to enable deafblind people with low levels or no Self Directed Support (SDS) and a reliance on

more traditional social care support to take their allowed daily exercise and to deal with food parcels left on their doorsteps.

A key factor that was clear before lockdown but that came even more sharply into view was the levels of isolation and loneliness that deafblind people experience. Without a Guide/Communicator far too many, face long periods of time where they have no opportunity to engage with other people. This lack of fundamental human contact is caused by a lack of access to communication support but the impacts are much further reaching, leading to deteriorating mental health and worsened physical health outcomes. It is also known to influence cognitive decline.

Guide/Communicators funded through SDS can provide this emotional and social support as well as the practical assistance mentioned earlier. However, many deafblind people are not assessed as eligible for SDS due to the criteria set by some local authorities - only critical and emergency levels of need are viewed as funding priorities. Despite the intent of SDS, often personal care needs are prioritised but communication support. Communication support is critical to health, mental health or indeed independent living outcomes. In many decisions, with notable exceptions, inclusive communication is viewed as a privilege and not a fundamental right.

Given this high level of unmet need, it is therefore not surprising that the Guide/Communicator role has evolved over the years to ensure that every contact adds value by addressing a range of inequalities. The increasing numbers of deafblind people and the ageing demographic mean that this is not a static level of communication poverty/deficit but a growing one.

Guide/Communicators in the past focused mainly on two key areas: supporting independent living through helping people to navigate their communities safely and meaningfully; and on assisting access to information that enabled deafblind people to make informed choices. Where this role is needed more than ever, Guide/Communicators are also now registered with SSSC and have SVQ health and social care qualifications. Deafblind Scotland registered with the Care Inspectorate to support the growth of care at home and home support functions. This is in recognition that often a deafblind person will receive only one

service through SDS and therefore Guide/Communicators need to be skilled at providing emotional and social support as well as practical assistance. Helping to alleviate loneliness and supporting deafblind people to build healthy coping strategies is now a key part of the role.

Guide/Communicators need to have a wide range of communication skills and are therefore trained to varying degrees in BSL levels 1-7 but also in Tactile BSL and Deafblind Manual. These latter two areas are important when communicating with deafblind people who have absolutely no sight or hearing or if their vision has deteriorated to the extent that they cannot see to access BSL if they are a BSL user. During Covid-19 this role has continued with Guide/Communicators supporting people within their own homes using PPE where social distancing is not an option.

A similar, lengthy narrative would describe the lack of systematic approach to the needs of people who are Deafened and need specialist access in English though notetaking and technology and those with mild to moderate hearing loss. It is often simply forgotten, for example, that hearing aids are assistive, not corrective.

As is indicated in the case studies, local authorities may cut allocated hours of self-directed support in an attempt to reduce growing social care spend. Social workers who assess people for social care often do not realise that by assessing communication needs at a low level then they are not only failing to provide for the most basic human rights of some of the nation's most vulnerable people but are also building problems for the longer term through re-enforcing health and social inequalities. Many of those carrying out assessments have little deaf and sight loss awareness training and so do not understand just how important it is for deaf/deafblind people to have specialised communication support which prevents isolation and increased vulnerability.

Having an SDS package can be the only route for a deafblind person to get the support they need as accredited Guide/Communicators accessed through Deafblind Scotland are the only social care workers with the necessary specialist skills to provide a person-centred approach to meeting their unique

individual support requirements. Other support for deaf people may come from specialist deaf organisations which is not a cheap option as these are specialist services in the same way that services for people with a Learning Disability or Autism are. Provision may be made for BSL Interpreters but far too often mainstream services do not book Electronic Notetakers or teach their staff how to type on a tablet so that they can communicate with someone whose first language is English but they can no longer hear.

It is exceptionally difficult for a BSL user, deafblind person or someone who is Deafened to access external supports that may be a choice for others. During lockdown, a majority were not even aware that extra community-based help was available, leaving them struggling with basics such as shopping and picking up medication.

The approach

A worrying trend is where framework tender processes require that all social care staff carry out a generic role bringing together all the areas of independent living with all 'providers expected to offer the full range of care and support'. We recognise the need for specialist communication support as well as assistance to support deaf people to live independent lives for as long as possible. However, there has been no investment that would allow an expansion of the breadth of specialist deaf and deafblind services offered and the consequence may be that the specialist communication needs of deaf and deafblind people will not be met when they come to the point that they need 24 hour care. We have anecdotal evidence of people at the end of their life in care homes or hospitals with no access to communication or language support.

The default of SDS should be the inclusion of wider social and emotional wellbeing rights of individuals with communication support necessary to access these rights to support the initial intent of SDS to promote choices for people that enable them to live as independent and meaningful a life as possible. SDS has so much potential but reducing people to a series of 'needs' and using this funding support in a task focused rather than outcome focused way has fallen critically short of the transformational change in the live chances of deaf and deafblind people that should have been possible. Digital technology and a wider

range of solutions are affordable and available to support an integrated, wrap-around package of measures.

For example, a more joined-up way of thinking using legislation (BSL (Scotland) Act 2015 and work being done on BSL plans) and existing strategies (for example, the See Hear Strategy) could be useful to look at a coherent National strategy and planning system to address communication poverty. In the meantime Adult Social Care can be an exemplar.

Understanding the communication and support needs across workforce planning, building qualifications and professionalism across communication and languages and significantly improve quality of life in a multi-cultural, diverse Scotland.

Recommendations:

- Review training and qualification expectations with improved communication at the centre to meet PANEL Principles in a rights based environment.
- Set standards for Inclusive Communication within the delivery and inspection environment. This would include environmental and people assessments, improved understanding of access, process and participation with relevant adaptions in place.
- Support a mixed market of communication skills and abilities.

4. **Case Studies**

A number of case studies are appended to demonstrate the significance and critical impact of communication and language support for those affected by deafness, particularly dual sensory and deafblindness at times of transition and deterioration.

The examples demonstrate the lack of staff awareness and knowledge outlining the disconnected input in many care packages treating conditions separately and not seeing the impact as a whole. This underpins our contention that much of what we deal with is through omission rather than deliberate but we must remind planners that sensory deprivation is a form of torture. We are increasingly concerned that the anticipatory planning for an aging population fails to see the gaps we explain and that the underlying culture and attitude devalues sensory

issues, fails to weight them accordingly in welfare and benefits packages and fails to recognise the damage to well-being built into the current system.

Deaf people do not understand that they can appeal decisions or complain about the lack of accessible and inclusive services without having these services rescinded.

- An older deafblind couple Mr and Mrs W who are housebound and live with a range of additional long-term conditions. One partner PW was recently admitted to hospital with Covid-19, the partner at home SW found this very distressing and required significantly increased support. This is a cost DbS has had to bear as an organisation as there was no flexibility in funding to cover this unusually difficult time for SW. With the support of a Guide/Communicator SW was able to call the hospital daily for updates and although the hospital was unable to let DbS take in a mobile phone to enable PW to talk to SW due to restrictions, DbS was able to sort out communication between the couple using assistive technology available on the ward. During this period SW not only did not receive additional support but had their personal care support reduced with little explanation of the rationale for this.

- Deafened man transferred from acute mental health service to care establishment. He has no communication support provided during his telephone based, dementia assessment – the result was borderline. He finds his hearing aids are no help in noisy, public conditions and has stopped wearing them. He also finds himself at the centre of guardianship wrangle involving people that have had little or no direct involvement with him in recent years. He has had no access to communication support when dealing with advocacy and legal services. SDS could have been used to support him and he might have been able to return to his home, self-managing for longer had his communication needs been taken into account. Instead his vulnerability was escalated and his risks of mis-diagnosis increased and there is little evidence to support his current situation. Legal intervention has called for a review,

however, it is an expensive lesson for the state and duty bearers have a requirement to understand the rights based approach better and differently.

- A woman who is BSL user (her only language) finds herself in a care environment with no staff able to communicate in her language, no online or actual BSL/English Interpreting in place and now has no direct support from friends and family due to COVID-19. Mandy deaf people find themselves in similar home care situations. Use of technology would clearly improve the situation significantly.
- A woman with mild to moderate deafness and mental health issues is in and out of services in a “revolving door”. A little hearing loss is just as disruptive to communication and the woman continually describes the difficulties she faces in “talking therapy”. Neither health nor care budgets have been used to address the communication support deficit.

We understand the average treatment time for moderate mental health problems is around three years. For those affected by deafness/deafblindness is nearer 19 years often due to chronic inability to match communication needs with appointments and interventions.

- Mr PS who is aged 65 and lives in South Scotland. He had 11 support hours funded through SDS but following a reassessment he lost all of this allocation on 1 November, 2019. Mr PS is profoundly Deaf and has a cochlear implant which allows him to hear some speech in a 1:1 environment. He has some residual sight which will inevitably deteriorate further as he has Usher Syndrome. He can communicate with speech in a quiet environment 1:1 but his preference is to communicate using BSL to compliment speech and this is his only form of communication when in noisy situations or meetings. Mr PS used his SDS to fund a Guide/Communicator service which enabled him to maintain his independence through support with shopping, phone calls, reading mail, IT and maintaining his home i.e. banking, paying bills, organising repairs. He also relied on the Guide/Communicator service

to provide emotional support during periods of distress as well as helping him to remain socially connected through maintaining links within his local community and in particular, attending church.

Mr PS was encouraged to accept a rehab worker to teach him to use a long cane to promote his independence prior to removing his Guide/Communicator service. He reluctantly accepted this as he felt he had no option but is not confident going out himself and seldom does so. The rehabilitation worker also set up Dial a Bus service to enable him to go shopping himself. This is not a solution as Mr PS has difficulty with orientation and cannot read labels. He needs to ask for assistance from store staff which is problematic as they are unable to communicate in BSL and speech is very difficult in such a busy environment.

Mr PS and his family were reluctant to take matters further using advocacy support. However, his brother has tried to discuss directly with Social Work without success. He has spoken with the team leader, however, she does not seem to be deafblind aware and does not understand PS's daily challenges. Mr PS and his family have considered approaching his local MSP or working with DbS to do so but they do not feel comfortable taking such a formal route. Mr PS feels that this has been extremely detrimental to his well-being. He explained that he has a new social worker and that they have made a decision that PS no longer needs service support and took all his hours away with no warning and no follow-up support.

- Mr JG aged 61 from the West of Scotland had 27 hours of SDS funding and has now been told that he will go down to 18 hours. This has yet to be fully finalised but seems fairly certain that the loss will be substantial.

  Mr JG is profoundly Deaf and has very little sight and also has Usher Syndrome. He communicates using Deafblind Manual and tactile BSL. Mr JG has used his hours to access a Guide/Communicator service to support him with most of his daily living needs, including shopping, reading mail and maintaining his home. He also used his support

hours for emotional support at times of distress alongside engaging with activities in the community such as attending a Deaf Club, going to the gym or barbers and importantly maintaining his role as a grandfather as his sensory loss worsened. Mr JG never goes out alone so is extremely isolated in his home when he does not have a guide. He cannot watch TV or read emails so has very little stimulation when he does not have 1:1 support.

We are currently in the process of helping Mr JG appeal. He was afraid that appealing would lead to further cuts in SDS support.

- Ms PR lives in the West of Scotland and is 72. She initially had 38 hours of SDS support per week which she used to access a Guide/Communicator service. The initial proposal was to cut this by 28 hours down to 10 hours per week. Ms PR is fully deafblind and has Usher Syndrome, using Deafblind Manual and some tactile BSL to communicate. As Ms PR is unable to go out independently she used much of this support to undertake essential daily activities. Due to her communication limitations she also used this support to help her with mail and phone calls. This support has been a vital factor in reducing her profound isolation and she has used this support to go watch football games and to gain peer support through attending the Deaf Club.

  Ms PR was extremely upset by the news but reluctant to appeal this, however, we managed to encourage her to contact advocacy services and she is now pursuing the appeal with support to this service and DbS. After much negotiation her hours have now been reviewed and we understand that she will now receive 25 hours a week. Ms PR may appeal this decision further when finalised as she is completely isolated when she does not have a guide. When she has felt desperate, she has gone out independently but she has been knocked down on several occasions. Ms PR has a history of poor mental health and regularly attends a mental health centre for support. It is feared a negative outcome from this will have dramatic effect on her mental wellbeing.

- Mr BA lives in south Scotland and is 58 years old. He

initially had 6 hours of SDS support allocated which has now been reduced to 2 hours from December 2019. Mr BA is profoundly Deaf and long sighted but can see to some degree with glasses. However, due to his very poor mental health and inability to go out independently due to anxiety, he has been receiving support from the Guide/Communicator services. Much of this support has focused on social interactions including supporting attendance at the Deaf Club and his mental health support group but he has also needed support understanding mail, paying bills and making phone calls.
His council's assessment is that funding is available for critical or substantial need and does not support shopping. Shopping is not seen as essential or a critical support need. Mr BA's Social Worker put forward a strong case to support his need for communication support and was only successful in securing funding for Mr BA to attend his support group, the reduced hours are not available to be used for any other purpose. Mr BA is reluctant to appeal this further as he feels his support group is life-line.

- Mr CY lives in west Scotland and is 63 years old. He has only received 4 hours a week in SDS support in total and used 2 of those to attend an art class and 2 hours for daily living support. He has acquired hearing and sight loss later in life and has a little residual hearing and some central vision but has significant level of impairment to be considered as deafblind. When he lost his SDS allocated hours recently, he stopped going to his his art class in favour of more pressing daily support needs as he is unable to read mail or pay bills independently. He is also unable to shop on his own. When we suggested that we support him to have his needs reassessed he stated that he would rather not in case he lost those 'precious' hours. So far we have not been able to persuade him otherwise.

Deafblind Scotland received a hand-written letter from an 86 year old man who lives on his own. Due to health conditions he is confined to his bed. His care package thankfully continued during lockdown albeit with reduced hours. He has a carer in the morning and again for 'tuck-in' service in the evening. This interaction had a very practical purpose offering little social

interaction. Due to his deafness and deteriorating sight the only way he can communicate with others is through writing information on a white board. This man has no access to technology or a mobile phone. During lockdown he had no way of contacting his brother and very limited contact with his niece who are his main supports. The content of the letter explained his situation but also illustrated how distressed he has been with the situation:

> *'I wish I had learned a hobby. Never learned any gadget at all. Never thought I would lose hearing. Is there any more people like me? I keep wishing and wishing and praying and praying. I am so scared and frightened and frightened.'*

After receiving this letter we sent a specialist Guide/Communicator to visit and thereafter scheduled a weekly session for a total of 5 weeks. Deafblind Scotland's first visit was to gauge his wellbeing and find out what support we could offer. First and foremost, he wanted company. During our second visit, we introduced him to some low tech solutions to some of the challenges he faced and as a result we are now supporting him to buy a hand-held LED magnifier. The following week we supported him to learn to use a "Synapptic" tablet. He surprised himself by managing to pick it up quickly. With support, he managed to send his brother an email. We are hoping to continue with this support and show him how he can video call with his brother. These visits have given this man a sense of purpose and something to look forward to week on week, however this communication need which had some practical solutions was not assessed as critical and therefore not funded.

deafscotland received over 500 calls/emails at the early phase of lockdown from family members seeking to communicate with loved ones in shielding categories, affected by deafness. Many inventive and person-centered solutions were found using technology to support communication. During the next phase, a significant increase in calls/emails from professionals were noted and similar solutions were involved. It is clear there is insufficient communication advice and assistance available.

5. **What needs to change and improve-Summary**

There are currently around 1,000,000 people living with hearing loss in Scotland, 200,000 with sight loss and an estimated 31,000-34,000 people with significant dual sensory impairment (at a degree where one sense can no longer adequately compensate for the loss of another). The numbers of those with mild to moderate dual sensory loss are more challenging to estimate but are significant, making sensory loss the most prevalent of disabilities which disproportionately impacts on the lives of people as they age. Sensory loss compounds those other long term conditions and disabilities that can occur as people age. Older people are among those that are most often dependent on social care services and vulnerable when these services fail them.

We are very aware of the impact that sensory loss has on an individual's ability to live an independent life if the right support is not made available but despite this the critical role of communication in supporting social connectedness and mental health and wellbeing is most often overlooked within the reality of current social care provision..

It is well rehearsed that preventing loneliness and mental health problems are an important endeavour in themselves. However, both loneliness and poor mental health impact on a whole range of other health and social outcomes. Without support to prevent loneliness and improve social connectedness we know that lives are shortened and that health outcomes are worsened (even within illnesses such as cancer). We also know the impact of poor mental health creating distress and real misery for people in the immediate term but that a failure to protect mental health and wellbeing upstream also has a longer term impact on demand for more specialist and critical services at a later point. The 'failure demand' described so well by the Christie report. However, the reality is that despite sensory loss posing one of the greatest risks to the social, emotional and psychological wellbeing of older people we currently have a social care system that most often prioritises personal care needs without due consideration of the central role that communication support plays in promoting that wellbeing for people.

Over the years we have found more and more people in the position of having communication support reduced when they find themselves needing personal care or having to choose

between communication support and personal care. Without communication support we find many people unable to maintain or establish even the most basic of human connections let alone be able to have meaningful relationships with others.

We welcome the framing of the Social Care Review around human rights.

However, the social care review needs to consider that universal access to emotional, social and psychological wellbeing should be a priority and inclusive communication placed at the centre in recognition of the mediating role it plays in enabling people to have their human rights upheld. Inclusive communication is needed to improve emotional, social and psychological wellbeing and needs to be viewed as a right not a privilege. The case studies highlight the distress that people have experienced when this lack of prioritisation misses out communication support.

Recommendations:

- Communication support needs should be assessed for SDS separately from personal care and not competing against each other.
- Assessment, appeal and budgeting processes should be undertaken nationally rather than within different parts of the Social Care system to prevent financial decisions creating inequity between individual assessment outcomes and a postcode lottery across different local authorities.
- Social Workers undertaking assessments should be able to evidence sensory impairment awareness and training put in place to support this.
- Sensory adjustment? services need standards, professionalised further and communication training should be further developed alongside the BSL language programme.
- Communication should be framed as a fundamental human right and articulated as a mediator to other positive mental health, health and social outcomes.

Although there is a need to enhance the skills of the more generalist social care workforce, there are a number of social care areas that are more specialised. Sensory impairment is one such area, alongside Autism, Learning Disability and Serious Mental Illness and Dementia. Deafblind Scotland's registered

social care workforce are not only generically qualified as required by SSSC (through SVQ health and social care qualifications) but are also trained extensively as Guide Communicators through Signature registered qualifications (K202, T201 and T202) and in BSL Level 1 -7 and Deafblind Studies diploma.

However, the current system needs to recognise this specialist training and require the necessary qualifications when commissioning and funding services. There are some good practice examples to draw on where local authorities require and acknowledge this specialist service including in payment rates. The inquiry should consider the need for a workforce framework that takes into account differing levels of specialism and payment rates as well as commissioning approaches that are accessible for more specialist services.

The National Flexible Framework provides a useful example, where daily information is provided for a large numbers of service users requiring services but with no indication of whether any have a dual sensory impairment. The focus needs to be person-centred not task-focussed. We have made some good progress with Quality standards and regulatory processes in place however, they are focused only on individual services rather than the wider system. We genuinely believe we can only realise ambitions around creating a person-centred, human rights based national social care service by strengthening the sector skill-base, creating career pathways and articulating the unique specialist contribution. It is also critical to improve accountability across the whole system so that planning and commissioning practices support the outcomes we seek for people can be achieved through social care provision in a transparent way. Currently the balance of accountability lies too firmly at the feet of individual services.

Recommendation:

- A workforce competency framework should be put in place that recognises these highly specialist areas of Autism, Learning Disability, Mental Health and of course Sensory Impairment as ‘allied social care professions’.
    - This framework should set out training requirements/qualifications needed to work in each area from more generic care settings through to

more specialist work.
    - Various practical routes to training and qualification include communication and language components.
    - Training budgets need to be made available to support a continuous development approach for social care staff in post.

- Social Care sector qualifications should be reviewed as part of this process and specialist courses developed in partnership with Education Scotland to create a workforce that is equipped with competencies needed to:
    - work in a person centred way;
    - promote independent living and positive risk taking;
    - support application of self-management approaches;
    - work in a co-productive way with communities and adopt participatory approaches with service users;
    - promote health, mental health and wellbeing;
    - ensure dignity in dying through provision of compassionate end of life care; and
    - tackle inequalities and promote human rights and equality.
- National Quality and performance standards (existing and new) and social care outcomes should be reviewed and developed using co-production and social care training aligned with the competencies required to achieve these.

Remedy and redress: shifting from negative to positive

- Developing access and participation “panels” to coproduce and inform services during redesign, review and development.
- To retain and develop specialist skills and stop the creation of a low skilled/casual workforce, TUPE practices that lead to staff moving from service to service as tenders are won and lost by organisations need to be applied in a more considered way.
- Commissioning need to be ethical, collaborative, transparent and created using a coproduction model to ensure that those people with the greatest inequality, older people living with sensory impairment, receive services funding proportionately.
- Consideration should be given to providing a complaints system similar to the “Patient Advice and Support Service” set up by Health as a community based remedy so that

people do not need to invoke a major complaint or process in order to negotiate a fairer deal. This could include some form of consumer testing/scrutiny for care/home care and services based on lived experience and able to inform and change practice based on suggestions rather than complaints.

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Dorward House

Dorward House, Montrose

Established 1838

2nd November 2020

Mr Derek Feeley,
Review of Adult Social Care
secretariat.adultsocialcarereview@govt.scot

Dear Mr Feeley.

Communication from Board of Directors of Dorward House, Montrose

As the Chair of the Board of Directors of Dorward House, Montrose I welcome and appreciate the opportunity to share information with your committee and have given considerable thought to this submission and have discussed its content with Board colleagues and Dorward House Management. I also wanted you to have input from a Voluntary Sector Care Provider and hope that when going forward you will discuss with us/this sector.
I note in reading the information published 1st September 2020 it stated that "An independent review is to consider the idea of a national care service" and I also noted that approximately 90% of the people who contacted the committee were in favour of this.

I wish to state that this is not my opinion nor that of my fellow Board members. The present system may need improvement but one of its important strengths is that it offers people choice at a time when many of their choices are limited. I feel that there would be a decided lack of choice if all homes were under one regime, a total lack of variety. Often different providers meet residents differing needs.

As there are a number of areas to cover and a number of issues to consider I hope it may be simpler and less wordy to identify headings and bullet point issues within these headings.

Background regarding Dorward House.

Dorward House is a voluntary organisation residential home caring for forty residents in Montrose Angus. The responsibility for the day to day running of the home is by a professionally qualified management team under the supervision of the Board of volunteer directors of whom I am the Chairperson. My professional background before retirement was as an Angus Council Service Manager with responsibility for Home Care, Residential Care and Daycare.

Dorward House was founded as a House of Refuge in 1838 for people of all ages but became a home for older people in 1950 and further following the recommendations of the SW Scotland Act 1968.

As you will appreciate there have been many changes over the years and in a complete refurbishment and new build, was completed in April 2008. This provided thirty-two ensuite rooms in the main house and a new built, specially designed unit for the specialist care of eight people with dementia and a four place respite unit. These changes were carried out following discussion and advice from Angus Council Social Work Department, Care Inspectorate and the Dementia Centre at Stirling University.

Background regarding Dorward House (continued)

Unfortunately through lack of financial support from Angus Council Social Work Department we were unable to maintain the provision of four respite places and converted three to permanent places retaining one respite place, as the Board recognises the value of Respite Care as part of a Community Care Package. This renovation cost approximately 2 million pounds which as you will appreciate was a huge undertaking. We had assets which we were able to sell and we were extremely well supported in our fundraising by our local community and received a generous legacy. It was a collective effort as Dorward House is seen as a Community asset.
The property is maintained to a very high standard and provides residents with a comfortable, attractive and welcoming home which is appreciated by residents and families alike.

As a Board of Directors, we are very proud of the standard of care provided by our staff teams consisting of Management, Senior Care Officers, Care Officers and Ancillary Staff, all of whom work together to ensure quality care for each individual resident. This high standard was verified by the Care Inspectorate who awarded Grade 6s at the last two years unannounced inspections.

Information and Points to Note about Dorward House

Dorward House

- A Voluntary Organisation residential home for 40 residents, 31 permanent places, 8 specialist places for people with dementia within a specially designed unit (Fairview) and 1 respite place.

- The home is managed by an experienced and qualified Management and Senior Care Officer Team and Care Officers qualified to SVQ Level 2 & 3. The staff group provide to all residents, quality holistic care which includes personal care, attention to individual interests, activities, encouragement to be part of local community and relationships with families and friends maintained. The focus of the care for the residents is to always be aware of their ever changing needs and frailty and to ensure that these needs and changes are met in a positive and helpful way. We believe our staff groups carry out their roles remembering the importance of each resident as an individual and the importance of following principles of Dignity, Privacy, Respect, Rights and Choice, among others. We believe in creating a happy home life. Our staff know their residents and plan their care to meet individual needs.

- Families and friends play an important part in residents' lives and are always welcomed into the house and kept informed of all that is going on.

- Demands of the present Pandemic - This may not appear to be particularly relevant to your committee discussions at present but I believe it is one example of the kind of additional matter which is constantly affecting life within residential care which has to be dealt with while continuing to ensure all residents are properly looked after. As you will appreciate only too well the present pandemic has added to the workload of our already busy staff groups. I have been disappointed that on Government updates there has been many references to care homes, usually sad news of deaths and although brief references to care being provided there is little real acknowledgement of the huge amount of work meeting all the guidance and ever changing demands on staff. Staff within care homes are very aware for example of the adverse effect lack of visiting has on residents and families but there has been little acknowledgement of the time and effort in planning and enabling of each visit, for example twenty minutes cleaning and sterilising after each visit plus time preparing resident and often supervising visit. I spoke with our manager about the pandemic effects and these were what she felt important.

- Demands of the present Pandemic (continued) - Good communication and relationships with families, care mangers and other health professionals / Staff knowledge of their residents and providing appropriate activities and interests during lockdown / Staff adapting to new way of life helping out with physio, podiatry, dietary issues as these services have/

been withdrawn during lockdown and many more. Examples of the flexibility needed in caring within residential homes.

Although sadly, we had a small number of residents pass away following a diagnosis of Covid19 we have not had any positive tests of residents or staff since the beginning of May. I feel that the hard work and extra special responsibility of all staff members deserves the credit for this

The Board of Directors is composed of people with a variety of backgrounds taking part in a variety of committees such as Property, Fabric, Staffing, Garden, Publicity etc. Our Finance Director is an Accountant who ensures all financial matters are in order. Recently, with the assistance of a Company of Solicitors specialising in Charitable Law The governance of the Board was changed from Trustees and Governors to Directors to better meet the needs of 21st Century Care. As you will appreciate having a voluntary board reduces costs which we are able to pass on to our residents. We are also able to pay staff higher salaries although more effective rates paid for local authority funded residents would allow increased payments. If the decision was to have one national service is it not the case that all national agencies become top heavy and are expensive in view of pension schemes etc.

Relationships within Angus

- **AHSCP and IJB**
  Personal relationships are pleasant but often in discussion it feels that the emphasis will always be in preserving the status quo of Angus Council provision, for example respite care delivered in Angus council homes despite elderly carer having to travel out of Montrose when Dorward House had a respite vacancy. Recent difficulty of agreeing funding for residents requiring specialist dementia care. Amount offered did not meet the cost of the provision and was far below the costs of Angus Council services. It was felt that the decision makers did not fully understand the care provided or the benefits of the Fairview unit, despite the fact, that Care managers were requesting Fairview care to meet assessed need.

- **Care Management**
  Good relationship with Care Managers and frontline workers. Feeling that service users needs are paramount. Decisions sometimes changed by senior management. Not always to benefit of resident, Suggestion of cost.

- **Provider meetings**
  These meetings are arranged and facilitated by Scottish Care Angus Local Integration Lead. Those attending are representative of Private and Voluntary Residential and Nursing Home providers. As members of a small organisation our managers find these meetings very worthwhile and appreciate the exchange of ideas and information. Support of Scottish Care Lead and these meetings are greatly valued by managers and it is very disappointing that the Committee to Review future care does not have a representative from the Private or Third sector or from Scottish Care to ensure a full representation of providers.

- **Angus Council Homes**
  I wonder if the suggestion of a National Care service in relation to residential care would follow the present day local authority provision. From Dorward House's point of view and I would suggest from some private providers in Angus this would not be seen as an improvement. Many private providers, and Dorward House as a Voluntary Provider, receive Care Inspection Grades of 5 or 6. This has not been the case for local authority homes.

- **Care Inspectorate**
  I wonder at the suggestion of the need for a national care service as a means of delivering quality care when we already have a Care Inspectorate whose remit is to inspect and grade care services to ensure quality care is being delivered. Perhaps the role of that organisation should be reviewed including its outcomes and the experience / qualifications of its inspectors and a standardisation of inspection methods by inspectors introduce. I am

pleased to say that Dorward House has a positive and productive relationship with their allocated inspector.

- **Conclusion**
  A review of social care which identifies the anomalies in provision is a positive step.
  In my opinion the members of the committee provide a well-balanced and experienced group. It is disappointing that there is no representation from the private or voluntary sector I would suggest Dr Donald Macaskill, CEO of Scottish Care.

- **Points to Consider**
  Regarding the suggestion of all care being provided by a National Care Service.

    - Would this not result in a more top heavy managerial layer, when we need more funding / training for front line staff.
    - When local authority considers budgets, it seems that Home care receives a priority over Residential care
    - Need to ensure that senior managers in a National Care System had knowledge and experience of how to manage residential care.
    - Lack of choice if all homes under same regime, Different homes meet differing needs.
    - Local Authority Homes more expensive to run than Third Sector homes.
    - At present funded residents when placed in private or third sector care are funded at the nationally agreed rate which is lower than the rate in local authority homes. How will this be reconciled in a national care service.
    - From managers' meetings it is already being said that private homes will accept self-funding residents before those requiring funding regardless of the assessment of need.
    - Dorward House (opened 1838) as a third sector provider maintained and improved the establishment to ensure all standards were met. It appears that a lack of insight or neglect on the part of the local authority managers allowed a local authority home, Seaton Grove (opened 1993) to deteriorate, requiring 1 million pounds to meet the required standard. Does this bode well for a national care service?
    - In creating a national care service will you be able to maintain capacity without the services at present provided by the private and third sector and will it be affordable
    - The specialist care for people with advanced dementia needs to be an important part of this review. This need has been denied by present AHSCP members despite the constant request of front line staff and the proven success of such provision within Dorward House who have been able to care in their Fairview unit who could not be cared for in other homes. The alternative option for these residents would have been hospital care, which may not have met their needs and at a much greater cost.

I wish you and your committee well with this important National Social Care Review and I hope, that this submission, will be of some help. If you require any further information, please feel free to contact me at the address above.

Yours sincerely

Hester M. Howie

Hester M Howie
Chairperson Board of Directors

Dr Alastair L Noble MBA - Moving Forward with Health and Social Care Integration in Scotland

Moving Forward with Health and Social Care Integration in Scotland

Shaping the Future Together

Integration of services between health and social care is now firmly enshrined in public policy. This paper sets out some considerations and next steps for moving integrated care forward in Scotland.

Wider Policy

Firstly, there is a need to look at wider Scottish Government policy. The direction of travel is clear with Community Empowerment, Place Planning and linking Community and Spatial Planning seen as the guiding principles to integrated care. All of this needs to be sustainable and green with the right education, jobs, housing, water, sewage, transport etc., with an infrastructure first approach taken.

The Role of Localities within Integration

Health and Social Care Partnerships (HSCPs) have a key role to play in communities and can both harness and build on the interconnectivity with the third and independent sector. HSCPs should embed community engagement and recognise the role and voice of the individual, their families, friends and local communities.

Health promotion, self-management, prevention, and early intervention are all key priorities for health and social care. Localities provide a route, under integration, to promote these priorities, all of which are integral within HSCPs Strategic Commissioning Plans and planning processes.

The Independent Review of Adult Social Care should be used as an opportunity to endorse these key priorities and propose a way forward that can:

- protect adequate funding;
- highlight the increasing need to actively tackle inequalities;
- address recruitment and contracting issues; and
- consider (as one option) the allocation / flow of funding be based on Fair Share Resource Allocation.

Integrated Teams

The priority must be integrated health and social care teams across all localities in Scotland.

- Further national work and support on locality development and the interface with the Primary Care Improvement Plan (PCIP) is required. This should encompass both physical and mental health and wellbeing.
- There is a need to define what is / is to be expected by the implementation of the Expert Medical Generalist.

There still needs to be discussions on clinical and professional governance in localities and communities. As part of this, there needs to be consideration of the role and place for consultant led beds in the community – whether this be in Community Hospitals or in models such as Hospital at Home.

There is also a need to consider how inter-professional and inter-organisational education and training can be embedded right from the outset to better support integrated working practices within locality teams.

Locality Data

Work has commenced on data collection in Primary Care and this is welcomed. There is an understanding that any locality model will require to evidence demand, capacity, activity, cost and most importantly patient and service user.

The great strength of locality-based outcome data sets is that it gives clear evidence and allows us to fairly compare the clinical pattern in different areas, and the clinical outcomes with as little observer bias as possible. Some would promote the simple tool, “which bed did you sleep in last night” as the basis of the over 75-year-old correct allocation of resource - both clinical and financial. This allows clinical activity x tariff to be done in a way that rewards good practice and penalises bad practice.

We require accountability and responsibility at all levels in health and social care. All clinical and financial data should be open and transparent and available to all as part of the locality planning process.

A Scottish “Mrs MacArthur” would help us to concentrate on the individual rather than forcing them into the only available silo. This is where the hard and soft data becomes real and focussed on the individual. It is also important to remind ourselves about the remarkably high death rate, and hospital and nursing home acquired infection rate in these institutional settings. They are not and never can be safe environments.

Health Economics and Covid-19

The emerging literature around health economics and Covid-19 mainly considers the cost of the pandemic and health economic issues surrounding the development of policies.

Health economics will continue to play a key role in reviewing the impact of Covid-19 within health and social care - including benchmarking against other health and care systems.

Moving forward there is a need to better integrate health economics into the policy development and implementation process within health and social care.

Integrated Resource Framework (IRF)

There is still significant disparity of resource allocation between acute and community care. To reduce any duplication of effort, eliminate waste and focus on whole public sector best value, there should be recommendation for each locality to have a fair share Integrated Health and Social Care budget. For example, a best value model where clinicians agree the best current care package for each individual and modify the care package to meet the changing needs of the individual, in their own community. This clinically led model illustrates a level playing field between community and acute hospital care.

Dr Alastair L Noble MBA

13/January/2021

Additional References

John Walker and Bill Nicol Fair Share Budget Paper

ACH presentation PowerPoint (ALN)

MAISOP 2013

MAISOP Presentation (ALN)

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Rural Smaller Care Homes in Scotland. An Overlooked Species. What Needs to Change?

Inappropriate and Hidden Cross Subsidies Discriminate Heavily Against Non-Urban Population and Small Care Homes Across Scotland. Impact is up to GBP 12m per annum.

Sandra Cooke*, Grace Middleton*, Thomas Scheibel*, Melanie Wilson*
**Authors contributed equally to formulating, research and writing this essay. Their names are listed alphabetically. Authors have only used publicly available information from 2017, so data may not accurately reflect exact budgets and numbers. The conclusions are however likely to be robust, irrespective.*

March 8, 2020

Summary

The authors show that in addition to the commonly known and discussed frictions of the Scottish care home market, such as (a) the difference between private funders and Local Authority funded fees, (b) the overall level of underfunding in the sector, leading to reductions in capacities and underspending on the facilities, and (c) the difficulty to recruit, motivate and reward qualified staff despite the substantial increase in spending on care staff as percentage of overall spending, there are three less known factors at play, causing major distortions which do counter general policies in Scotland.

In identifying these three factors, the authors postulate that addressing these will not only (1) reduce the overall amount of necessary spending by the public sector on the provision of care in Scotland, but equally help to (2) reverse the significant flow of funds from the Scottish countryside to the few urban centres.

First, the authors have identified the fact that ignoring the existence of the „Rural Small Care Home “ (RCH) in a Scottish rural setting as a separate category, in regulations, funding rules and associations, has led to a significant transfer of wealth away from the already struggling rural communities to already wealthy urban communities, that is on the back of public spending.
Second, the detail of how privileged funding of nursing homes actually works in practise creates further additional profits and economies of scale furthering the concentration and clustering of care home capacity without actually providing better care to residents.
Third, the absence of VAT offset of care homes cannot find any justification in business nor fairness, both considering the residents, who ultimately have to pay more, and the care home itself, which still is a business but has to act as the stealth tax man on behalf of the general public purse, despite being viewed by its clients as VAT exempt.

As a result, the authors propose to:

(1) Introduce three categories of local authority funded care home tariffs, for homes up to 25, between 26 and 50, and 50 residents and above, while using the same principles as already established and deploying an easy formulaic approach without increasing the overall public sector spending,

(2) Terminate the nursing care tariff category all together, and re-focus - in line with new Care Inspectorate Principles focusing on outcomes rather than institutional categories - on the dependency

levels actually present in care homes and making sure that appropriate care is being provided in care staff numbers, with the expensive nursing supervision being delivered as required from district nurses, rather than expensively on stand-by 24/7 on site.

(3) Abolish the incomprehensible rule of not allowing VAT recovery for care homes altogether or introduce both VAT on care services and its recovery; the current situation is just increasing the cost base without justification by about 10% or more, making care homes the tax man for the general public purse without residents knowing about it (as they seem to believe that it is VAT free service delivery by care homes).

Keywords
Small Care Home, Rural Small Care Home, COSLA, Scottish Care, Fixed Cost, VAT, Nursing Care, Hidden Transfers.

Introduction

This paper aims to describe, analyse and draw first conclusions on the current high level funding structures in place for care homes for the elderly in Scotland. The authors of this paper are all active in the sector as directors and managers and together have an experience of over 30+ years working in and managing smaller care homes in Scotland. In conclusion the authors suggest to refine the the public sector funding mechanisms in place to have a more targeted and fair distribution of the scarce resources of the public purse. In addition, there are some recommendations concerning the way COSLA and Scottish Care are working together with regards to the identified issues.

The paper is structured in 3 parts. First, a short high-level description of the current structure of the sector as relevant to this paper, as well as of the key mechanics driving the distribution of public sector funds. Second, the authors propose a high-level economic distribution model (EDM) to analyse the impact of the identified key mechanism identified on the sector and the economy. Third, the authors draw some obvious and less obvious conclusion and make some suggestions to the interested public. While there is a lot of references and data available, the purpose of this paper is not a review of all existing literature and studies, but rather to draw from a very practical day-to-day experience and select few points supporting the thesis.

Part One - Introduction, Definition and Description

Scottish Care Homes by Numbers

In Scotland there are about 854 care homes for the elderly providing a total of 37.300 places for residents, with about 32.700 in occupation in 2017. There are various specialisations present, as well as different payment levels, but for purposes of this paper, the authors suggest to follow the methodology of the Scottish Government.

Thus, the main categories considered in official statistics are nursing/residential home, private/council/voluntary owned home, and finally the split in local authority paid fees and privately paid fees. Herewith the authors would like to refer to the fact that some councils are paying additional fees for higher dependency levels, which are material (but are excluded from consideration here, as they are not applied universally), where the rewards introduced for rating categories are welcome, but not material in the context of this analysis. Notably one classification is absent in said statistics, and - as shown below - in consideration, that is that of the size of a home, as well as to nature of private ownership.

On average the occupancy of a care home is at about 38 residents in Scotland with an average tariff of privately funded residents about 40% above that of local authority funded residents. Needless to say that each care home is a significant local hub of economic activity creating not only qualified jobs, but also purchasing local services and goods, driving innovation and providing a vibrant local hub for the community. As such a care home has to be at

the core of every community, in particular though those communities which are part and making up the Scottish countryside. Every council should be proud to have well run functioning care homes at the centre of their populations, not only large, central urban communities. For further discussion in this paper, the authors propose to categorise smaller care homes as those well under the national average (38 and less residents), those between average and 50 (chosen by COSLA) and larger ones those which are well above 50 residents.

constructing new „perfect " care homes complying with latest rules and regulations, there are - without further reference - various other factors to consider when discussing size.

The actual management of residents still takes place in form of practical small „floor families " which allow oversight individually. Ideas to create star-type structure to leverage oversight over larger corridors reminds more of prisons than of providing care. As a result, the provision of care with staff should not be depending on the

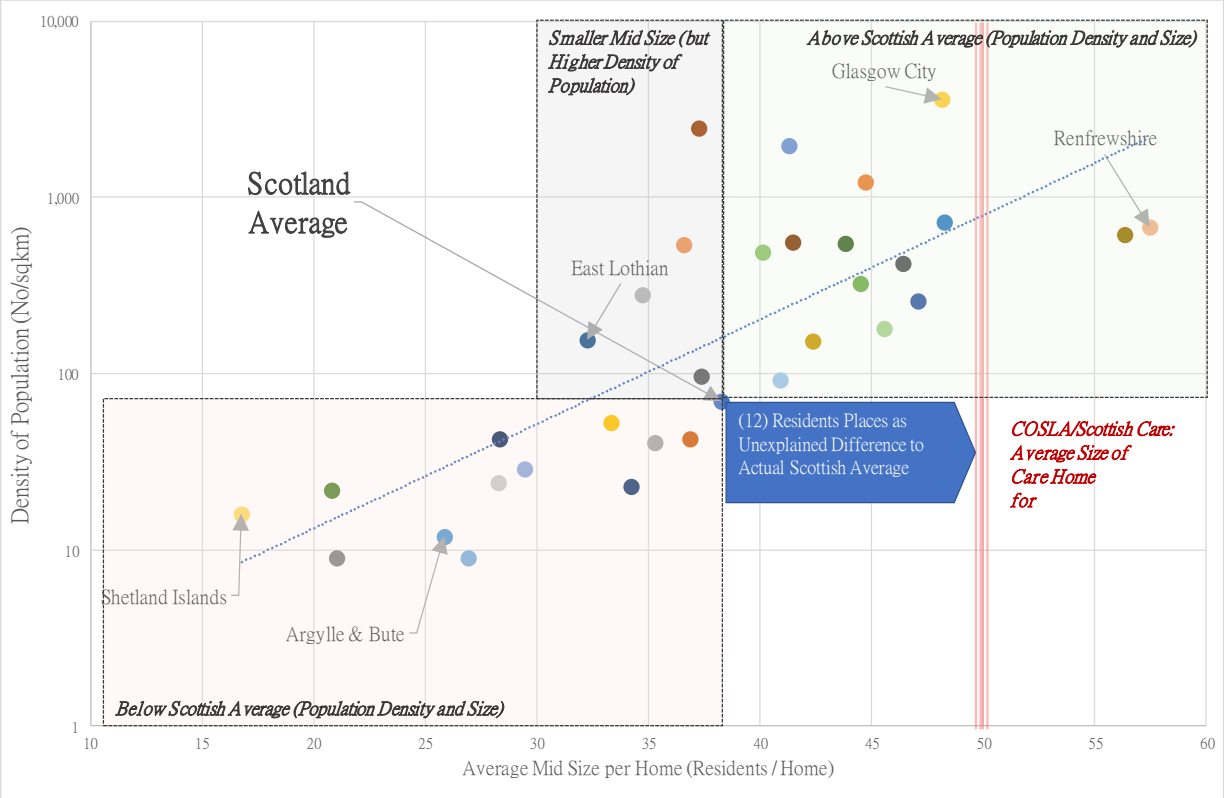


Figure 1 - Rural Areas with Smaller Care Homes

Overlooked Factor: size matters for fixed and semi-fixed cost

One of the key observations is that the size of homes varies significantly. The largest institutions are at about 80 or more residents where the smallest ones can be at 11 or so residents. While it is obvious that in the past there have been large economies of scale available by pooling many residents into one large complex, in particular in the context of

size of the care home. A larger care home should thus just need equally more staff. The reality however is that the number of staff on shift goes down as resident numbers under management go up. In larger institution, this is in particular driven by the ability to swap staff over different floors and reduce the staff on standby, holiday or sickness in exchange for paid overtime, as well as ability to absorb short term absence with lower staff over more residents, while in smaller settings there is a need then to replace with short term call on agency staff. Similar arrangements are possible and can be found in place with non-

care staff, that is housekeeping, kitchen and activities.

The provision of oversight (the home manager) and administrative support however - as it is by definition super numerous to care staff, however is a fixed cost per care home, not per resident. Equally this applies to a larger extent to various infrastructure and other cost items which are built-in for any care home, including insurance, fees, accounting services, etc.

As a result, the authors observe a relatively high and material share of fixed and semi-fixed cost in smaller care homes, whereas in larger care homes the share of both fixed and semi-fixed cost is significantly lower.

nursing home is the nursing care tariff, which is about 20% above the residential care rate. The sole condition for the tariff being applicable is whether a nurse is scheduled to be on the floor 24/7. Originally meant to provide the compensation for having higher qualified staff on the floor, this rule is a historic dinosaur and is in contradiction to the overall focus on outcome based provision of care.

To illustrate the point, if none of the residents has a particular high dependency level and requirement for nursing care 24/7, then still the LA rates are based on the fact that nursing care (whatever that actually entails) could be provided. Equally, the authors note that there is rarely ever a case when a resident is moved from

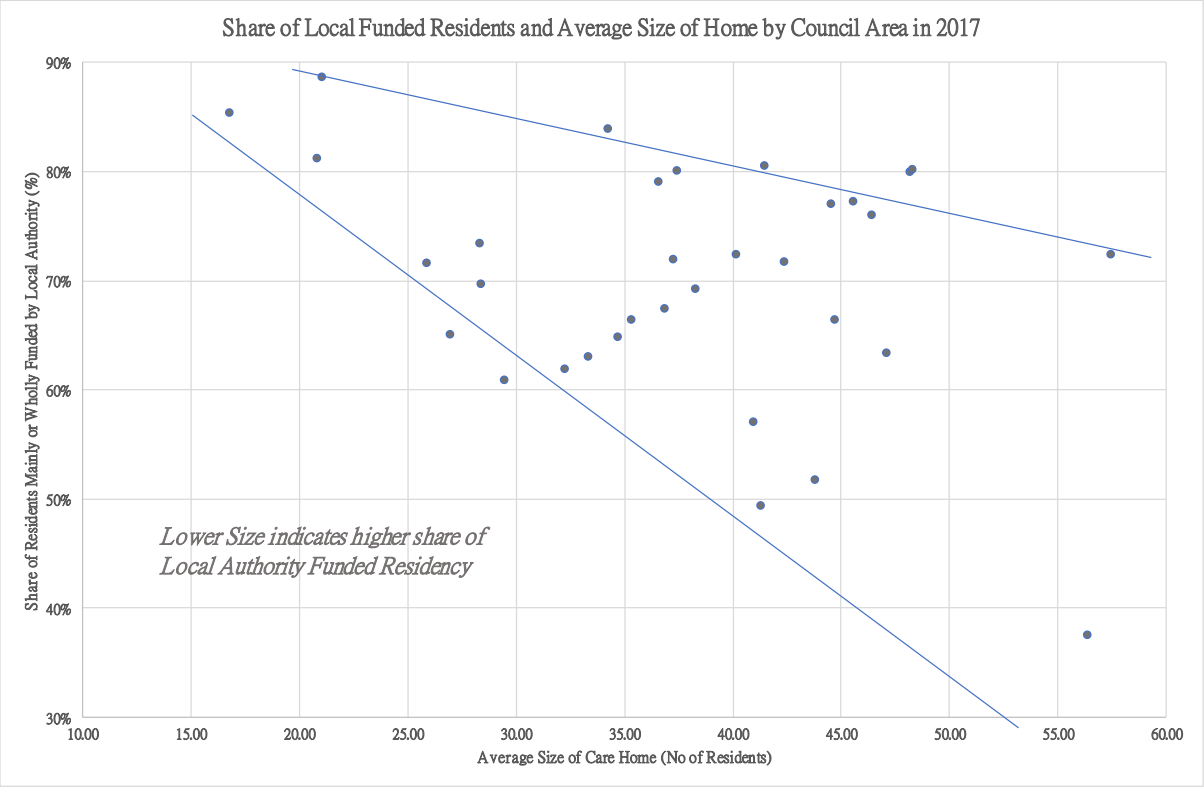


Figure 2 - Smaller Care Homes with Higher Share of Council Funded Residency

Nursing Care Provision: Outcome Based or Institution Based

Today, nursing care homes make up about 2/3 of all care homes in Scotland, primarily situated in urban communities with on average larger care homes. The tariffs for any resident residing in a

residential care to nursing care. Rather, the residents are remaining in their familiar environment but the supervision provided by the district nurses and the demands on care staff on the floor are increased to the extent that there need to be more staff. But, noteworthy, not more nursing staff.

Economically, it is thus only a capacity payment for having a nurse on the floor, just in case. Practically speaking, the ability to call doctors, NHS nurses or other staff when necessary, as well as the fact that Senior Carers today have a higher level of qualification and responsibility anyhow, even if no nurse is on duty, makes - in the authors opinion - the need for „nursing care " as defined today, obsolete.
Rather, the tariffs should be outcome based and oriented on the need of the residents. So, if a resident is falling into a higher dependency category the tariff should appropriately reflect such need, and vice versa. Equally, there should be a much stronger alignment of care staff numbers with overall dependency present on the floor, rather than a institutional assumption of a nurse on the floor can provide required care to address higher dependency levels.

Impact of Urban Environment and Rural Environment

From a care home perspective, it is much better to be based in an urban environment. This is the case due to higher availability of qualified staff, lower cost of various supplied services due to higher competition and market size for suppliers, as well as higher property prices, which allows privately funded residents to be charged more (as they have more assets). In addition, if and when there is a movement to appropriate compensation of capital invested in care homes, the fact that property is valued higher means also that the rates will be higher creating self-perpetuating spiral of price increases.
From a rural environment perspective, it more difficult to find enough qualified and motivated staff, travels are longer, property prices are low thus affordability for privately funded client is lower, cost of supplies and services is high etc.etc.

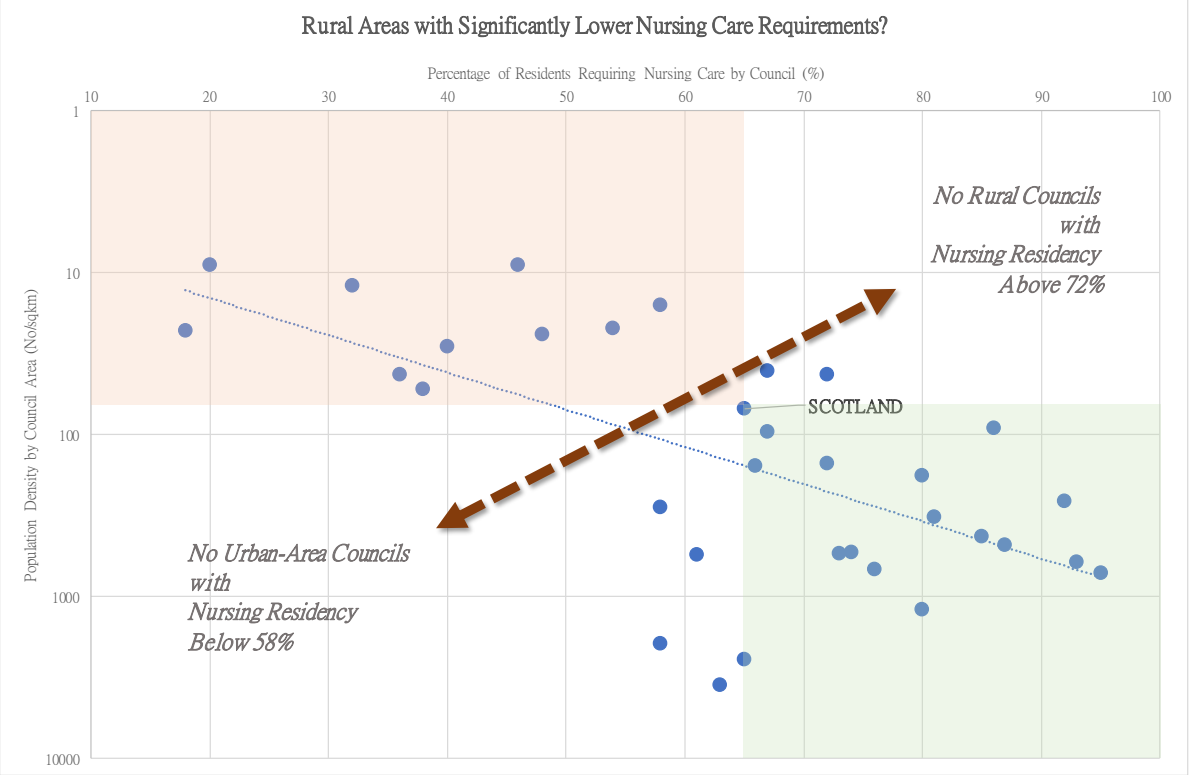


Figure 3 - No Reason for Rural Areas Not Needing Nursing Care

Cross-subsidisation of local authority funded residents by private funded residents

While this is not a new topic, and has been well analysed, discussed and recommended on latest by the Fair Market Practise Authorities in 2018, it is for the purposes of this paper an important aspect which acts as a multiplier of various dislocation effects identified herein. It is only when considering all these factors together that the underlying gigantic money transfer machine can be identified in its true scale. The authors just take this as a given for now.

Correlation across Categories: „ if it rains, it pours "

It is evident from public available data that there is a strong positive correlation between being a smaller care home, sited in non-urban communities, providing non-nursing care and having a higher share of local authority funded residents.

This is evident when considering that the share of local authority funded residency is higher the more rural the councils concerned are. Also, the average tariff possible to charge to a privately paying resident is lower, the higher share of local authority funded residency is. In other words, not only have rural homes a lower percentage of

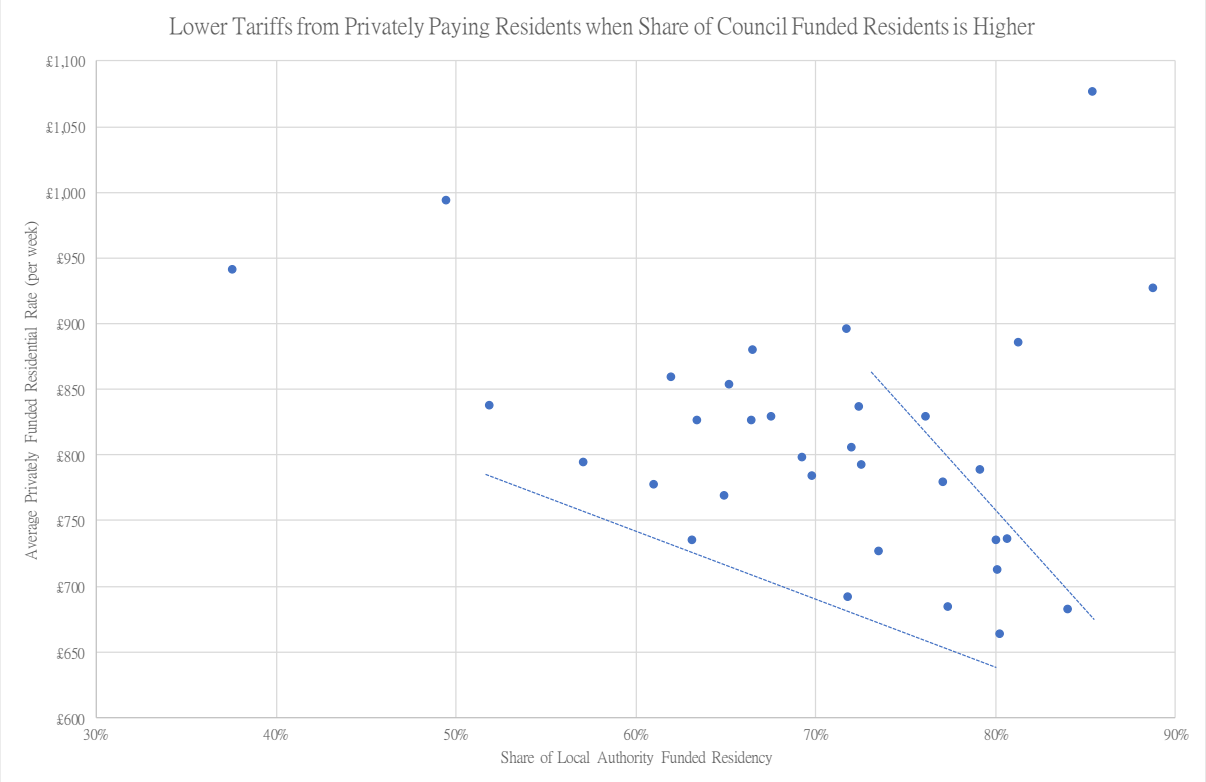


Figure 4 - Lower Private Tariffs When Higher Council Funded Residency

private paying residents, but these each pay also less. This is the exact opposite to the relationship in urban areas.

Equally, there is no reason to assume that elderly in rural areas are less likely to require nursing care, than those in urban areas. This then leads

the authors to conclude that there is a pressure for rural communities to move towards more urban areas for nursing care, if such were required and would be measured on outcomes and not on institution. As the authors stated earlier, this is however not the case.

Residents in rural areas are as likely to require higher level of care, just that the homes are not getting paid for it. Rather the money is spend on having institutionalised nursing care without reference to outcome in urban areas.

Put the other way around, a larger care home it is more likely also a nursing care home, set in a urban environment with a larger share of privately funded residents. In addition, the authors observe, that is also more likely to be younger home and have a higher rating in the category „environment “.

In the average rural care home is thus put at an initial disadvantage on many levels. It has higher level of fixed cost, more difficulty recruiting and retaining qualified staff, not qualifying for nursing care tariffs and a higher percentage of local authority funded residents, while likely paying higher prices for all supplies and services without ability to recover these. It will be on average older and thus have lower rating in the environment category, while likely have good or very good ratings in all other categories, ie outcome based.

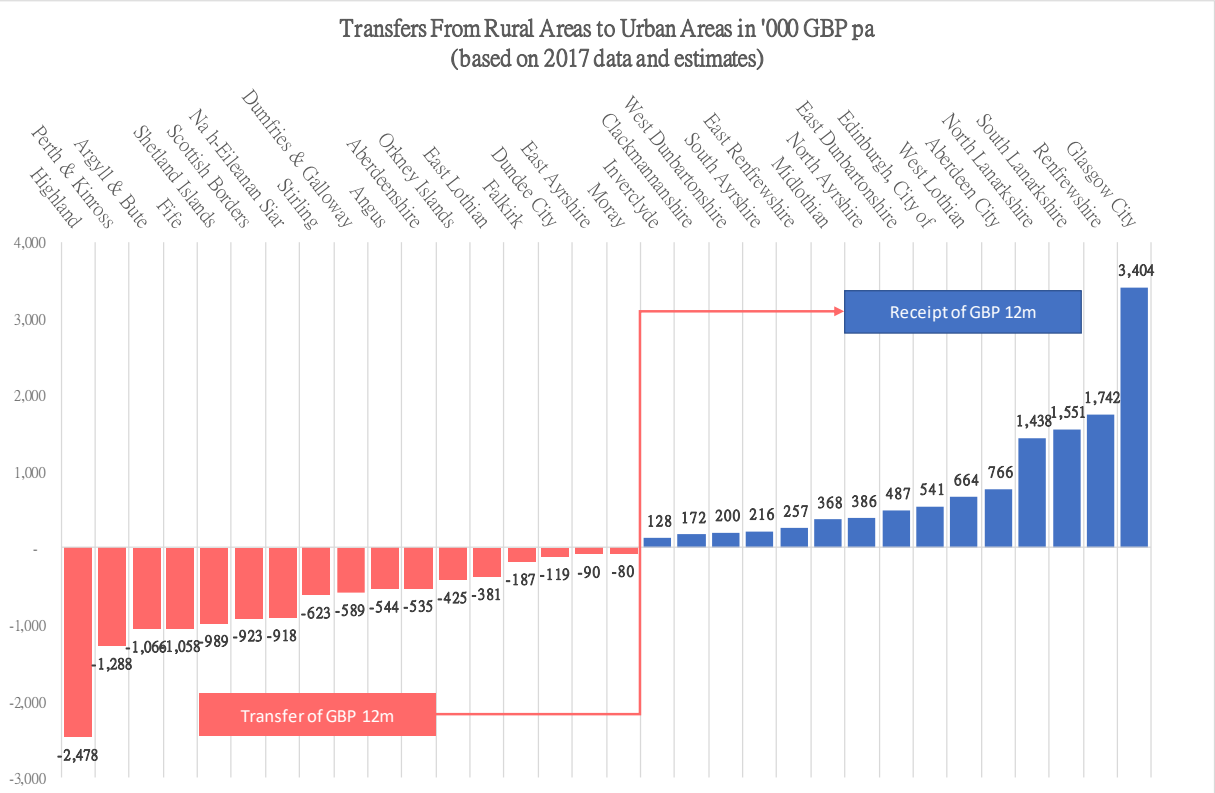


Figure 5 - Hidden Transfer Payments from Rural to Urban Areas

Part 2 - Economic Distribution Model of Public Sector Transfer Payments Away from Rural Communities to Already Rich Urban Communities.

„ Some are more underfunded than others “

The authors first suggest to take for purposes of this analysis the status quo in funding as a cap on spending, ie not - as one should in general - assuming an increase in relative funding by the public. It is important to highlight that the sector

overall is being assessed as underfunded, irrespective of categories, locations etc.
It just appears to be the case that the way public sector funding is working today, it creates significant disparities and unwanted side-effects, contradicting overall Scottish Parliament policies, such as strengthening the non-urban communities, creating wider spread jobs and paying more to social care workers, amongst many other.

Of course, if the overall policy objective is a reduction in care homes and care places that would be one different policy objective which clearly is in reach today. But if it means to provide better care, than it means also better care delivered locally where people live and have their community support systems, rather than moving them into large centralised care centres away from their known relatives and friends. At the same time depriving local communities from an important economic factor for job creation and local demand for supplies and services.

Economic Distribution Model Description

The economic model suggested by the authors is a tool to quantify indicatively the transfers of economic value between different stakeholders compared to a transparent and evidence based public sector spending approach. As such, the numbers and calculations employed are indicative and do not claim to be representative of any particular individual care home setting. It is subject to criticism and review which the authors invite to be made.

The authors suggest to focus on the following major distribution mechanisms deployed by the public sector today. These are the distinction between (1) residential and nursing care, the (2) de facto placement of LA funded residents in co-funded care, and (3) impact of VAT.

Residential Care. If we assume that the total spending for any given period is a total of a sum fixed at B (Public Sector Budget) for a given number of local authority funded residents (Rla) per year, then these above 3 major rules determine the distribution of funds to each and every single care home. The income thus of each care home can be defined as the sum of a share of B (itself a result of these 3 mechanisms), and its income for privately funded residents (Rpf), which is the private tariff multiplied by Rpf of each home.

Analysing the impact of the public sector distribution mechanisms on how B is being spend, the authors look at each aspect in turn.

In overall terms, however, one can thus state the obvious, ie that revenue per home is higher the larger it is, the more privately funded residents it has and if it is a nursing care home.

Equally however, one can state that the ***relative gross profit margin*** expressed as percentage of such higher revenue will be higher for such home due to the fixed cost relationship alone, as described. As a result the formula to adjust weekly tariffs paid by local authorities should be designed as follows:

$$Adjusted\ Tariff\ (week) =$$

$$Standard\ Offer * \left(\frac{50}{Registered\ Beds} - 1\right) * Fixed\ Cost\ \%$$

As Cosla/Scottish Care refer to a 50 standard size care home, there is an additional aspect to consider. That is the fact the average care home size in Scotland is at about 40, not 50. That would imply a structural underfunding assumed within funding framework itself, of about GBP 41.4m per annum.

As each LA funded resident is paying however the same tariff across Scotland, it means that those residents fees in smaller care homes are in effect cross subsidizing larger care homes, but enabling a higher relative profit margin in percentage terms on larger revenues. The capital invested in a smaller care home is rewarded less by the public sector than larger care homes.

Nursing Care. When considering nursing care tariffs and their impact on individual LA funded residents value for money, it is the obvious conclusion that any resident is paying higher fees just for the presence of one particular qualified person on the floor, but not for the adequate care which may or may not be required. In fact, profit maximisation can be achieved on the back of minimising dependency levels while still having one nurse in the home. The more residents can be thus care for with the same care staff, except for one of them being a nurse, makes automatically everyone paying the higher rate. However, there is adequate qualification in care staff, as well as availability of district nurses and GP to make sure adequate nursing supervision is available if delivered in residential care homes. It appears broadly in contradiction to outcome-based care delivery, and has to be replaced with a system which makes use of the existing tools to deliver nursing supervision, while making sure that adequate care staff is available, instead qualified, but more expensive nurses. The Authors have not been able to quantify this effect in more detail, but will do so in due course.

VAT. Finally, as care homes are not charging VAT to their residents, today care homes have not the ability to recover VAT they pay on their incoming supplies and services. While this seems a fair arrangement on first sight, on second look it is rather the question of why then the public sector care budget should be paying VAT back into the general budget for services received from the private sector. While temporarily this could have may be providing some relieve for residents tariffs (that is reducing the tariff by the VAT component), it is not sustainable if both the public care budget and the care home sector are both underfunded. Either one introduces VAT and its recovery symmetrically or one abolishes it symmetrically. The resulting effect would be that the cost of care is truly allocated to the public sector care budgets, and not confused by transfer payments, in effect from the public social care budget to the general budget.

Given, as stated above, that there is a high correlation between the criteria of size, nursing care and share of privately funded care, as well as type of community urban/non-urban), there are some mutually amplifying factors at work, highlighted by the EDM.
The authors have calculated that - using EDM - every single LA funded resident in a smaller care home is in effect creating super-profits in larger care homes by about 7.35 GBP every single week.

In turn, that means that every council of a more rural setting is in effect highly likely to transfer wealth to wealthier urbanised councils, while running at the same the risk of losing significant economic activity altogether, as smaller homes are not sustainable with the above distribution mechanisms.

Part 3 - Conclusions

Given the results above, it is understandable to consider alternative mechanisms of distribution of public sector funds in care. In general terms these mechanisms should comply with principles of equality, fairness, sustainability and general policy alignment. Todays identified mechanisms fail on all 4 tests.

However, the introduction of three measures within the existing rules and regulations can, in the opinion of the authors, remedy the situation.

(1) Introduce three categories of local authority funded care home tariffs, for homes up to 38, between 38 and 50, and 50 residents and above, while using the same principles as already established and deploying an easy formulaic approach without increasing the overall public sector spending,

(2) Terminate the nursing care tariff category altogether, and re-focus - in line with new Care Inspectorate Principles focusing on outcomes rather than institutional categories - on the dependency levels actually present in care homes and making sure that appropriate care is being

provided in care staff numbers, with the expensive nursing supervision being delivered as required from district nurses, rather than expensively on stand-by 24/7 on site.

(3) Abolish the incomprehensible rule of not allowing VAT recovery for care homes altogether or introduce both VAT on care services and its recovery; the current situation is just increasing the cost base without justification by about 10% or more, making care homes the tax man for the general public purse without residents knowing about it (as they seem to believe that it is VAT free service delivery by care homes).

One alternative to the proposed action plan is to consider closing all smaller care homes altogether and aim for a minimum size of care home of not less than – say - 60 residents or even more. The purpose of this would be to create the more apparent and elusive economies of scale, as described above, ie have only one home manager and creating thus incentives for larger groups to run operations, while ultimately taking funs away from the front line. While this may well be one of the naïve but welcome side effect of the rules currently in place, this ignores at its own peril three important factors.

First, the higher the concentration of elderly the more removed they will be from their original community when considering a non-urban context. Second, the ability to recruit and fill a larger home becomes equally more challenging the further staff has to travel and the wider the "catchment area" has to be, forcing staff into long journeys at extreme hours at night or day. Third, larger places are more vulnerable to epidemics or systematic failures, mis-management, less involvement of residents and relatives, and alike due to being "too big to fail" having long lines of command, while making it more difficult to intervene.

A system of more dispersed homes, while using all available technology today and cost savings available in joint support service procurement and digitalisation is in its entirety much more robust against any external disruption and spreads economic benefit much wider into all regions of Scotland, instead of concentrating profits even more in only a few places.

From a public sector perspective, the conclusion must be to consider a more fair and aware tariff calculation system, such that the funds which are available each year are more effectively spend on outcome-based care in care homes, rather than subsidising already well rewarded areas and businesses.

Policy should be to strengthen the rural areas in Scotland, and allow delivery of care as effectively and sustainable as in urban areas.

Supporting Materials

From
Scottish Care Homes Census and Care Inspectorate Registration List 31st March 2007 - 31st March 2017

1. Number of Registered Beds for Elderly People In Scotland by Council

Local Authority	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Scotland	37,540	38,078	38,401	39,150	38,341	38,465	38,508	38,441	38,164	37,746	37,278
Aberdeen City	1541	1639	1758	1709	1622	1648	1562	1488	1434	1472	1,440
Aberdeenshire	1912	1929	1937	1865	1860	1860	1956	1913	1923	1814	1,790
Angus	1055	1015	1008	1112	1062	1078	1111	1103	1099	1072	1,079
Argyll & Bute	728	720	697	603	672	686	638	637	594	594	576
Clackmannanshire	234	288	288	222	222	284	282	218	243	282	282
Dumfries & Galloway	1171	1193	1184	1202	1120	1144	1140	1136	1126	1075	1,081
Dundee City	1053	1104	1117	1094	1077	1077	1138	1134	1137	1133	1,148
East Ayrshire	697	845	849	933	910	909	907	931	930	912	912
East Dunbartonshire	496	494	528	563	498	584	640	722	724	740	740
East Lothian	698	627	689	658	650	663	662	660	632	618	616
East Renfrewshire	533	493	496	626	623	613	604	608	716	766	813
Edinburgh, City of	2911	2942	2932	3115	3011	2936	2998	3048	2912	2853	2,824
Falkirk	930	949	1022	987	972	972	972	981	980	981	1,002
Fife	2572	2602	2670	2862	2832	2846	2860	2902	2947	3007	2,998
Glasgow City	4424	4401	4417	4332	4346	4341	4365	4400	4297	4297	4,147
Highland	1927	1871	1912	1902	1868	1801	1800	1812	1823	1780	1,679
Inverclyde	701	701	791	784	774	773	782	753	748	759	760
Midlothian	588	617	659	589	597	597	597	556	558	558	558
Moray	580	585	581	570	609	595	592	592	592	594	592
Na h-Eileanan Siar	219	210	210	216	208	208	204	206	206	216	216
North Ayrshire	1076	1075	1077	1144	1180	1180	1176	1164	1132	1077	1,076
North Lanarkshire	1956	2103	2099	2120	1914	1836	1812	1773	1796	1794	1,711
Orkney Islands	129	129	129	131	124	108	111	111	111	111	111
Perth & Kinross	1419	1513	1477	1568	1533	1583	1598	1572	1469	1458	1,429
Renfrewshire	1276	1358	1358	1374	1455	1455	1450	1452	1485	1372	1,372
Scottish Borders	798	765	729	750	789	791	764	750	731	699	688
Shetland Islands	143	144	153	154	162	162	170	170	149	149	149
South Ayrshire	893	927	897	956	956	1045	1054	1048	1124	1126	1,107
South Lanarkshire	2813	2788	2742	2896	2590	2619	2593	2588	2579	2419	2,391
Stirling	618	635	599	633	576	564	555	554	508	498	498
West Dunbartonshire	608	605	605	610	614	592	522	567	567	628	605
West Lothian	841	811	791	870	915	915	893	892	892	892	888

1. Data are sourced from the Scottish Care Homes Census and Care Inspectorate Registration List 31st March 2007 - 31st March 2017.
2. Due to the way the figures are categorised and presented by ISD Scotland, they may differ slightly to those published by the Care Inspectorate.
3. The main client group refers to the majority of residents in the care home.
'Other Groups' include care homes for adults with alcohol and drug misuse, blood borne viruses (AIDS/HIV), acquired brain Injuries, and other vulnerable adults.
4. "Percentage change" refers to the difference between two numbers expressed as a percentage e.g. the percentage change from 10 to 15 is 50% i.e. ((15-10)/10)*100.
5. "Percentage point change" is calculated by subtracting one percentage from another e.g. the percentage point change from 10% to 15% is 5 percentage points (15-10=5).
6. n/a indicates no change, or data not available.
7. An asterisk (*) indicates that a value has been suppressed to help protect the identification of individual residents.
8. Please see the glossary for information on completeness of data and estimated data.
9. The percentage occupancy should not be greater than 100%. If it is, the number of residents submitted in the census is incorrect (too high), or the the number of registered places is incorrect (too low).
10. The Local Authority is the Local Authority in which the care home is located.

2. Number of Care Homes In Scotland by Council

Local Authority	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Scotland	949	944	948	943	920	916	911	902	892	873	854
Aberdeen City	35	36	38	37	34	35	33	31	30	31	30
Aberdeenshire	52	51	51	49	49	49	50	49	49	46	45
Angus	32	31	31	31	30	30	30	30	30	29	29
Argyll & Bute	28	28	26	24	23	24	22	22	21	21	20
Clackmannanshire	6	7	7	5	5	6	6	5	6	6	6
Dumfries & Galloway	37	37	36	36	33	33	32	31	30	29	29
Dundee City	25	26	26	26	26	26	27	27	27	27	27
East Ayrshire	21	22	22	23	22	22	22	22	22	21	21
East Dunbartonshire	10	10	10	10	9	10	11	12	12	12	12
East Lothian	19	18	19	18	18	18	18	18	17	17	17
East Renfrewshire	12	11	11	13	13	13	13	13	14	15	15
Edinburgh, City of	67	66	65	68	66	64	66	66	66	63	61
Falkirk	21	22	23	21	21	22	22	23	23	23	23
Fife	73	74	74	77	75	75	75	76	76	76	76
Glasgow City	87	85	86	81	81	81	81	82	79	75	72
Highland	69	66	68	66	64	62	62	61	59	58	56
Inverclyde	17	17	18	18	18	18	18	17	16	16	16
Midlothian	13	13	13	12	12	12	12	11	11	11	11
Moray	17	17	16	15	16	14	14	14	14	14	14
Na h-Eileanan Siar	9	9	9	9	9	9	9	10	10	10	10
North Ayrshire	26	26	26	27	26	25	25	24	23	22	22
North Lanarkshire	37	38	39	40	37	35	34	32	32	32	30
Orkney Islands	7	7	7	7	6	5	6	6	6	6	5
Perth & Kinross	42	44	44	44	43	44	44	43	42	42	40
Renfrewshire	22	23	23	23	24	24	24	23	24	21	21
Scottish Borders	25	23	22	22	23	23	22	22	22	21	21
Shetland Islands	10	10	11	11	11	11	11	11	9	9	9
South Ayrshire	25	25	24	25	25	25	24	24	25	25	24
South Lanarkshire	55	54	55	56	52	53	51	50	51	49	46
Stirling	20	19	19	18	17	17	17	17	16	15	15
West Dunbartonshire	14	14	14	14	14	13	12	12	12	13	13
West Lothian	16	15	15	17	18	18	18	18	18	18	18

3. Sources of Funding in Scotland by Type of Care and Origin of Funds

	Year as at 31 March										
Source of Funding	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Publicly Funded With Nursing Care	£472	£501	£523	£540	£551	£566	£566	£587	£590	£609	£637
Publicly Funded Without Nursing Care	£407	£435	£450	£465	£474	£487	£487	£499	£508	£525	£548
Self Funded With Nursing Care	£552	£589	£631	£657	£679	£698	£726	£754	£775	£814	£870
Self Funded Without Nursing Care	£509	£535	£562	£582	£607	£632	£658	£683	£708	£755	£798
All Funding With Nursing Care	£510	£540	£577	£598	£617	£632	£646	£669	£694	£709	£749
All Funding Without Nursing Care	£455	£479	£502	£520	£539	£561	£574	£592	£614	£625	£659

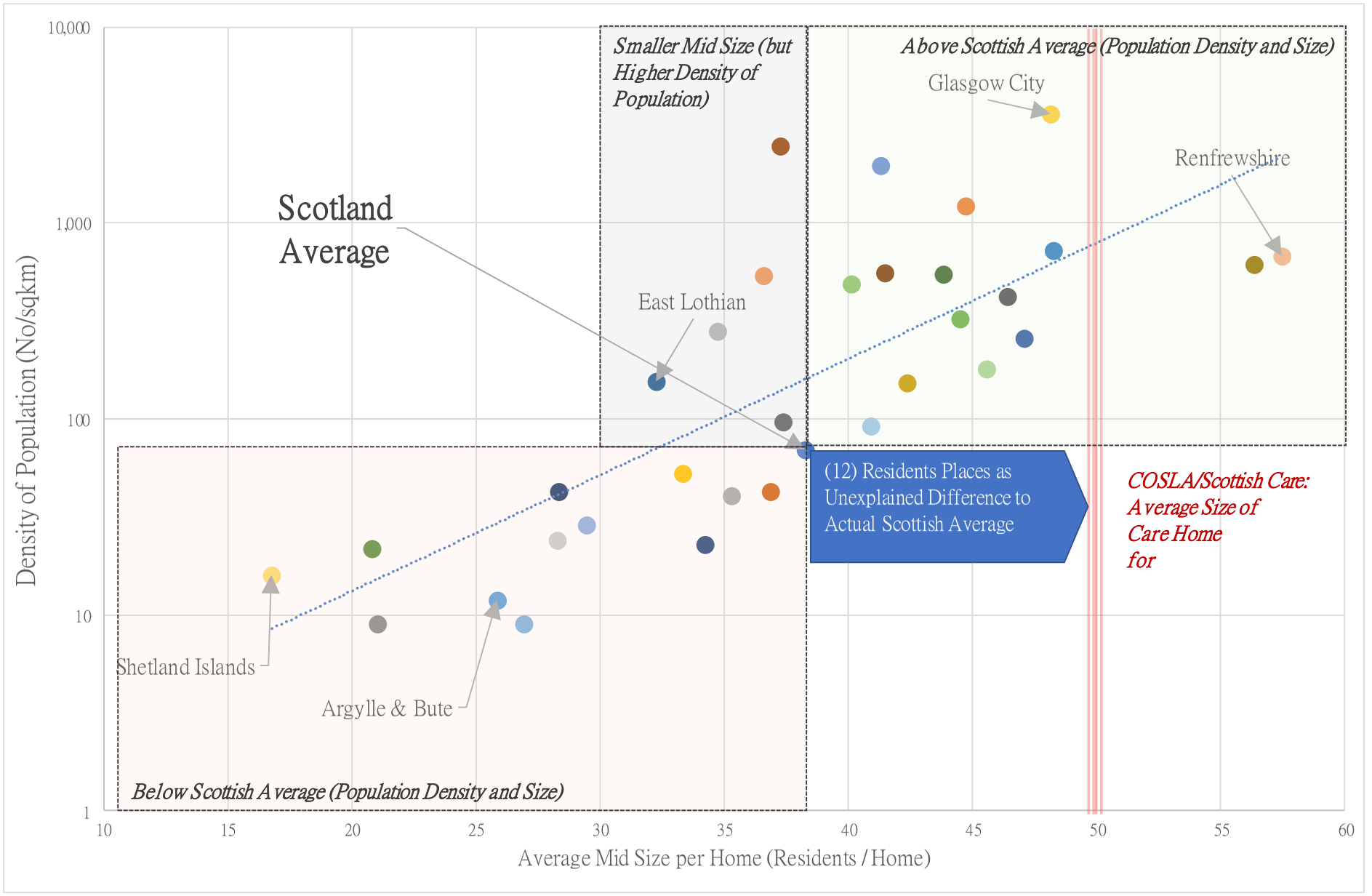
4. Self Funding Rates per Week in 2017

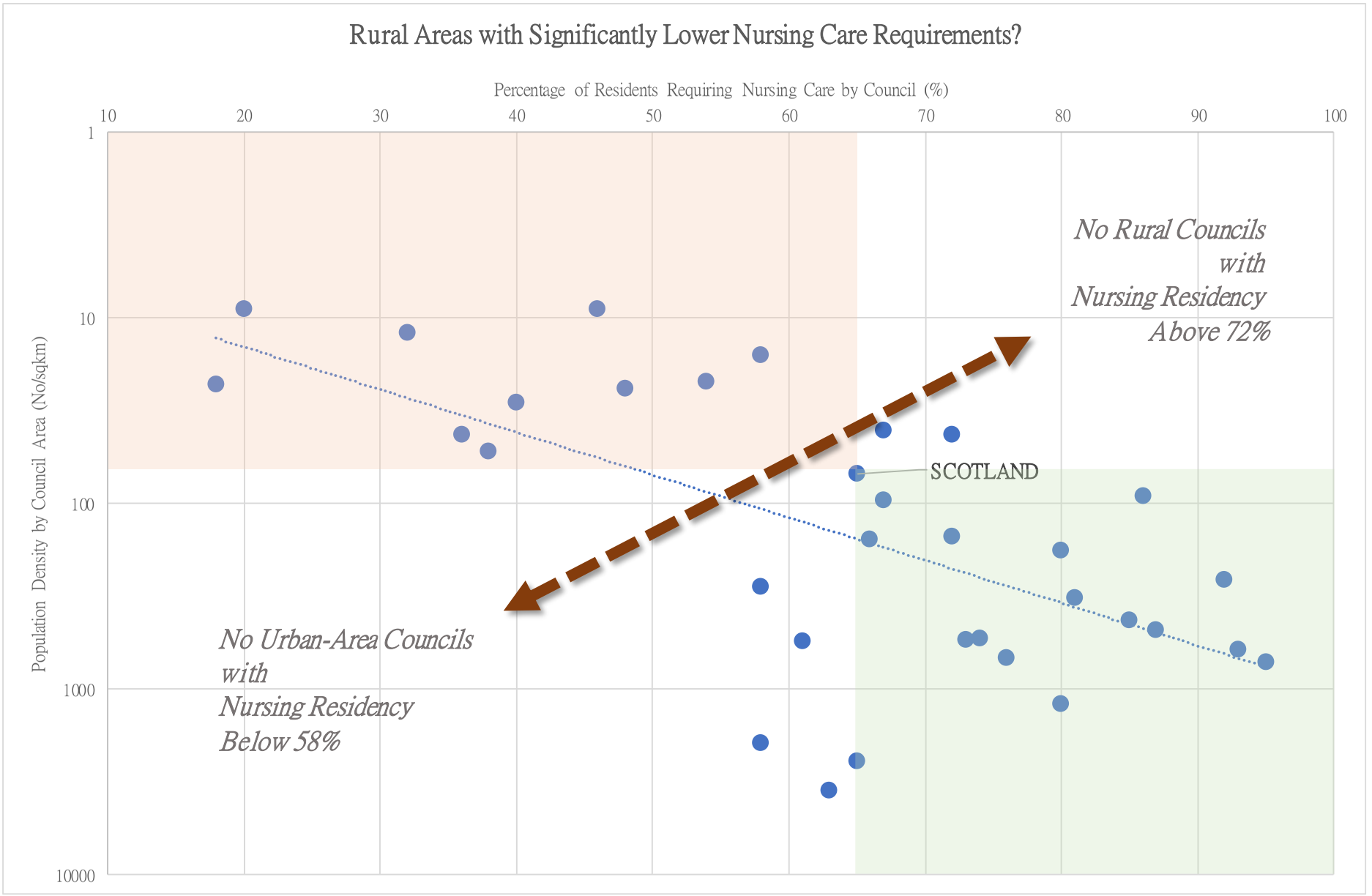
Local Authority	Self Funders Without Nursing Care	Self Funders With Nursing Care	All Self Funders
Scotland	£798	£870	£824
Aberdeen City	£881	£1,061	£947
Aberdeenshire	£826	£889	£849
Angus	£736	£915	£775
Argyll & Bute	£897	£990	£908
Clackmannanshire	£779	£814	£799
Dumfries & Galloway	£682	£754	£696
Dundee City	£805	£875	£822
East Ayrshire	£713	£804	£754
East Dunbartonshire	£941	£969	£955
East Lothian	£860	£877	£858
East Renfrewshire	£838	£879	£846
Edinburgh, City of	£994	£1,070	£1,019
Falkirk	£789	£815	£788
Fife	£769	£844	£802
Glasgow City	£735	£787	£762
Highland	£854	£903	£871
Inverclyde	£793	£866	£844
Midlothian	£827	£916	£883
Moray	£830	£874	£851
Na h-Eileanan Siar	£927	£909	£914
North Ayrshire	£692	£754	£722
North Lanarkshire	£664	£754	£715
Orkney Islands	£886	N/A	£886
Perth & Kinross	£778	£864	£806
Renfrewshire	£837	£914	£873
Scottish Borders	£727	£799	£764
Shetland Islands	£1,076	£1,130	£1,076
South Ayrshire	£795	£854	£816
South Lanarkshire	£684	£794	£728
Stirling	£784	£853	£808
West Dunbartonshire	£737	£796	£745
West Lothian	£829	£838	£835

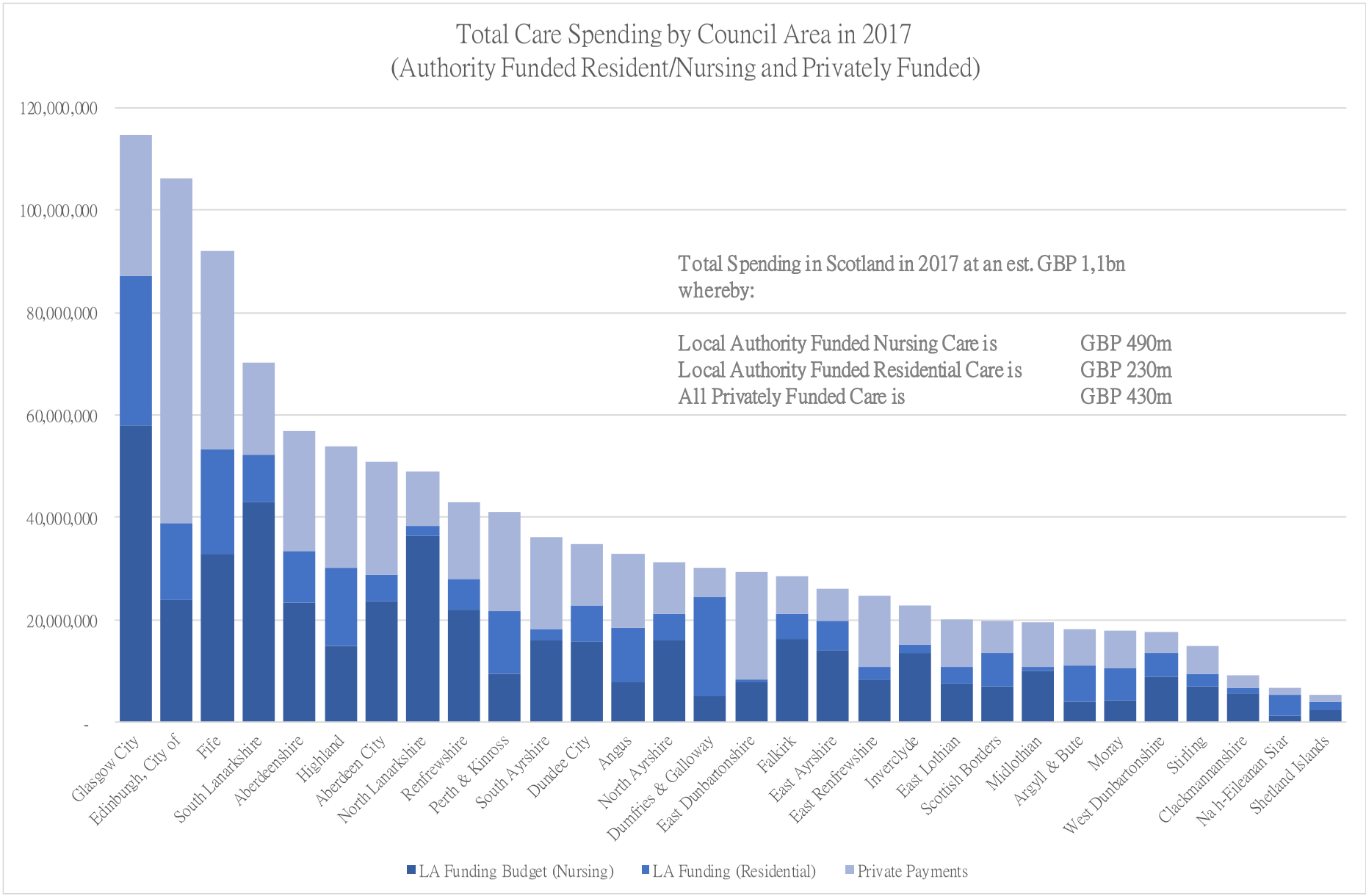
1. Data are sourced from the Care Home Census, 31 March 2017.
2. Average weekly gross charges based on care homes in all sectors (i.e. local authority, private and voluntary).
3. Self funders are residents with capital (including property) worth £26,250 or more.
4. Self funding residents must meet their care costs in full (over and above any assessed entitlement to free personal and nursing care).
5. Charges for self funding residents are agreed on a contractual basis between the individual and the care home provider.
6. Comparisons between Local Authority areas should be interpreted with caution as charges may vary due to size of room and whether room has en-suite facilities.
7. The Local Authority is the Local Authority in which the care home is located. This may differ to the Local Authority that pays for the care home stay.
   If a resident's stay is mainly or wholly funded by a Local Authority, it is the Local Authority in which the resident used to live prior to entering the care home, that pays.
8. Orkney local authority area does not have any care homes that provide places to self funding residents with nursing care.

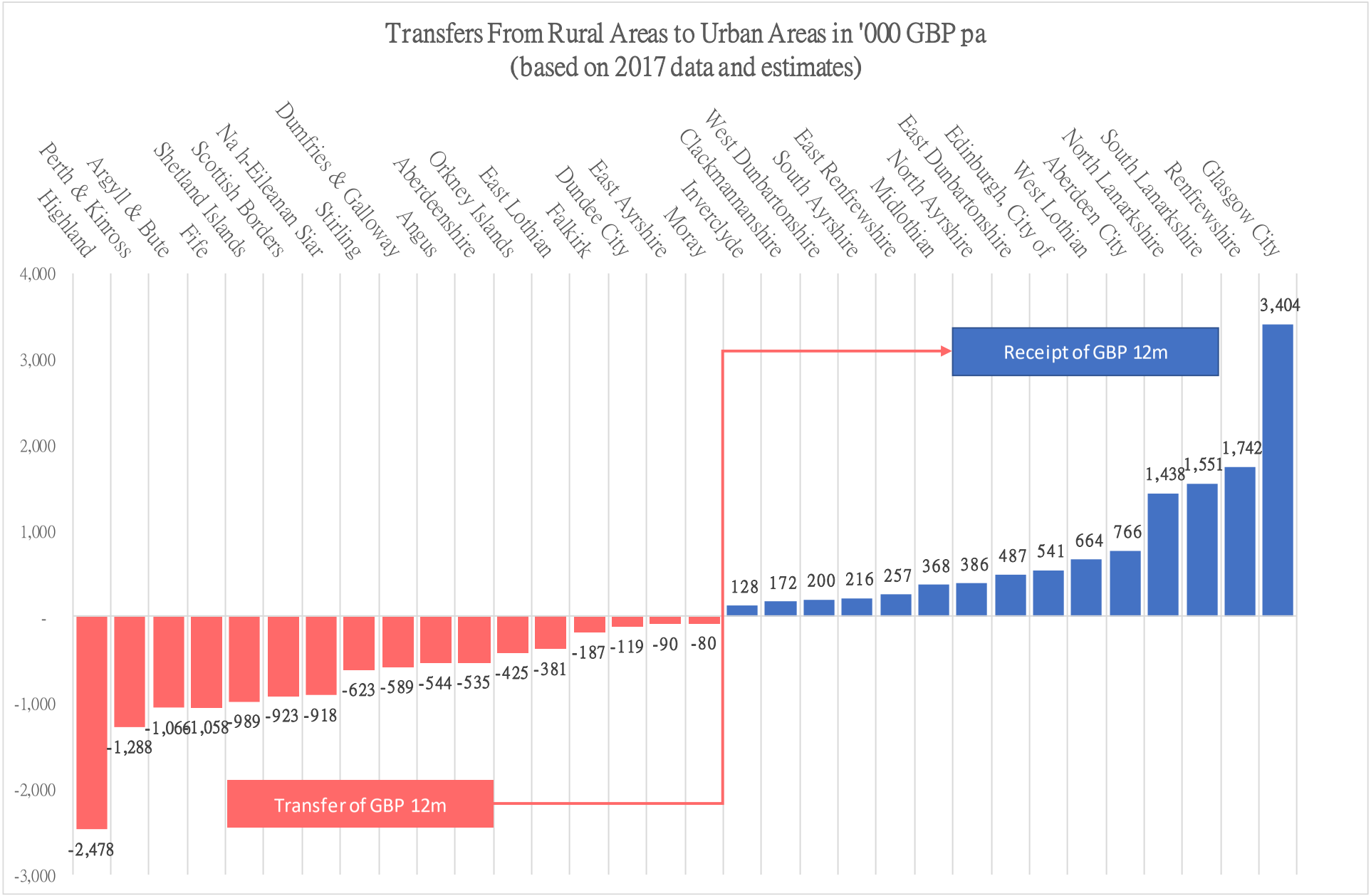
5. COSLA/Scottish Care 2018/19 Draft Rate Calculation Tool

Cost headline	Key benchmark	Value	Value (per resident per week)
Staffing Cost – Standard Carer	Living wage Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours of care Staffing contingency	£8.75 19.22 3%	£214.53
Staffing Cost – Senior Carer	Agreed hourly rate Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours of care Staffing contingency	£9.76 5.99 3%	£75.11
Staffing Cost – Domestic Staff	National minimum wage Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours per week	£7.83 5.75	£55.38
Staffing Cost – Chef/Cook	Agreed hourly rate Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours per week 0.75	£8.93 0.75	£8.30
Staffing Cost – Manager	Agreed hourly Rate Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours per week 0.80	£20.19 0.8	£20.73
Staffing Cost – Management Support	Agreed hourly Rate Statutory on costs (NI, pension, Holiday, SSP, training backfill) Hours per week	£9.32 1.03	£11.93
Other staffing costs	Direct Training Expenses (Fees, facilities, travel, materials)		£3.14
Total Staffing costs per person per week			£389.13
Building costs	Maintenance Capital Expenditure Repairs and Maintenance(Revenue) Contract Maintenance of Equipment		£30.00
Non-staffing costs	Activities and outcomes Food Utilities Insurance & Registration Office costs Sundries Personal & Nursing Equipment		£92.82
Business costs	Management costs Capital costs and return on capital	4.60% £50,000 4%	£62.01
Commercial Return	Providers Return	4.50%	£23.04
	Efficiency	-1%	-£5.12
Total Residential Care Fee per person per week 2018/19			**£591.88**


10,000
1,000
100
10
1
Density of Population (No/sqkm)
10
15
20
25
30
35
40
45
50
55
60
Average Mid Size per Home (Residents / Home)
Smaller Mid Size (but Higher Density of Population)
Above Scottish Average (Population Density and Size)
Below Scottish Average (Population Density and Size)
Scotland Average
Glasgow City
Renfrewshire
East Lothian
Shetland Islands
Argylle & Bute
(12) Residents Places as Unexplained Difference to Actual Scottish Average
COSLA/Scottish Care: Average Size of Care Home for


Rural Areas with Significantly Lower Nursing Care Requirements?
Percentage of Residents Requiring Nursing Care by Council (%)
10
20
30
40
50
60
70
80
90
100
Population Density by Council Area (No/sqkm)
1
10
100
1000
10000
No Rural Councils with Nursing Residency Above 72%
SCOTLAND
No Urban-Area Councils with Nursing Residency Below 58%


Total Care Spending by Council Area in 2017
(Authority Funded Resident/Nursing and Privately Funded)
120,000,000
100,000,000
80,000,000
60,000,000
40,000,000
20,000,000
-
Total Spending in Scotland in 2017 at an est. GBP 1,1bn whereby:
Local Authority Funded Nursing Care is GBP 490m
Local Authority Funded Residential Care is GBP 230m
All Privately Funded Care is GBP 430m
Glasgow City
Edinburgh, City of
Fife
South Lanarkshire
Aberdeenshire
Highland
Aberdeen City
North Lanarkshire
Renfrewshire
Perth & Kinross
South Ayrshire
Dundee City
Angus
North Ayrshire
Dumfries & Galloway
East Dunbartonshire
Falkirk
East Ayrshire
East Renfrewshire
Inverclyde
East Lothian
Scottish Borders
Midlothian
Argyll & Bute
Moray
West Dunbartonshire
Stirling
Clackmannanshire
Na h-Eileanan Siar
Shetland Islands
LA Funding Budget (Nursing)
LA Funding (Residential)
Private Payments


Transfers From Rural Areas to Urban Areas in '000 GBP pa
(based on 2017 data and estimates)
Highland
Perth & Kinross
Argyll & Bute
Fife
Shetland Islands
Scottish Borders
Na h-Eileanan Siar
Stirling
Dumfries & Galloway
Angus
Aberdeenshire
Orkney Islands
East Lothian
Falkirk
Dundee City
East Ayrshire
Moray
Inverclyde
Clackmannanshire
West Dunbartonshire
South Ayrshire
East Renfrewshire
Midlothian
North Ayrshire
East Dunbartonshire
Edinburgh, City of
West Lothian
Aberdeen City
North Lanarkshire
South Lanarkshire
Renfrewshire
Glasgow City
4,000
3,000
2,000
1,000
-
-1,000
-2,000
-3,000
-2,478
-1,288
-1,066
-1,058
-989
-923
-918
-623
-589
-544
-535
-425
-381
-187
-119
-90
-80
128
172
200
216
257
368
386
487
541
664
766
1,438
1,551
1,742
3,404
Receipt of GBP 12m
Transfer of GBP 12m

Edinburgh Integration Joint Board (EIJB)

Independent Review of Adult Social Care

Submission from Edinburgh Integration Joint Board

5 November 2020

Dear Mr Feeley

The Edinburgh Integration Joint Board (EIJB) is pleased to be able to respond to the call for views in relation to the Independent Review of Adult Social Care. This is a significant and important piece of work, being done at a time of real pressure and challenge across our system and in a very short timescale and we hope that the challenges in both of these support an outcome that delivers the best possible outcomes for people to live as independently, in their community as possible.

It's noted that in inviting views, that the panel has not provided any specific questions or narrative in relation to its work and so we have developed this response based on what we believe are key principles for the review and any future model of adult social care to operate within, as well as from our own ambitions as an Integration Authority (IA) and our strategic transformation plans.

IRASC Terms of Reference

The terms of reference for the review is wide reaching, giving an opportunity to resolve some of the barriers to deliver truly integrated health and care services especially at a time where there are significant demands for health and care services across Scotland.

The EIJB welcomes the inclusive approach to the review, taking account of the importance of housing and education and those other services and partnerships that support people in their communities.

We note from the Terms of Reference that one element under consideration is that of the structures through which social care is delivered however we also believe it important to recognise that structures – and massive organisational restructure – alone do not lead to transformation and that their undertaking can itself detract from driving the change being sought. In that theme therefore, any alternative structural arrangements (as part of the outcome of the review), must be considered through the lens of its achievability and the real impact on people.

The panel is aware that Integration Joint Boards(IJBs) are themselves relatively new, having been brought into formal being in 2016. While there remain challenges with the model which have been set out by Audit Scotland among others, it is the case that the formal integration of health and social care, under legislation, has made a difference and driving improvement across Scotland. This has been seen most recently in the agile response of IJBs and their Health and Social Care Partnerships (HSCPs) in response to the first wave of the Covid19 pandemic and the support they provided in partnership as one of the leading Public Sector Bodies, alongside Councils and NHS Boards.

There is much that can be improved in the integrated landscape by way of its complex relationships, accountabilities and governance but the principle of services, as close to the populations they are designed for and with, with local democratic accountability, and which integrated from planning, decision making and delivery must be a cornerstone of the Panel's work and we would urge that any consideration of structural reform focusses on strengthening the role of IJBs to be truly responsive to their communities as an accountable Public Body.

Edinburgh IJB Transformation Programme

The EIJB is ambitious to transform the way we work and our relationship with the citizens we serve. We believe that the Panel welcomes learning from innovation happening now in adult social care and that examples from some of the work we are doing in Edinburgh will be of interest and strong relevance to its work. The following sections sets out some of what we are doing, and we would be very happy to discuss any aspect of this directly with the panel.

Over the next few years, the EIJB is focused on four key areas to deliver a caring, healthier, and safer Edinburgh:

- Redefining the Edinburgh Pact
- Embracing the Three Conversations Approach
- Adopting the principle of Home First
- Advancing our Transformation Programme
- Developing a 'One Edinburgh' approach to our work with providers of care

The EIJB face some real challenges in delivering a health and care system in Edinburgh, therefore the EIJB need to think differently and the review is timely in supporting the EIJB to boldly shape services. The EIJB's ambition is to deliver a health and care services in a way that supports people to be well at home and in their community for as long as possible.

Within Edinburgh, through its strategic plan are focusing through its transformation programme to develop both the **Edinburgh Pact** and **Three Conversations** model which put people at the centre of decision making.

Previous approaches to delivering adult social care have used triage systems and an allocation process approach, have staff and individuals complete lengthy assessment forms and presumes the need for formal services. Too often this leads to people having to wait as resources have reduced. They must wait for an assessment and then, once assessed, wait for a 'package' of formal care. This system is broken and, as resources are put under further demand while need increases, is not sustainable. The EIJB agreed to change the way we work with people – to achieve better outcomes for them, a better and fairer use of resources and a more empowering model for our professionals.

The Three Conversations Approach which we are working on with Partners4Change is about working differently with individuals to achieve good outcomes for them and their families. The model is centred around having a more dynamic and flexible approach to helping and supporting people, recognising the power of connecting people to the strengths and assets of community networks, and work dynamically with people in crisis. The model focuses on what is important to individuals and conversations are person centred, leading to a reduction in support which undermines independence and allows intensive support to be used where there is most need. This model also aligns with the Self-Directed Support (SDS) philosophy where people should have the right to choose how their care needs are met.

This approach will be embedded in everything we do, including the workforce, commissioning approach, and links to other parts of the community which impact on the health and care of individuals, such as housing, third sector and community assets.

We want to support people to live independently in their own homes or in their communities therefore we need to ensure that there is sufficient community infrastructure in place to support this, takes account of best practice and cognizance of local voluntary activity.

Our initial work on this is demonstrating transformational change for people and for our practitioners who report greater empowerment, the ability to do what's needed and better role satisfaction. Our early evaluation demonstrates fewer people needing a formal service following a conversation than under our previous models and more people able to access either advice or one-off support to address their initial enquiry. There is huge potential in this model in changing how we work and pushing decision making and power to where it is most impactful – our citizens and our frontline professionals.

The Edinburgh Pact aims to reflect a pact made between individuals and providers to prevent crisis and support people to manage their health and personal independent at home as we believe that individuals are experts in their own lives.

The intention is that we will work with individuals to identify what matters most to them and support them to reach their potential. We must also provide clarity to citizens of Edinburgh on what we can provide and redefined what statutory service can contribute.

This can only be achieved through working in collaboration with partners to tackle inequality in communities and having meaningful engagement with citizens so that citizens who find themselves needing our support, know how to engage with us and realistically what to expect from that relationship. Working with the strengths of our citizens and communities to make sure that age, disability, or health conditions are not barriers to living a safe and thriving life in Edinburgh.

Significant work is being undertaken to ensure services are designed with people at the centre of decision making, however there is still more to do in fully implementing Self Directed Support effectively.

It is important that we develop ways to engage with citizens and service users and involve them in the transformational developments and initiatives underway. The EIJB have started that journey with two public engagement sessions running in November to get feedback on health and care services and the citizen experience of using these services.

Experience of people who work in social care

The workforce is our key resources and ensuring we have the numbers and skills to meet the increasing service demand remains a priority for the Edinburgh Health and Social Care Partnership (EHSCP). It is vital that we engage with, motivate, and support our workforce, to improve and sustain their knowledge, skills, and experience as we face the challenges and opportunities ahead. The workforce is

ageing in several areas and there is a constant struggle to recruit and retain health and social care professionals in the city. Baseline indicators identify across the Partnership that 45% of the total workforce is age 50 and above. Further scrutiny also highlights issues of supply with less than 10% of the workforce below the age of 30. Into this mix, the ageing city population, as well as Edinburgh's buoyant employment position and the high cost of housing, poses further challenges with recruitment and subsequent service delivery. We also need to encourage individuals to see health and care services as an attractive career path, easily access training with a clear route into a valued, supported, well paid career path.

To meet the increasing demand, the EHSCP workforce planning group has highlighted the need for targeted recruitment, for example offering modern apprenticeships and vocational learning, as well as the need to transform roles and encourage more applicants from ethnic minorities to better reflect modern society, to allow for a step-change in the way our workforce deliver services now and in the future. A workforce strategy is being developed, will form part of our transformation programme, and will be published in the coming months

Through the integration of health and social care services we have managed to integrate teams successfully across a range of disciplines. However, there are ongoing challenges around the operation of two difference cultures, systems and processes that still exist between health and social care services. These can hold us back in delivering the kind of agile change we need and force us to remain in traditional professional silos. The review must give consideration to a vision of a future workforce that encompasses new roles and how we train, educate and prepare the workforce for the future and create jobs that support recruitment of highly motivated and skilled people, appropriately and fairly rewarded for the work they do.

A significant focus of the inquiry will focus no doubt on the workforce across our third and independent sector partners who deliver essential, person centred care for many thousands of people across Scotland. This is a crucially important partner

workforce, and we encourage the panel to consider models which ensure parity of esteem with the public sector. Consideration must be given to how we value this workforce and these roles in Scotland and how we recruit to them, prepare, train and educate people to undertake them and the career progression and support they can and should expect in their undertaking. We have seen great progress in delivery of the Scottish Living Wage to this workforce, but the panel will recognise that for several IJBs, securing the funding to do this is particularly challenging, despite our commitment. This needs a sustainable solution if we are to aspire to parity with training, pay and conditions, and career progression.

Opportunities to redesign the overall system of social care

The review offers a real opportunity to redesign a fit for future system for health and care services. The principle of integrated health and social care is the right approach; however, the current structure of integration (the Body corporate model) is inefficient and clunky and has been slow to evolve. Any further proposed structural changes in the health and care area, could bring considerable uncertainty for staff groups and would have to be managed, and could be more disruptive than positive. It has also introduced additional levels of bureaucracy and not managed to develop a single budget nor single needs assessment.

There are significant strengths in local relationships and interfaces with other service areas and organisations that would be lost should the review lead to the development of a more regional or Scotland wide organisation of adult social care. There is a recognition that there is not enough funding in the system, which stops the ability to do fast and deep redesign at pace. Further development is also needed to identify where the funding opportunities and resourcing is.

Any new system of health and care needs to focus on a culture of learning, evidencing, problem solving, respecting and being accountable. The further developing of relationships with third sector and people with experience of using and delivering services with communities is fundamental to delivering the Edinburgh Pact and any wider redesign of health and care services.

Services needs to take account of the different lifestyles and personal outcomes and design support arrangements to empower people and services should not be designed in a one size fits all approach. It is also important to recognise that family carers are fundamental and provide sufficient support for them to support their families.

Arrangement for funding, governance, ownership, administration and deliver of social care services.

It is recognised that there needs to be a greater national focus on the distribution of funding and resources across the health and care landscape. Currently there is a varying landscape and resource distribution, which creates a postcode lottery and variability in terms of quality and performance.

Full integration of health and care services should continue. IJBs have managed to achieve this to some degree, however there is further work to do – we've touched on some of the work the EIJB is driving and know there will be multiple other examples of this across Scotland. We acknowledge that we have made progress in terms of the challenges facing our budgets, however IJB budgets continue to be complex and further work needs to focus not on how we manage within the complexities as 3 Public Bodies but toward truly understanding what we require to meet the needs of our citizens. We would ask that the review considers the potential to look at placing effective responsibility with the ability to act in one place which would be more effective and take integration further.

Our requests of the Review

We would wish to close by setting out the following 'requests' of the review – for them to consider as they continue their important, and potentially far reaching work. We would ask that:

- The panel puts people, and not structures or re-organisation for the sake of it, at the heart of what it does and that in thinking of its final conclusions can

answer clearly the question 'does this make it easier for people to access the advice and support they need to live independently, or when in crisis, or when they require long term care and support?'

- The panel sets what it does against the principles of self-determinism and self-direction and ensures that its recommendations support a drive to embed further self-directed support
- The panel recognises the importance of social care as a distinct entity to the provision of healthcare. It is not just a means to provide care and reduce delayed discharges and social care services should have parity of esteem in a fully integrated system.
- The panel recognise that care services, however organised, has been in the past, and remains sometimes, seen as subordinate to the NHS. There is a very real risk that social care becomes medicalised, a risk that is perhaps heightened with this review being initiated during the worst global pandemic in recent history. While we must learn lessons from working within the pandemic, we must also imagine the future beyond it.
- Given the important opportunity the Independent Review is presented with, we ask that it **not** focus on how the system might be organised within existing funding levels but seizes the opportunity to question more fundamentally what we are willing, as a society, to pay for these services and that the kind of excellence in care we are ambitious to see in Scotland, will need investment and additionality.
- Finally in relation to finances, we ask the panel to recognise that funding for adult social care is too important for people and the workforce, to be subject to the current significantly challenging and complex one-year processes across 3 organisations. This is not serving us well and it detracts both the EIJB and officers from the important work of delivering its strategic plan ambitions. We urge the panel to consider how to address both the sustainability of adequate funding for social care in Scotland and ensure the mechanisms for its allocation for delivery of these crucial services and supports can be simplified.

Best wishes

Angus McCann

Chair – Edinburgh Integration Joint Board

Edinburgh Napier University and University of Edinburgh - Researchers aligned to the Care Home Innovation Partnership

Written Evidence Submitted by Researchers from Edinburgh Napier University and University of Edinburgh, aligned to the Care Home Innovation Partnership in Lothian, Scotland

Executive Summary

- The evidence presented here relates to four research studies conducted in relation to workforce resilience, burnout and support around death and dying in the care home sector.
- While there are a wealth of resources to support care home staff well-being online, their use by, and usefulness to, front-line care workers is limited. Self-care and psychological well-being need to be incorporated into practice-based learning.
- In particular, practice-based learning in relation to palliative and end of life care and death and dying which incorporates self-care and psychological well-being could support long-term resilience in the care home sector.
- Embedding monthly online Supportive Conversations and Reflections about death and dying, delivered by palliative care specialists, is a mechanism for incorporating palliative and end of life education and support for care home staff, particularly front-line care workers.
- Long-term resilience of the care home sector requires career pathways and professional development opportunities for front-line care workers and nurses to develop as leaders in the social care sector, beginning with pre-registration nursing curricula and ongoing continuing professional development opportunities.

Our Team

We are a group of researchers aligned to the Care Home Innovation Partnership in Lothian Scotland. We work closely with the care home workforce researching a range of issues. These include: palliative and end of life care; the development of a Care Home Data Platform in Scotland; relationship centred care with people with advance dementia in care homes; and developing the research capacity and readiness of care homes in Scotland through the Enabling Research In Care Homes network. Four of our recent projects, two funded through the Chief Scientist Office Rapid Research in COVID programme, speak directly to the

enquiry aims – setting out the experiences of care home staff and evidence based recommendations for areas that need significant improvement.

Lucy Johnston, MSc, Research Fellow, Edinburgh Napier University. Background in Social Policy and expertise in conducting health and social care service evaluations and research studies.

Dr Jo Hockley OBE, PhD, RN, Senior Research Fellow, Usher Institute, University of Edinburgh. Expertise as a Consultant Nurse for Care Homes and developing palliative and end of life care in care homes in the UK, supporting and educating care home staff.

Dr Julie Watson, PhD, RN, Senior Research Fellow, Department of Nursing Studies, University of Edinburgh. Expertise in care home research in palliative and end of life care, dementia care, supporting care home staff and care home nursing in the pre-registration nursing curriculum.

Dr Cari Malcolm, PhD, RN, Lecturer in Nursing, Edinburgh Napier University. Expertise in resilience in the care home workforce.

Dr Susan Shenkin, MD, Geriatrician and Reader, University of Edinburgh. Expertise in geriatric medicine and building capacity for research in care homes.

1. Background:
   1.1 In care homes for older people, the majority of direct personal and social care is provided to residents by staff who are not registered nurses which we refer to here as frontline care workers (FCWs).
   1.2 Whilst FCWs work alongside registered nurses and other health and social care practitioners, they have different training, skills and duties compared to registered nurses.
   1.3 Moreover, in contrast to registered nurses, FCWs are less likely to have connections to professional bodies or organisations and thus lower levels of awareness of how to identify and access evidence-based information on care practices and how best to

support their wellbeing at work.

1.4 FCWs may be at greater risk of burnout given a number of factors including, but not limited to: long and unsocial working hours, low pay and status, and the increasingly demanding physical and emotional nature of their work *(VonDras et al. 2009; Health Foundation 2017; Dreher et al. 2018).*

1.5 FCWs have a higher rate of turnover than other members of social care workforce (*Donoghue et al. 2010; Rosen et al. 2011*).

1.6 The impact of the ongoing COVID-19 pandemic on care homes has intensified the need to ensure the care home workforce is supported to build resilience, avoid burnout and remain in their roles delivering quality and compassionate care to older people.

1.7 Evidence for best practice in supporting the resilience and retention specifically of frontline care workers in care homes is extremely limited, of variable quality and lacks generalisability. At present, it is dominated by cross-sectional studies mostly from out with the UK. The small number of intervention studies are inconclusive.

1.8 Multiple factors are suggested as being associated with best practice in supporting resilience and retention - Culture of Care; Content of Work; Connectedness with Colleagues; Characteristics and Competencies of Care Home Leaders and Caring during a Crisis.

1.9 Key guidance for supporting health and social care has emphasised the importance of promoting awareness of wellbeing resources available to staff, and where to access additional support when needed (*WHO, 2020; British Geriatrics Society, 2020; University College London, 2020*).

2. Emotional and psychological wellbeing of Frontline Care Workers:

Building on the above context, researchers at Edinburgh Napier University and University of Edinburgh received funding from the Chief Scientist (Scotland) Rapid Research in COVID-19 programme, to examine how the wellbeing and psychological and mental health of frontline care workers (FCW) in care homes for older people has been supported during COVID-19 (February to July 2020). We also undertook a scoping review of the published literature. The key findings of these studies are as follows:

2.1 There is a wealth of wellbeing resources available online and more were made available during the pandemic. However, for FCWs, identifying relevant, high quality resources can be difficult and time consuming and online resources were reported as not being a main source of support.

2.2 Online wellbeing resources need to be tailored and targeted to FCWs in care homes to bridge the identified delivery and uptake gaps.

2.3 There is a need to better understand how best to assist care homes to facilitate uptake of tailored and targeted resources by FCWs.

2.4 Care homes, families, residents and staff benefited greatly from morale boosting creative activities and staff groups and individuals 'going the extra mile'. However this is not sustainable and internal and external resources for wellbeing must be replenished so staff are able to continue to provide effective and compassionate care to residents and look after their own health and wellbeing.

2.5 The benefits of supportive communication within the home for staff wellbeing have been identified. They can take many formats and be either formal (for example end of shift huddles/checklists and supervision) or informal (for example peer support and an open door culture).

2.6 This work reinforces that the culture, leadership and supervision practice of each care home is key to staff wellbeing.

2.7 RECOMMENDATION: **Work to develop wider quality improvement and training initiatives for practice-based preventative psychological wellbeing must be embedded within homes.**

2.8 Care home managers wellbeing and practice development is aided by sharing their learning and experiences with peers.

2.9 **RECOMMENDATION: Support Groups and networks for care home managers should be established, facilitated and resourced.**

2.10 **RECOMMENDATION: High quality, adequately powered, co-designed intervention studies, that address the fundamentally human and interpersonal nature of the resilience and retention of frontline care workers in care homes are required** (*Johnston et al 2020*)

3. Online Supportive Conversations and Reflections for care home staff:

COVID-19 Trauma Guidance suggests opportunities for structured, time-limited discussions about challenging experiences should be offered. The same researchers undertook a second study funded by the CSO Rapid Research in COVID-19 (June 2020- October 2020) to pilot a system of Online Supportive Conversations and Reflections (OSCaRs). These sessions were delivered by palliative care specialists to support care home (CH) staff in relation to death and dying. The key insights from this body of work are as follows:

3.1. The sessions identified that where there were a large number of deaths in the care homes, often combined with a large number of staff who were absent due to COVID-19 or shielding.

3.2. Although a wide range of staff including physiotherapists and activities teams were able to pull together, this still resulted in a high level of disruption of care at the end of life. Usual practices to support a resident who was dying, such as sitting with them, holding their hand, talking to them and the families, etc were no longer possible, leading to emotional distress for staff.

3.3. Some deaths were unexpected, while other residents had dreadful breathlessness which was very frightening for CH staff especially with no on-site nurses and no general practitioners visiting care homes.

3.4. Staff were really pleased when some residents who were Covid-19 positive 'pulled through', however the 3-month isolation had had a big psycho-social and physical toll on residents especially those with dementia.

3.5. Overall, the emotional strain on care home staff has been enormous – and there is a huge need to understand this especially in care homes without on-site nurses – with no real healthcare professional support. We fear these staff will find the second wave of the pandemic extremely difficult to cope with.

3.6. Staff taking part in the online briefing sessions reported feeling 'lifted'; staff who had previously been 'misunderstood' felt more accepted, and staff spoke openly in front of one another, including staff who would not usually interact during their daily work.

3.7. The sessions provided valuable learning about death/dying from experienced healthcare professionals.

3.8. **RECOMMENDATION**: **We strongly recommend that ongoing support of sessions that both support and advance practice-based learning in palliative and end of life care are maintained for Care Home staff including front-line care workers, nurses and ancillary staff.**

3.9. 57% of care home residents die within a year of admission and education on palliative and end of life care, which incorporates care of self and psychological well-being, will help foster resilience and prevent burnout.

3.10. Valuable initiatives, such as OSCaRS, that link practice-based learning and psychological wellbeing cannot be provided as a short term response to COVID-19. The real benefits for staff and residents will come from working collaboratively with care homes to embed recovery for their staff and empower longer-term resilience.

4. Care Home Workforce

The background and recommendations in this section draw on a project funded by the University of Edinburgh exploring student nurses' attitudes to care home nursing and the co-creation of curricular content on care home nursing in the pre-registration nursing curriculum (*Watson et al 2020*).

4.1. Pre-COVID, the resilience of the social care workforce in care homes has been precarious for some time. A Scottish survey (*Scottish Care 2015*) found an overall nurse vacancy level of 28% in the independent CH sector with 98% of CH providers having difficulty filling nursing posts, and vacant posts taking on average 7 months to fill.

4.2. Retention of nurses was also a significant issue with a 30% turnover rate.

4.3. This is placing many care home providers in an increasingly precarious position which risks the quality and continuity of care of frail, older people and sustainability of services (*Scottish Care 2015*).

4.4. The problem has become more acute as the care home population has increasingly complex care needs relating to the combination of age (85+), multi-morbidity, cognitive impairment, limited mobility, polypharmacy and the need for palliative care (*Gordon et al 2014*).

4.5. This complexity requires specialist knowledge, but opportunities for professional development for the Care Home workforce are currently limited (*Spilsbury et al 2015*).

4.6. **RECOMMENDATION**: **Career pathways and professional development opportunities for nurses to develop as leaders in the social care sector are urgently needed.**

4.7. Appropriate support and valuing of nurses in the care home setting, the integration of such care within the wider health care system and optimal models of health care delivery, are all fundamental prerequisites for future care home nursing (*Gordon et al 2018, Pijl-Zieber et al 2018*).

4.8. Research has shown that care home nurses themselves see their role as stigmatised, partly due to perceptions of the general public, and from within the nursing profession, that their work lacks clinical sophistication (*Thompson et al 2016*).

4.9. There is international recognition of the need for well-educated nurses to meet the complex needs in the social care sector including care homes (*Spilsbury et al 2015, Kiljunen et al 2016*). This necessitates the embedding of older people nursing in settings such as care homes in responsive curricula and education programmes, including practice placements, and there are examples of this occurring internationally e.g. Finland (*Kiljunen et al 2019*), Australia (*Loffler et al 2018*), the Netherlands (*Snoeren et 2016*) and in the UK (*Tiplady et al 2018*).

4.10. However, in the UK, student nurses in Higher Education Institutions (HEI) receive the majority of their clinical placement learning in acute care nursing (Spilsbury et al 2015) with little emphasis on older people nursing settings.

4.11. **RECOMMENDATION**: **Explicit inclusion of care home nursing in pre-registration nurse education** (*Watson et al 2020*) as well as challenging prevalent professional and public misconceptions about role of CH Staff and residents' experiences.

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Section 2

Lucy Johnston, Cari Malcolm, Lekaashree Rambabu, Jo Hockley, Susan D Shenkin

Supporting the resilience and retention of frontline care workers in care homes for older

people: A scoping review and thematic synthesis
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ENABLE Scotland

Independent Review of Social Care

Submission from ENABLE Scotland – November 2020

Executive Summary

ENABLE Scotland believes that excellent quality, self-directed social care is a critical element of a Scottish wellbeing economy and welcomes both the Independent Review of Adult Social Care.

Employing 2,200 staff: 1,800 of whom are directly employed via individual contracts, to support to support over 1,000 individuals across 27 local authority areas to live the life they choose. ENABLE Scotland is one of the UK's 30 largest providers of community based social care services, and the second largest in Scotland. As a national and influential charity, ENABLE Scotland is a strong advocate for the delivery of self-directed care and support which facilitates independent living for all, and for an effective reward and skills strategy for the frontline workforce.

ENABLE Scotland has developed a highly specialist, human rights-based self-directed social care delivery model – our ***"Personal Assistant (PA) Model"*** – which is built around the principles of Self-Directed Support (SDS) and enables individuals to live the life they choose, supported by a bespoke, customer-selected, well remunerated workforce. The PA Model, by its very design, enables high quality, personalised support to be delivered at scale. Further supported by a modern, digitally enabled infrastructure, the PA model delivers consistent high-quality support, with 80% of our services graded 6 (excellent) or 5 (very good) by the Care Inspectorate, against a national average of 56% (with 99% of all ENABLE Scotland's services are graded 4, 5 or 6).

The PA model has resulted in a 75% increase in self-directed service delivery over the last 5 years, both through people choosing ENABLE Scotland as their provider of choice, and also as a result of crisis management intervention to rescue service from failing provision. The impact of this success has meant that individuals supported by ENABLE Scotland are now not only people who have a learning disability. It should be noted that our model has expanded our reach significantly to provide self-directed support to all people of Scotland within a variety of diagnoses, care and support requirements, and long-term health conditions.

Over the past four years, the organisation has also advocated for sectoral reform of adult social care to maximise the investment in frontline staff in order to attract and retain the best quality staff to deliver the highest quality care as part of consistent teams, chosen by the individual. The charity has invested in frontline workforce and specialist infrastructure to provide the best self-directed care and support to all citizens, with a particular focus on those individuals who are in delayed discharge or at risk of admission as a result of provider failure or breakdown.

Scotland has a thriving charity sector, which COVID-19 has demonstrated is never more needed in communities across the country. Beyond the charitable contributions of organisations, this review must deliver what is required to create a modern, vibrant and sustainable social care sector, focussed on individuals regardless of labels or conditions.

We therefore offer our learning to this process from a position of strength, with a view to offering tested solutions and models which should be embedded into a social care service for Scotland which achieves the aims of the review to ***"provide consistently excellent social care support for people who use these services, as well as their carers and their families".***

Whilst there are many theoretical debates to be had around the principles of social care and the potential shape of a national approach, our submission focuses on practical suggestions, on the basis of tested models and demonstration sites that, if applied nationally, would have a significant impact on individuals, communities and systems.

Priorities for consideration within the Independent Review of Adult Social Care

ENABLE Scotland would ask the Independent Review of Adult Social Care to consider the following critical priority areas as essential in demonstrating the stated change required build a self-directed, sustainable social care sector.

1) A stronger, integrated, proactive regulator with zero-tolerance for continued under performance, evaluating all social care delivery through the legislation and spirit of the Social Care (Self-Directed Support) (Scotland) Act 2013 to ensure all individuals have true choice and control in their lives, and to prevent ongoing failure.

2) Introduce an absolute requirement for a de minimis reward structure that recognises the value and contribution of frontline social care professionals, beyond the current policy of the Scottish Living Wage.

3) Deliver sectoral reform that allows choice and control at an individual level, and removes excessive duplication and infrastructure costs across multiple providers to achieve an efficient and effective self-directed social care provider landscape, including determination of which interventions need to be applied universally across the sector on an annual basis (such as annualised uplifts in baseline pay).

4) Introduce an integrated regulatory framework encompassing NHS and Social Care to eradicate delayed complex hospital discharges, including:
   - i. A defined role for clinical governance and the mental welfare commission;
   - ii. A tripartite partnership of equals across NHS, Local Authority Social Work and not-for-profit providers; and
   - iii. A robust funding model that fully supports the critical transition costs required to adequately resource and sustain the transition and ongoing delivery of complex care

1. Embedding Self-Directed Support

A stronger, integrated, proactive regulator with zero-tolerance for continued under performance, evaluating all social care delivery through the legislation and spirit of the Social Care (Self-Directed Support) (Scotland) Act 2013 to ensure all individuals have true choice and control in their lives, and to prevent ongoing failure.

The role of the regulator should be more deeply informed by the specific interventions and environments required for authentic self-directed support to flourish. The commissioning, delivery and outcomes framework for a new approach to social care in Scotland already exists – it is the Social Care (Self Directed Support) (Scotland) Act 2013. The principles of this Act are universally applauded in principle – yet in practice, have not yet been fully implemented.

In our opinion and experience, the onus on individuals and families to request their right to access a truly self-directed model of social care is one of the critical points of failure in the system. If not specifically requested, or in many cases, fought for, individuals will simply not have access to Options 1, 2 or 4, and therefore get 3 as their default. Our experience as a social care provider has demonstrated that there is another way to achieve human rights led social care for all.

The PA Model ensures every single person supported by ENABLE Scotland has access to Option 2 of the Self-Directed Support options, regardless of commissioning arrangement in place. This enables every individual to design their own support, choose their own outcomes and select their own support team to work with them in achieving their outcomes.

Increasingly across the social care landscape, the sector is experiencing market failure at an alarming rate, with some providers unable to continue to deliver good quality care and support within this market context. Where this happens, vulnerable citizens are at the sharpest end, experiencing disruption and change in their lives which they have not chosen. To combat this, the regulatory framework must include improved use of data and insight to track persistent market failure in order to inform earlier interventions and restore quality to local commissioning frameworks and, crucially, improvements in the lives of people supported. A further independent review which has been summarised at appendix 1 is included to illustrate the direct impact that can be achieved when applying the PA model, coupled with additional critical strategic interventions, when turning around failing service provision.

Furthermore, during Covid-19, many people found that their usual building-based day service provision had to be closed or cancelled. Whilst for some individuals, this was a challenge, for others, this presented an opportunity to think differently about how to life their life and achieve their outcomes. In a modern, inclusive Scotland, this Review should consider and make recommendations about the position of building based day centres as part of our social care system, with reference to existing rights that individuals to access their social care budget in different ways to meet their outcomes.

The social care review could usefully make recommendations to align the regulatory responsibilities more closely to the Social Care (Self-Directed Support) (Scotland) Act 2013, and include improved use of data and insight to track persistent market failure.

In addition, the review should recommend that every person accessing social care support, does so through a self-directed option, and does not fall to the default option 3 position as currently prevails.

2. Enhancing workforce reward

Introduce an absolute requirement for a de minimis reward structure that recognises the value and contribution of frontline social care professionals, beyond the current policy of the Scottish Living Wage.

If social care is all about people, this is as true of the workforce as it is of the individuals it supports. The de minimis position for the social care workforce has been the Scottish Living Wage since 2016, and following a significant campaign from ENABLE Scotland, this was extended to all hours worked, including overnight support, since 2018. This still presents a significant lack of parity with public sector employed care and NHS staff, and a pay gap with other industries.

ENABLE Scotland has introduced a number of ‘demonstration sites’ where we have increased the rate of pay excess of the Real Living Wage, in full negotiation with UNISON, our recognised trade union partners. Paying £10ph in these demonstration sites, we have been able to demonstrate significant improvements in attracting and retaining the highest quality candidates through our bespoke recruitment process. This has also resulted in the removal of all agency staff, increasing consistency and quality of support at the frontline, as well as reducing unnecessary rate inflation costs attributed with agency delivery.

In one area, where ENABLE Scotland had stepped in to support individuals following provider failure, our enhanced reward demonstration resulted in:

- Recruitment levels increasing from less than 80% to 100% in 8 weeks;
- Turnover reducing from 42% to 8% in 6 months; and
- Quality grades increasing from the inherited position of 2’s (weak) to 4’s (good) in just 18 months.

The impact of this investment was highlighted in a recent independent review of ENABLE Scotland social care services, and is summarized in Appendix 1, which noted that ’direct support staff are valued, well trained, consistently competent, well-remunerated and well-supported’.

ENABLE Scotland would request the social care review recommends the implementation of an enhanced reward strategy that truly recognises the value and contribution of frontline social care professionals, beyond the current policy of Scottish Living Wage.

3. Create Pathway for Sectoral Reform

Deliver sectoral reform that allows choice and control at an individual level, and removes excessive duplication and infrastructure costs across multiple providers to achieve an efficient and effective self-directed social care provider landscape, including determination of which interventions need to be applied universally across the sector on an annual basis (such as annualised uplifts in baseline pay).

In recent years, a trend has emerged in the social care sector in Scotland which has seen significant and unprecedented social, political and demographic change linked to an environment of austerity and cuts, which has been compounded by an increased demand for services and rising costs as result of pressures, such as changes to holiday pay legislation and frontline reward policy.

Whilst social care is considered an essential public service and increasingly a partner of the NHS to keep people well in the community of their choice, it has to date also suffered from a fragmented provider landscape, where infrastructure costs are duplicated across the multiple providers delivering critical services. If this pattern of delivery continues, it will inevitably result in collapse of the sectors sustainability longer term, given the ongoing and increasing pressure on public finances. This challenge was identified 4 years ago in an independent review commissioned by SCVO, which is included at Appendix 2. This has been further reinforced more recently in The Third Sector and the Forth Industrial Revolution speech by Bank of England Chief Economist Andy Haldane, where he recognises the critical role in non-funded delivery to meet the demands of public services more generally.

All of the evidence available suggests that the current model for the delivery of social care services in Scotland is unsustainable. Furthermore, PwC report that 47% of charities are planning on drawing on reserves in order to fund services, suggesting that investment in technology to enable more efficient and effective working practice at scale is not possible for individual organisations, which inhibits a progressive approach to harnessing the benefits of new technologies so often available in the private sector.

A report from New Philanthropy Capital – *Let's Talk Mission and Merger* (2018) made a compelling case for more charities to consider formal partnerships and mergers, arguing that too many charities put survival before mission, and stating that mergers and formal partnerships should often be considered by Boards and CEOs as a tool for achieving more for their charitable cause. The consolidation of not for profit social care providers may be necessary, and would also allow a stronger third sector to take on services that too often fail when delivered by private-equity backed providers. Beyond this, it would also allow for more public funds to be diverted to the frontline of social care delivery, rather than back end processes and functions, and therefore more directly on improving lives.

The Social Care Review should address the issue of fragmentation across the provider landscape recommending delivery of a streamlined and collaborative provider environment, which is designed to reduce infrastructure costs and direct more resources to frontline delivery.

The review should also recommend embedding a universally applied funding mechanism that guarantees and seamlessly delivers annualised funding increments, such as baseline pay increases.

4. Enable the Delivery of the 'Coming Home' Agenda

Introduce an integrated regulatory framework encompassing NHS and Social Care to eradicate delayed complex hospital discharges, including:

i. A defined role for clinical governance and the mental welfare commission;
ii. A tripartite partnership of equals across NHS, Local Authority Social Work and not-for-profit providers; and
iii. A robust funding model that fully supports the critical transition costs required to adequately resource and sustain the transition and ongoing delivery of complex care

As identified within the Coming Home Report (2018), there are over 700 people currently living in acute hospital settings or out of area placements, delayed in returning home to their own community to live the life they choose. Many of these individuals are considered to have complex support needs that has resulted in them being caught between health and social care agencies, highlighting a lack of streamlined funding and accountability to expedite the transition home for these individuals.

ENABLE Scotland, in partnership with the NHS and Local Authority, has demonstrated that it is possible for a commissioned third sector provider to achieve transformational change for these individuals in the immediate term, without unnecessary delays. The success of this journey has been captured in an independent evaluation of our work, which is included in Appendix 3.

As demonstrated, key to the successful transitions has been a strong commitment from all stakeholders to work collaboratively, transparently, and flexibly, with an unwavering commitment to getting it right for the individuals. The Radical Visions evaluation therefore finds a critical success pathway as demonstrated through the ENABLE Scotland experience, which can be shared as a blueprint for others:

- Whole organisation commitment to the human rights of the person, from frontline practitioners to CEO
- True multi-disciplinary approach and flexible partnership based decision making
- Consistent commitment to achieving for purpose home environments that meet the needs of each individual
- The demonstration of critical upfront investment in transition related costs
- Investment in specialism across the workforce, enhanced reward strategy
- Application of the principles of self-directedness, as demonstrated by the "PA Model".

The review should recommend the introduction of a collaborative funding, commissioning and delivery model that is designed to eradicate delayed complex discharge, including:

i. ***A defined role for clinical governance and the mental welfare commission;***
ii. ***A tripartite partnership of equals across NHS, Local Authority Social Work and not-for-profit providers; and***
iii. ***A robust funding model that fully supports the critical transition costs required to adequately resource and sustain the transition and ongoing delivery of complex care***

Appendix 1: **Independent review summary of ENABLE Scotland's PA Model and enhanced reward structure in the delivery of high-quality self-directed support, during the turnaround of failing service provision.**

Appendix 2: **Scotland's social care sector: The financial evidence that is driving change**

Appendix 3: **Independent review summary of the successful and collaborative transitions of three complex hospital discharges into sustained community-based living**

Appendix 1: Independent review summary of ENABLE Scotland's PA Model and enhanced reward structure in the delivery of high-quality self-directed support, during the turnaround of failing service provision.

East Lothian Service Turnaround

A case study of transformative impact and investment in social care

1. Summary:

ENABLE Scotland believes that good quality, personalised social care is a critical element of a Scottish Wellbeing economy. The charity's experience in East Lothian, evaluated independently by Radical Visions in June 2020, of turning around the poor quality of social care delivered previously by failing, private equity backed care providers, demonstrates the impact of third sector not-for-profit social care providers' investment back in to improving frontline service delivery.

2. Background:

ENABLE Scotland delivers c£2m of services *per annum* across East Lothian, supporting 50 individuals who have learning disabilities and their families, and employing 95 people across the community, predominantly as frontline Personal Assistants (PAs).

ENABLE Scotland were approached by East Lothian Council to tender for this significant service due to the fact that the incumbent provider, a private-equity backed social care provider, had failed to deliver on any measures of quality of life for the vulnerable citizens in their care, resulting in CI Grade 2s for at least 12 months. It should be noted that this was the second consecutive private sector provider failure for these citizens, and that staff had gone through at least three consecutive TUPE processes as ownership of the company changed hands. Since formally taking over the service in late 2017, it has taken ENABLE Scotland three years of concerted and sustained effort and investment to turn the service around to a position where the quality of life for people supported is improving through a high quality, consistent workforce.

*"**There is no question about the scale of the challenge embraced by ENABLE in 2017. There had been a major failure of service delivery on the part of the previous service provider. The situation inherited was characterised by chaotic disorganisation and an extremely poor quality of service to those reliant on it: not only in terms of their day-to-day experience of the service, but also in terms of its ability to help them address the big issues in their lives and assist them to take their places as active citizens in their own communities. Inconsistency and discontinuity were to the fore and people were often supported by people they barely knew or sometimes had not met. In addition, the families of the people supported by the service had lost all faith in its ability to deliver to even a basic standard of quality**."* (*Radical Visions Evaluation Report, June 2020*)

3. Impact:

Since the services transferred to the charity in late 2017, significant progress and improvements have been delivered in all aspects of service delivery and quality, as well as staff recruitment and retention. ENABLE Scotland, as a national third sector provider at scale, has **invested** considerable resources, outwith the terms of its contractual agreement with the Council, **of £0.5M.**

The evaluation finds that ENABLE Scotland approached the work with a "***high degree of resolution and commitment to getting it right for the people supported"*** based upon its extensive experience of delivering at 5s and 6s across some of the most complex learning disability services across Scotland, and the key impacts can be summarised as follows:

3.1 **Reduced turnover from 37% in 2018 to 8%** in 2020 as a result of implementing £10/hour rate. Turnover reduced steadily from 37% in 2018 to 20% within 12 months, to 14.3% by end of 2019, and to 8% currently**.** *Note:- it is the judgement of the charity, benchmarking across the entire 2,200 workforce in 27 local authorities where it delivers commissioned social care, that there is a definitive causative link, not a correlation between reward and turnover. ENABLE Scotland has work underway across two further demonstration sites where it pays above Living Wage supporting the delivery of highly complex social care.*

3.2 **Moved on 30% of the inherited workforce** due to lack of compliance with ENABLE Scotland standard recruitment and vetting procedures

3.3 **Increased recruitment levels** from less than 80% to 100% of hours of support commissioned by the local authority

3.4 **Increased Care Inspectorate Grades** from 2s to 4s in 18 months – and on a continuous improvement trajectory to that charity's standard position of 5s and 6s. 80% of ENABLE Scotland services are currently graded 5s and 6s

3.5 CEO of ENABLE Scotland proactively met with CEO of Care Inspectorate to advise of the challenges inherited and to ensure a transparent and open partnership approach on the complex turnaround of key regulatory inspection criteria

3.6 **100% of people** supported now **have an individualised outcome-based support plan** in place based on the models of Self-Directed Support, achieved through the application of ENABLE Scotland's innovative **PA model**

3.7 Implemented an **enhanced hourly pay rate**, through its **Reward to Retain** initiative, of **£10/hour**, to demonstrate the impact of the application of a rate in excess of the Real Living Wage, in full negotiation with UNISON, our recognised trade union partners

3.8 Provided consistent, enhanced and effective **leadership** at local, regional, and national level

3.9 Invested in a **new workforce strategy unit** which includes **ENABLE Recruits**, a bespoke internal recruitment agency, as well as **a modern, digital Learning & Development function**.

4. Additional Information:

4.1 About ENABLE Scotland: ENABLE Scotland is the country's second largest provider of community based social care services, and as a national and influential charity, is a strong advocate for the delivery of person centred care and support which facilitates independent living, and for an effective reward and skills strategy for the frontline workforce.

Since 2016, ENABLE Scotland has embedded its PA model of delivery as standard across all social care service, which involved "***partnership with UNISON to develop new contracts of employment…: clearly designating the organisation as the employer; but stating unambiguously that the employee has been recruited to work directly for a specified individual. This step is integral to the achievement of … dedicated teams for individual people - enabling the person to have more choice, control and consistency of support whilst the organisation continues to assume responsibility for staff employment. This way of working in partnership with trade unions to develop creative contractual arrangements, embracing the values and principles of self-directed support, demands determined strategic leadership. It demonstrates the ability of a large organisation to act nimbly towards the goals of personalisation and is an example of good practice to be shared nationally."*** *(Radical Visions Evaluation Report, June 2020)*

Over the past four years, the organisation has also advocated for structural reform of adult social care to maximise the investment in frontline staff in order to attract and retain the best quality staff to deliver the highest quality care as part of consistent teams, recruited by and with the individual. The charity has demonstrated the impact of this approach in East Lothian.

4.2 Sector Analysis: In recent years, the delivery of social care provision in Scotland has faced enormous challenges. Whilst it is considered an essential public service and increasingly a partner of the NHS to keep people well in the community of their choice, it has to date also suffered from a fragmented commissioning and provider landscape, which has ultimately resulted in the most fragile workforce with fragmented terms and conditions, supporting the most vulnerable citizens.

- Over 200,000 people are employed in social care
- 31% of the social care workforce are employed in the voluntary sector; 43% private, and 25% public
- The social care sector contributes £3.1 billion to the Scottish economy
- There are over 1,000 different providers of social care in Scotland, with a mixture of third sector and private sector commissioned providers
- 42% of Scottish charities reported using reserves due to a deficit position in 2018

All social care providers (until 1st April 2020) negotiate commissioned rates within a competitive tendering landscape. The fragmentation of the current social care system can lead to different approaches to investment in quality of care.

Increasingly across the social care landscape, the sector is experiencing market failure at an alarming rate, with some providers unable to continue to deliver good quality care and support within this market context. Where this happens, vulnerable citizens are at the sharpest end, experiencing disruption and change in their lives which they have not chosen.

A recent investigation into the position of private equity backed care providers across the UK reported that £1.5 billion (half of Scotland's total social care budget) is considered as 'leakage' out of the system as profit[1]. Whilst there is no estimated equivalent figure for Scotland, we can extrapolate that at least 10% of that amount – approximately £150 million – is lost to the Scottish social care economy in this way. ENABLE Scotland's experience in East Lothian demonstrates the impact of third sector social care investment back in to improving frontline service delivery, as opposed to leaving the system for profit.

5. About ENABLE Scotland

ENABLE Scotland is a leading campaigning charity in Scotland, one of the country's key commissioned social care providers and one of Scotland's five largest third sector employers. Over the last five years, it has grown to employ 2,200 staff delivering social care, employability and charitable services, on an income of £50m, as follows:

ENABLE All delivers personalised care and support services to over 1,000 people, many of whom have a learning disability alongside underlying health conditions and complex needs. The charity upholds the human rights of all people to live in the community of their choice, and is developing specialism in supporting individuals who have complex health and social care support needs out of hospitals and long stay institutions and into a home of their own.

ENABLE Works delivers training for employers and employability support to 1,489 people who have disabilities, supporting approximately 400 people into paid employment every year.

ENABLE Scotland Charity supports 897 adults and children who have a learning disability through a combination of local groups, membership support, and charitable projects, including campaigning and activism.

In 2019, **the Piper Group** was established to deliver central services support functions to allow the three arms of ENABLE Scotland to fulfil their purpose. To date, it has overseen an investment of £1m in developing a digitally enabled workforce across all ENABLE Scotland delivery.

[1] https://news.stv.tv/scotland/concerns-over-offshore-ownership-of-scotlands-care-homes?top

Appendix 2: Scotland's social care sector: The financial evidence that is driving change

JA Analysis

Scotland's social care sector:
The financial evidence that is driving change

Jo Armstrong
Summer 2016

1. Key Messages

Funding

1.1 The Scottish Government's TOTAL Revenue budget (RDEL)[1] is projected to fall £1.1 billion in real terms between now (2016-17) and 2019-20, a real terms fall of over 35% (see Figure 1). This will present a severe challenge for the Scottish Government on what services to favour and when.

1.2 Local authorities' gross spending per capita on Adult Social Care has fallen from its peak in 2009-10 of £700 to £680 by 2013-14, a real terms decline of over 3% in 4 years (see Figure 3). Assuming the Scottish government's budget allocations to local authority mirror historic allocations of funds available (ie, based on the Scottish Government's Draft Budget 2016-17) and demand for services continues to rise, this per capita allocation will fall, increasing the pressure for additional co-payments or that 'extra' quality will be more at risk.

1.3 Adult Social Care spending has seen its share of the total Social Work budget fall. Local authorities will have to ensure they continue to meet statutory services and may well have to deal with taking back in-house services that are 'handed back' if care providers cannot deliver with smaller budget allocations.

Demographics and Demand

1.4 The latest Scottish population projections confirm continued population growth, but it will be an increasingly aging one. By 2030 the total population is projected to increase by 5%, the 75+ cohort will grow by more than 40% and those 85+ will increase by almost 60% (see Table 1).

Costs

1.5 Organisations providing care and support across all user types (not just those in the older age groups) face doing so whilst also having to accommodate increasing cost pressures. The built-in increases in the National Living Wage provides a benefit to front-line staff but at the same time adds to the financial pressures on employers. As an illustration, if wages account for between 50%-60% of the total expenditures of the 30 largest Scottish-based care providers, their total turnover would need to rise by between 4%-5% in real terms annually by2020 just to meet these cost pressures alone.

Reserves

1.6 Just under three-quarters of the smallest Scottish-based charities have had to dip into their cash reserves to cover operating losses in at least one of the last 3 years. If the total funding available from the public purse remains constrained, this suggests charity Trustees and Directors will increasingly need to assess their operating models to ensure costs remain affordable.

Plan Bs!

1.7 Against this financial and demographic background, it is obvious that social care service providers will have to increase incomes, reduce non-wage costs or reduce service levels (eg, quality) to remain financial viable. Given the continued budget challenges facing all of Scotland's local authorities and health boards:

[1] Departmental Expenditure Limits (DEL) comprise revenue (resource) grants as well as capital grants and loans. Non-domestic rates income is classified as AME (Annually Managed Expenditure).

- is it reasonable for all care providers to assume they can and will secure the necessary increases in their incomes?

- given the size and extent of cuts and efficiencies many providers have already accommodated, can all providers secure the necessary reduction in operating expenditures or are the regulatory requirements and quality thresholds now setting a floor on the minimum costs necessary to provide a service in the sector?

- can those in need of care and support pay higher charges or cope with the imposition of co-payments to retain the services and providers they want?

1.8 The answer to these questions will inevitably vary by provide and user alike. However, are all Trustees considering less comfortable, more radical options in their financial planning process and do they have adequately developed and truly viable plan Bs up their sleeve should they have to cope with all the factors outlined above turning against them?

Data caveats

1.9 This high level analysis looks at the financial figures relating to adult social care in Scotland; Scottish and local authority data; and OSCR returns for the top care providers classified as such in the Scottish regulator's database. It is aimed at highlighting key issues and underlying high level trends that the sector needs to be considering as part of their strategic planning process. Inevitably, therefore, the relevance of the analysis may be of lesser importance to some organisations than for others. Notwithstanding this caveat, all organisations relying on public sector funding will have to be planning for some or all of these severe financial pressures.

2. Reasons for undertaking this analysis

2.1 As the funding available for the provision of care services across Scotland is and remains under severe pressure, the financial sustainability of many providers is now being severely tested. Some level of structural change seems all but inevitable. However, given the speed at which this is likely to happen, are we certain the outcome will deliver an optimal or even acceptable level and quality of service for all users and those in need of support?

2.2 Scotland's third sector providers of care and support services have and continue to deliver their varying brands of assistance for Scotland's most vulnerable citizens. This is despite the increasing and sometimes conflicting challenges of rising demand for services and tight, or even falling, public sector budget settlements. Delivering this care and support without diminishing service quality is and continues to remain a vital feature for most providers. Ensuring the care and support provided is also what users want (ie, is truly bespoke), continues to challenge the more traditional 'business models' of service provision.

2.3 Nonetheless, large scale contracts with local authority commissioners continue even after the introduction of legislation to drive self-directed support and individual budgets. However, such contracting arrangements are changing and not just because funding is falling. The drive for increasingly individualised services alters the contracting arrangement between users, providers and local authorities. Individuals in need of support will have more of a say in how and what care arrangements are to be procured (even if they do not directly make the final payment or manage the funding involved). As a consequence, care providers now more than ever need to be attuned to these needs and wants, adapt their internal systems to suit and not expect users and customers to adapt their expectations to fit in with existing working practices.

2.4 To effect what might be perceived by many as the need for structural change in times of plenty would not be straight forward. To deliver against a backdrop of budget cuts will be even harder. Each individual service organisation's response will inevitably vary; there is no one solution or business model that is 'ideal' for all organisations to adopt. However, if there is a common understanding of the financial outlook within which all will need to operate, discussions will allow opportunities to arise that, to date, have not been viewed acceptable or possible.

2.5 The purpose of this paper is to outline the various financial issues that will need to be taken into account when looking at such challenges and so aid and help inform the debate on how third sector organisations can influence the shape of inevitable change in social care in Scotland.

2.6 Section 3 offers some conclusions that arise from a high level, initial analysis of key financial data[2] that are and will continue to drive and affect the sector (details of which are provided in Appendix A and B) and then raises some initial issues to help start the necessary discussion.

[2] Extended analysis could include, for example, Scottish health spending, 3rd sector specific support, DWP and EU-supported activities, Trust funding along with various forms of user charging. However, as a general indicator of financial trends this initial review uses revenue DEL support since it is the largest ubiquitous support for core activities in the care sector.

3. Conclusions and issues for discussion

Conclusions

3.1 If local government retains its 2016-17 % share of the Scottish Government's revenue (RDEL) budget, this would take its Scottish government revenue grant support down to £9 billion by 2019-20, in inflation adjusted prices. This represents a cut of almost one quarter since the high watermark of 2010-11 or, a further 5% in real terms from 2016-17 (see Figure 5). **This clearly illustrates the on-going financial pressure facing all of Scotland's local authorities and so why they will continue to look to their 3rd sector providers to manage some of their financial pain**.

3.2 Social Work and Adult Social Care spending has plateaued at around £3.9 billion and £2.9 billion per annum respectively (in real terms) since 2008-09 (see Figure 2). Again, this clearly signals the financial challenge to individual business models; **how to meet increasingly bespoke services which may require changes to working practices?** If internally generated reserves are not available then accommodating cost cutting will be essential or, providers may need to step back from delivering the extent and breadth previously undertaken.

3.3 Notwithstanding the clear drive to personalisation of care, Self-Directed Support budgets still account for only 6% of total Adult Social Care spending in 2013-14 (see Figure 4). This does not mean service provision will not be bespoke and individual to the user and their needs. Legislation continues to offer users and carers the opportunity to receive such a service, irrespective of what budgets fund it. Care providers are adapting their business models to accommodate such an approach. **The implications on the on-going financial sustainability for some providers in this adapted environment may be open to question as 'surpluses' on individual contracts become increasingly difficult to divert to 'loss' making services.**

3.4 The introduction of the National Living Wage (NLW), although welcome for employees, represents a particular risk for the budgets and operations of social care organisations over at least the next three years. The commitment to the living wage is somewhat undermined by the fact there is no requirement on local authorities as part of the agreement to increase wages to the new NLW rate when it is announced in November. **However, if organisations are to commit to this higher rate, this will require budgetary planning and considerations**.

3.5 The NHS has national wage bargaining which is not the case in the social care sector. Paid for social care (as distinct from 'free' care from friends and relatives) is rationed via strict eligibility criteria. NHS care is however, also rationed but via waiting times. The funding models for both type of care and support vary markedly. Whilst it is still unclear quite how the new health and social care arrangements will affect the funding for social care providers**, is it prudent to assume all care providers in this new world will secure the funding needed to fully compensate them for their increasing living wage obligations?**

Issues for discussion

3.6 Whilst the results of this simple analysis of the finances of Scotland's largest care providers represents a snap shot over the last 3 years, it nonetheless provides evidence of the financial strains being experienced; more than 60% of all charities in the sector have experience a deficit in at least one of the last 3 years. **With local authority and Scottish Government budgets**

remaining under severe pressure, should care providers be planning activities on the basis of being certain of securing adequate income increases or how do Trustees robustly challenge any such assumption?

3.7 The impact of these financial pressures appears to be focussed more on the smaller charities. Around 70% have had an operating deficit in at least one of the last 3 years as compared to only 30% of the largest and just over 50% of those or with a turnover of £10 million or more. The flexibilities available to ensure financial sustainability are inevitably fewer for smaller charities specifically, there are fewer costs to cut. **If the only alternative open to Trustees is then to close down or drastically scale back the quality and/or the size of their operations, what does this mean for issues such as user choice and service innovation?**

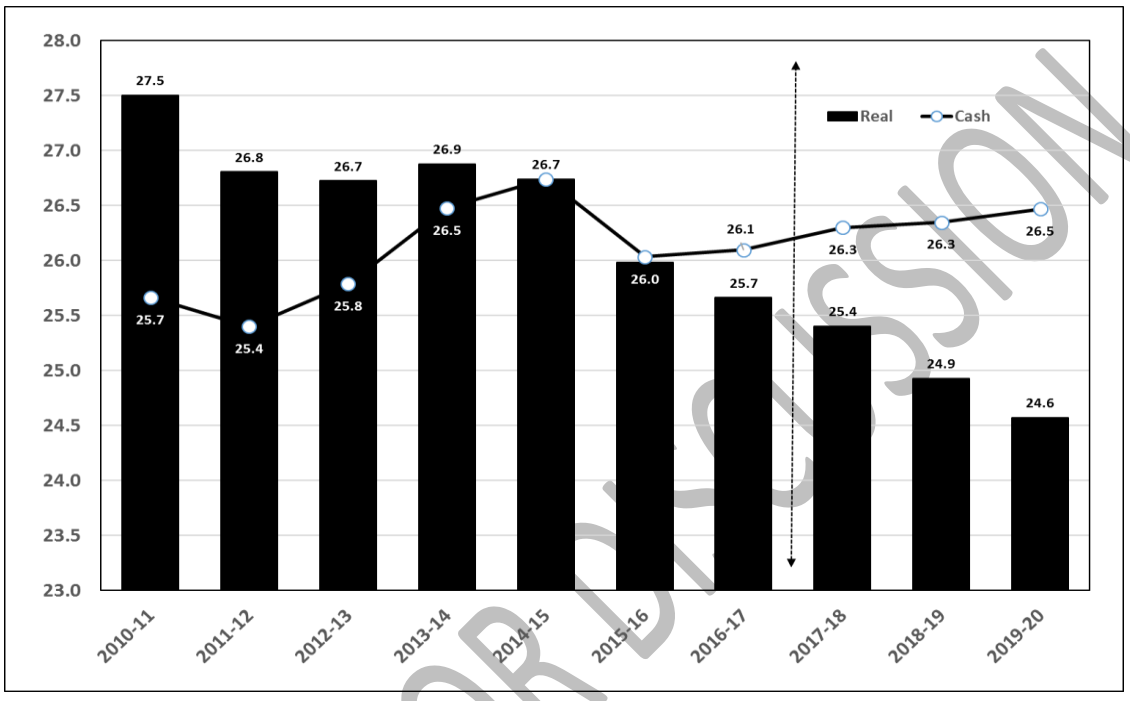
3.8 Just under three-quarters of the smallest charities have had to dip into their cash reserves to cover their losses in at least one of the last 3 years. The wage costs pressures facing all are well known, with a 25% increase in the current national living hourly wage rate in the pipeline for 2020. **With pressure on incomes and depleted cash reserves, Trustees have to ask can the necessary efficiencies savings be delivered across all other costs areas to ensure they remain solvent for the longer term and, if not, what is there plan B?**

APPENDIX A

BACKGROUND EVIDENCE: PUBLIC FUNDING, DEMOGRAPHICS AND FINANCE PRESSURES

Scottish Government budget

Figure 1: Scottish government resource DEL budget, 2010-11 to 2019-20, £ billion



Note: figures to right of dotted line are Scottish government projections
Source: Scottish Government, Draft Budget 2016-1

- The Scottish Government's TOTAL Revenue budget (RDEL)[3] is projected to fall £1.1 billion in real terms between now (2016-17) and 2019-20, a real terms fall of over 35% (see Figure 1);
- What is now accepted as the high water mark for revenue spending in the Scottish government was 2010-11. The total real terms expenditure in that year was £27.5 billion. In the subsequent 4 years, the budget never exceeded £27 billion;
- From 2015-16 onwards, the real terms value has, or is projected to fall year-on-year. Whilst in cash terms the Resource DEL is projected to be around £26-26.5 billion, in inflation-adjusted terms, it is projected to fall to £24.6 billion by 2019-20;
- If this 2019-20 figure is the outturn spend it will mean the Resource DEL budget has fallen by almost £3 billion in real terms since 2010-11, a real terms fall of over 10.5%.

[3] Departmental Expenditure Limits (DEL) comprise revenue (resource) grants as well as capital grants and loans. Non-domestic rates income is classified as AME (Annually Managed Expenditure).

Scottish population

Table 1: Projected population of older people in Scotland, 2014-2030

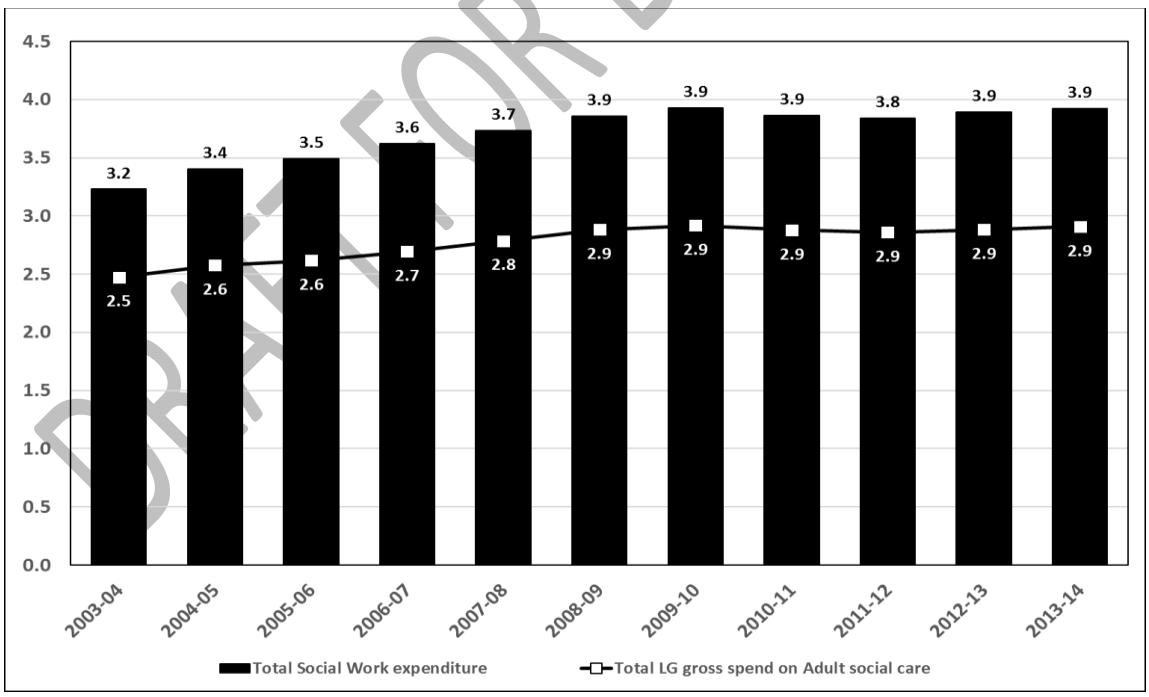
	2014	2030	% change
ALL Scotland (000)	5,348	5,624	5%
Population 75+	433,235	640,129	48%
% of ALL	*8.1%*	*11.4%*	*41%*
Population 85+	114,375	187,219	64%
% of ALL	*2.1%*	*3.3%*	*57%*

Source: Audit Scotland, 2016; National Record of Scotland, 2016

- Scotland's population is set to grow by around 5% between 2014 and 2030 whilst also aging;
  - The population aged 75+ is projected to reach over 640k, an increase of almost 50% in the 16-year period and by 2030 will account for more than 11% of the Scottish population;
  - The cohort aged 85+ will all increase in importance rising by almost 65% to 187k and account for over 3% of the Scottish population by 2030;
  - Multimorbidity is also a growing concern for providers, with health services often organised to provide care for single diseases or conditions. Recent analysis has shown that there are more people in Scotland with multimorbidity aged below 65, than there are aged 65 and over.

Local authority spending on care services

Figure 2: Gross spending on Adult Social Care, 2003-04 to 2013-14, £ billion, 2013-14 prices



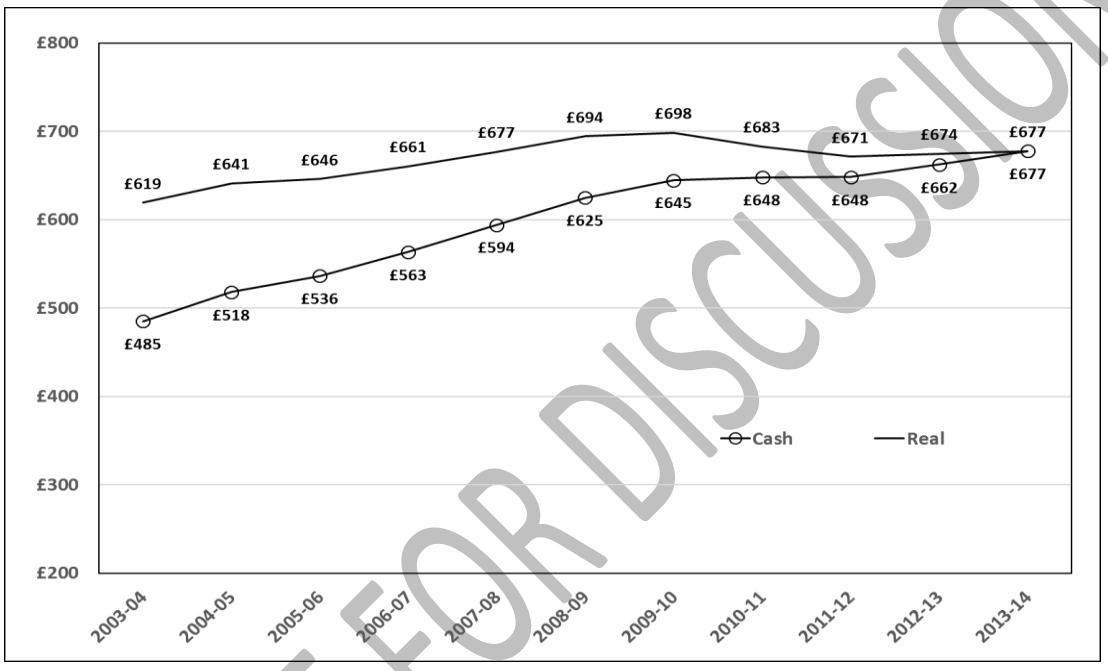
Source: Scottish Government, 2015

- More than three-quarters of all social work spending is used to fund adult social care;
- Gross spending on social work services has plateaued in real terms at around £3.9 billion since 2008-09 (its peak year was 2009-10);

- Gross expenditure on adult social care rose 18% in real terms between 20013-04 and 2009-10; up from £2.47 billion to £2.92 billion. Since then it has remained at around £2.9 billion annually;
- So, as a consequence (at least in part) of the public sector finance cuts, the rate of growth in local authority spending on both social work activities and on spending on adult social care experienced in the first half of this decade, has not been maintained;
- Since many social care providers are reliant on their incomes from local authority contracting, it is this financial uncertainty that all providers need to plan for in the event local authorities seek to continue to need to share the pain of their own financial challenges.

Adult Social Care per capita

Figure 3: Gross spending on Adult Social Care, 2003-04 to 2013-14, Per Capita

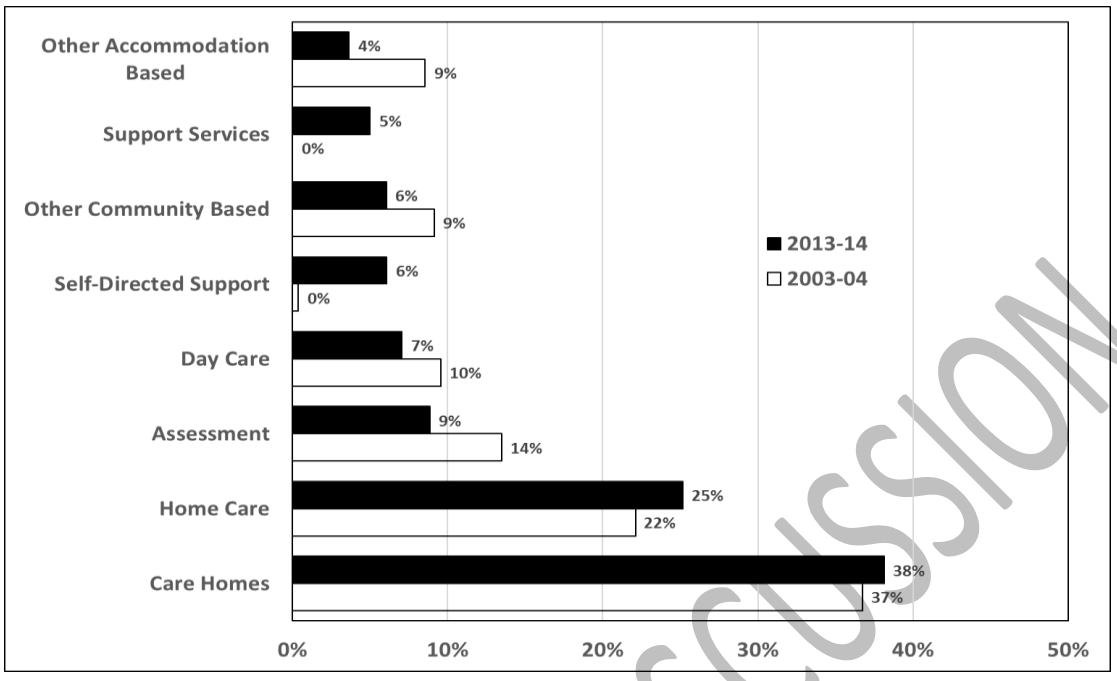


Source: Scottish Government, 2015

- Gross Spending per capita also rose annually between 2003-04 and 2009-10; from just under £620 to just under £700 per person (see Figure 3). This represents a 13% real terms increase over the 6-year period;
- It is clearly the case then, that as demand for services rises within a fixed or even falling budget total, the send per capita is going to fall.

Adult Social Care by service type

Figure 4: Percentage of gross spending on Adult Social Care, by service type

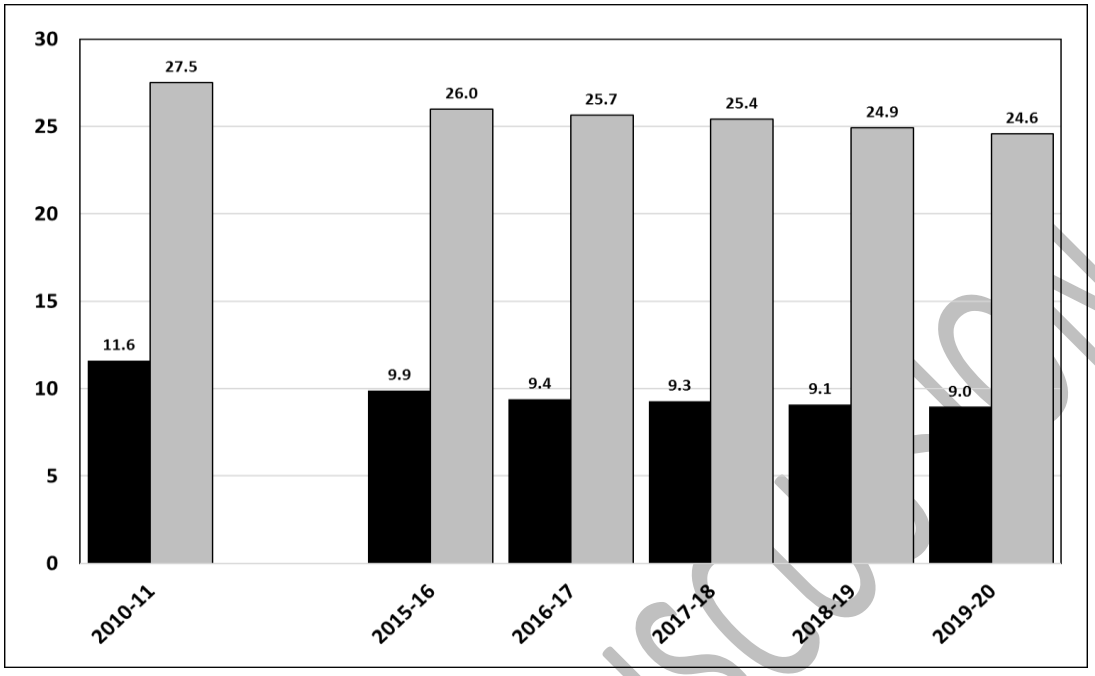


Source: Scottish Government, 2015

- In the decade 2003-04 and 2013-14, local authority gross spending on adult care for those in a Care Home rose marginally as a share of the total, up from 37% to 38%;
- Home Care support has risen, up from 22% to 25% as a share of total gross spending;
- Notwithstanding the increased focus on Self-directed Support (SDS) over this period, gross spending on SDS remains low at 6% of local authority gross spending on adult social care;
- Assessments spending has experienced a substantial fall in the share spending from 14% in 2003-04 to 9% in 2013-14.

Illustrative set of Local Government Funding Projections

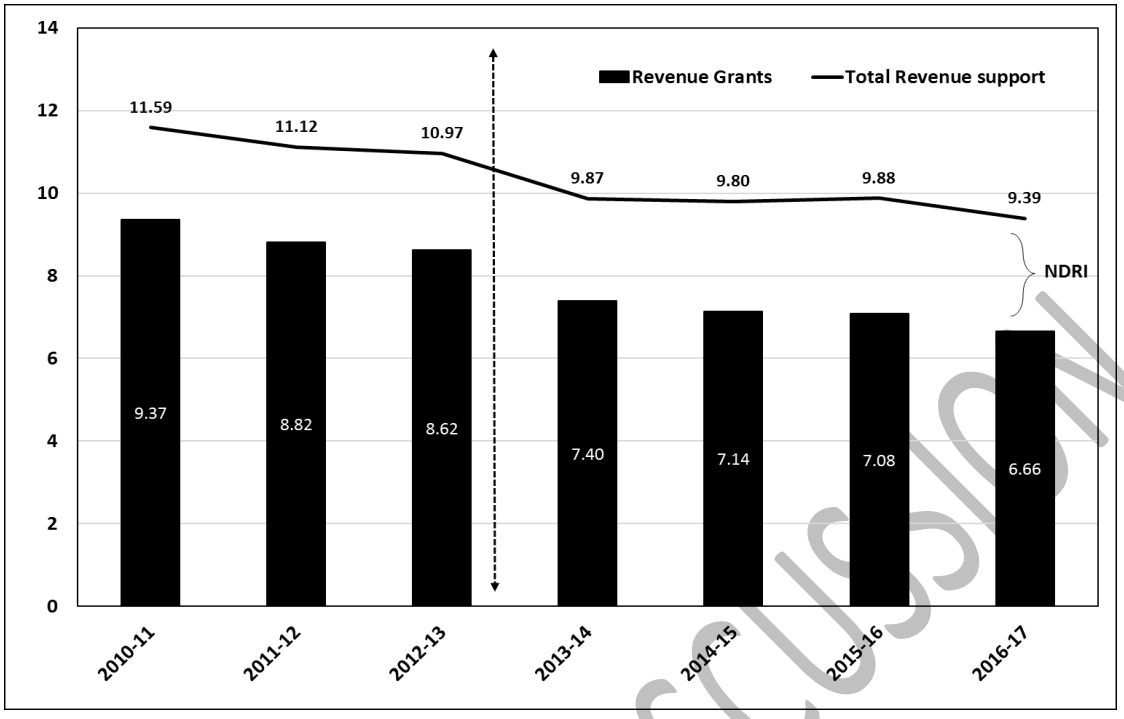
Figure 5: Scottish Government's Revenue support funding & projected allocation to Local Government (ILLUSTRATIVE ONLY), £ billion, 2014-15 prices



Source: Scottish Government, various budgets; Scottish Parliament (2016); own projections

- The Scottish Government's Draft Budget 2016-17 provides totals for the Revenue DEL in inflation-adjusted terms, which is set to fall to £24.6 billion (2014-15 prices), a decline of £2.9 billion over 2010-11 or a real terms fall of almost 11%;
- If revenues from Non-domestic rates income (NDRI) remain at 2016-17 levels in cash terms (see below), AND local government retains its 2016-17 share of the total, then the local government revenue grant support might also be expected to fall, from £11.6 billion in 2010-11 (2014-15 prices) to £9 billion in 2019-20, a real terms fall of £2.6 billion or almost 23%;
- Non-domestic rates income (NDRI) has become an increasingly important source of funding for the Scottish Government to fund local authority grant support; in 2010-11 NDRI accounted for less than 20% of local government support but by 2016-17 this is set to reach almost 30%;
- The Scottish Government has historically signalled local authorities would not be exposed to any shortfall in projected NDRI, ie, the Scottish government guaranteed the total grant support proposed. The draft budget 2016-17 indicates NDRI is projected to fall in both cash and real terms between 2015-16 and 2016-17 (see Figure 6). This illustrates the new challenges facing the Scottish Government; it has to raise more of its own funding from taxes and growth measures that are set in Holyrood which may or may not raise the projected funding required.

Figure 6: Scottish Government's Revenue support funding for Local Government, 2010-11 to 2015-16, £ billion (2014-15 prices)



Notes: NDRI is the non-domestic rates income that the Scottish Government use to part fund Scotland's local authorities.

The dotted line represents a break in the time series following reclassification of Police and Fire grant support.

Source: Scottish Government, various budgets; Scottish Parliament (2016)

APPENDIX B

INCOME AND EXPENDITURE DATA OF SCOTLAND'S CARE ORGANISATIONS[4]

Turnover

Table 2: Turnover of Scotland's Largest Social Care providers, 2015

Turnover	Total No of charities	%	Total turnover £M	%	Number with increase over 2014	% increase
Greater than £50 million	10	4.5%	1,197	59%	7	2.7%
Between £10 million and £50 million	34	15.2%	728	36%	23	0%
Between £1 million and £10 million	108	48.2%	301	13%	72	3.7
Between £100k and £1 million	72	32.1%	48	2%	33	-1.8%
ALL	**224**	**100%**	**2,274**	**100%**	**135**	**1.9%**

Source: OSCR charity database

- Of the 224 in this cohort, around one fifth (44) have a turnover in excess of £10 million, of which, just under 5% (ie, 10) have a turnover of more than £50 million. The sector is therefore dominated by a relatively small number of large, or very large organisations;
- Of the 10 largest, all but one is classified by OSCR as being cross border, ie, is part of a larger UK-headquartered organisation. The implications of any policy proposals on these very large organisations would therefore need to be reviewed separately;
- Total turnover generated in 2015 was £2,274 million with the larger charities (ie, those over £50 million) accounting for almost 60% of this total; ie, £1,197 million;
- Three quarters of the organisations (ie, 190) contributed total turnover between them of £380 million (15% of gross turnover in 2015), and one third (72) less than 3% of the total.
- The average increase in turnover was 1.9% between 2014 and 2015, but there were variations:
  - those in the £1-10 million category fared better achieving an average increase of 3.7%;
  - the largest also achieved an above average increase at 2.7% increase,
  - those in the £10-50 million category received the same cash income in 2015 over 2014; and,
  - the smallest charities faced the toughest outcome, with an average fall in income between 2014 and 2015 of -1.8%;
- The smallest charities experienced a wide range in income change; ranging from as low -35% to a high of 122%. Whilst this one-year picture does not obviously reflect a trend, the variability is significant. Against a backdrop of continuing global pressure on incomes and rising costs (see below), planning for the longer-term is essential but is becoming increasingly difficult.

Surplus / deficit position

[4] The organisations used in this analysis are Scotland's health and social care organisations as classified by OSCR in its online database. It is therefore important to note that some of these organisations will undertake more than social care activities but it is not possible to identify what share of their turnover and costs is purely social-care related.

Table 3: Turnover and Expenditure of Scotland's Largest Social Care providers, 2013-15

	Greater than £50 million	Between £10 & £50 million	Between £1 & £10 million	Between £100k & £1 million	ALL
No with a Deficit in 2015	2	9	42	27	80
% of total	*20%*	*26%*	*39%*	*38%*	*36%*
No with Deficit in 1 of last 3 years	3	17	65	50	135
% of total	*30%*	*50%*	*60%*	*69%*	*60%*
% with Lower Income in 2015	30%	32%	33%	54%	40%
% with Higher expenditure in 2015	50%	71%	77%	54%	67%
% with Lower Income AND Higher Expenditure in 2015	0%	12%	17%	19%	16%

Source: OSCR charity database

- Critical to the long-term financial sustainability of the sector and each individual organisation an ability to generate a level of operating surplus to ensure adequate levels of unrestricted cash reserves[5] but the cash pressures on many in the sector are becoming apparent;
- Of the 224 charities analysed, more than one third (ie, 36% or 80 organisations in total) generated insufficient operating income to cover expenditures in 2015. This rises to 60% (or 135 organisations) who have been unable to cover their annual expenditures with operating income in at least one of the last 3 years;
- This deficit challenge appears to be more marked among the smaller charities; in 2015, almost 40% of the smaller charities (ie, with turnover between £100k and £10 million) had an operating deficit in 2015 (ie, 27 organisations) and the number rises to between 60% and 70% (ie, 50 organisations if this is extended to a deficit in at least one of the last 3 years;

- Perhaps not too surprising a finding, two-thirds of ALL charities experienced an increase in their operating expenditures between 2014 and 2015. Also, even though the largest charities fared marginally better, there was still a 50% increase in operating costs of charities with a turnover greater than £50 million;
- Lower incomes contributed to the 2015 deficit in 40% of the cohort, by far the greatest cut in income was experienced by the smallest charities; almost 55% of this group experienced a cut in their incomes compared to only 30% of those charities in the largest group.
- Almost one fifth of the smallest cohort had to accommodate lower incomes with higher expenditures in 2015 over 2014. This is in sharp contrast to none in the largest group and 16% of all 224 charities.

[5] The need for a surplus annually is less critical if there are cash reserve that readily available to accommodate short-term losses. The level of reserves Is for each individual Board of Trustees to agree.

Appendix 3: Independent review summary of the successful and collaborative transitions of three complex hospital discharges into sustained community-based living

Summary of Independent Review: Successful transitions from acute hospital discharge to community living

Summary

ENABLE Scotland believes that everyone has the right to live in the home of their choice, in the community of their choice, supported by the people they choose, to do the things they love. We have campaigned for the rights of every person who has a learning disability to experience this since 1954, and believe that high quality, self-directed social care is a critical element of the delivery of this vision for all citizens in a modern Scotland, and is a key part of a Scottish Wellbeing economy post Covid-19. Prior to the 2018 Coming Home report, the charity had set out its strategic objectives which included a key focus on supporting more people to live within their communities and out of acute hospital settings.

In order to deliver this strategy, ENABLE Scotland proactively invested in its leadership, frontline reward and clinical expertise. The impact of this investment is demonstrated through the positive and sustained changes in the lives of many individuals across Scotland. This work has been evaluated independently by Radical Visions between August and October 2020, looking specifically at the journey of five individuals who have been supported through a transition from an acute hospital setting into their home within their local community. The findings of this review demonstrates a blueprint for success.

Background

ENABLE Scotland measures success on the basis of individual outcomes for the 1,000 people it supports, and provides 2.2 million hours of social care support, 80% of which are independently graded 5 or 6 by the Care Inspectorate. ENABLE Scotland is Scotland's largest Living Wage accredited care provider. For the purposes of this review, Radical Visions have taken a deep dive into three service areas where ENABLE Scotland has been working creatively with the Health & Social Care Partnerships to support five individuals out of hospital and residential placements into a community-based setting. The charity has demonstrated that it is possible for a commissioned third sector provider to achieve transformational change for these individuals in the immediate term, without unnecessary delays – but the evaluation acknowledges that this has required strong leadership and the significant investment of time and resource. The success and pace which ENABLE Scotland has demonstrated had been enabled and sustained by a simultaneous strategic organisation redesign to employ specialist health practitioners, and deliver enhanced employee reward strategies for the frontline keyworkers to attract and retain the highest quality staff. Crucially, it has been built on the solid foundation of ENABLE Scotland's "PA Model" – a human rights based, self-directed bespoke social care delivery model built around the rights, will and preference of individuals, delivered at scale.

"***ENABLE Scotland has made major organisational commitments to the people involved in this study… The heart and mind of the organisation appears committed to the people it seeks to serve, and this is further reflected through the clearly evidenced major investments of its own resources of time, money and energy…This is not just about…resources ….it is also clear that a conscious investment is being made within the organisation to equip it for ongoing improvement and its ability to do this difficult job as well as it possibly can***." (Radical Visions Evaluation Report, October 2020)

Overview of Services Evaluated

Service	Background	Status & Critical Success Factors
A	Person A lives in a single tenancy in the north east where they have lived for six years. They have a history of institutionalisation since childhood and had another short-term, temporary admission to hospital, within the last few years. Significant periods of challenge have resulted in multiple acute setting admissions and failed community supports. They require support with learning disability, mental health conditions and with stressed and distressed behaviours.	**Successful**: Person A's home is adequately adapted to her environmental and stimulus needs. ENABLE Scotland and multi-disciplinary team arranged for a temporary admission and a capital investment in order to make the essential environmental changes required to enable her to successfully live safe and well within her home. A is living happily in her updated home that is conducive to their needs, with a fully resourced, dedicated & stable team.
B	Person B lives in a single tenancy in the central belt, with a very intensive level of support. They have a history of institutional care including childhood residential education outwith Scotland and a recent six-year hospital admission when their support in the community failed. They require support with their learning disability and stressed and distressed behaviours.	**Successful**: Person B has been living in their own specially adapted home for a year. B is happy and is regularly engaging with family, who observe this to be the happiest B has been since childhood. Good engagement with staff team, and significantly reduced incident rate.
C, D & E	Persons C, D and E live in shared accommodation in the central belt, having very recently been discharged from two separate hospitals having spent between three to eight years in hospital due to community support breakdowns. They live in a house in multiple occupation and have shared histories of mental health problems in addition to their learning disabilities and stressed and distressed behaviours.	**Successful**: Persons C, D and E are settling in well to their new, adapted home. It is early in the transition following a summer 2020 move, which involved a full multi-disciplinary approach with input from all families in the process to reacquaint Persons C, D and E to introduce them to their new home.

Summary of findings - the ENABLE Scotland Model ("PA Model")

ENABLE Scotland has developed a highly specialist, human-rights driven social care delivery model for transitioning, and crucially, sustaining, individuals from institutional living into the community of their choice. The impact of this has been recognised within the fuller in-depth, independent report.

"***ENABLE Scotland instituted "Project PA" demonstrating a commitment to redesign its support services to ensure compliance with the spirit and the letter of new legislation, and by this means promote the human rights of those supported. This approach has further equipped it to respond sensitively and effectively to people requiring support, not least to those whose support requirements are "complex" and who require the greatest levels of understanding and competence, and to demonstrate its commitment to the principle of universality***." (Radical Visions evaluation, October 2020)

Key to the successful transitions has been a strong commitment from all stakeholders to work collaboratively, transparently, and flexibly, with an unwavering commitment to getting it right for the individuals. The Radical Visions evaluation therefore finds a critical success pathway as demonstrated through the ENABLE Scotland experience, which can be shared as a blueprint for others. The critical success factors identified within the independent review are as follows:

1. **Whole organisation commitment to the rights of the person, from frontline practitioners to CEO**
   The evaluation finds that "*service commissioners and support providers had a fundamental belief in and shared vision for the person requiring support*." ENABLE Scotland and its partners provided consistent, enhanced, and effective leadership and negotiation at local, regional and national level, which enhanced and facilitated effective partnerships, transparency around challenges faced, and a rights focused approach to problem solving. Every stakeholder had that person centred approach at the forefront about every decision made, at every turn.

2. **True multi-disciplinary approach and flexible partnership based decision making**
   The report recognised that the commissioning of services had its basis in joined-up, transparent partnerships. In each service area, all partners were prepared to be responsive to the evolving nature of some transition requirements moving quickly and collaboratively through good governance procedures to pivot and take solutions focused, person-centered decisions.

   "I wanted to thank you and the rest of the team for the commitment and dedication you have shown to getting this right for X. <u>It is the most complex hospital discharge we have ever achieved.</u> There were a lot of challenges we had to face but we all learned a lot as we went along – and I don't think the outcome would have been so good for X if we hadn't had to face the challenges we did. Everyone is very happy that X seems so happy in (his new home)." *RMO*

3. **Consistent commitment to achieving for purpose home environments that meet the needs of each individual**
   The review found that '*good housing was procured and the design of the living environment was specified in relation to the person requiring support*'. In the absence of long term strategic housing planning, pragmatic housing models were developed which achieve the best approach for the individuals through partnership working with RSLs and property developers, which as a core operating principle maintains contractual distance from the service provider in order to maintain the right to choice and control for the individual.

4. **The demonstration of critical upfront investment in transition related costs**
   The report recognises the significance of the decision of the commissioning authorities to commit to the necessary transitionary costs that are critical to the long-term success in sustaining community based living, stating: "*The approach to the design of Person B's service has been to front-load the provision of staff support in order to effect a safe and secure transition from hospital to his own home, with a view to the subsequent reduction of support safely over time."*

5. **ENABLE Scotland's dedication, innovation and relentless commitment towards enhancing the lives and opportunities of the people they work for and the people who work for them.**
   Beyond the holistic, multi-agency success factors, the review has also identified the following critical elements of the ENABLE Scotland's strategic interventions which were fundamental to the success of each transition, as well as the sustained support in place now:

   i. Intentional, long term and sustainable strategic investment in specialist Learning Disability nurse practitioners, and a specialist Practice Development Team to support and sustain across the ENABLE Scotland social care workforce; a dedicated, specialist planning and onboarding Mobilisation Team;

   ii. Investment in a new workforce development unit which includes ENABLE Recruits, a dedicated internal recruitment agency, delivering targeted recruitment campaigns, bespoke to the individual and the community, to attract and retain the right staff, as well as a modern, digital, Learning & Development function which develops and delivers bespoke training solutions, built around the individual and their team.

   iii. The implementation of an enhanced hourly rate of pay, beyond the Scottish Living Wage, for the dedicated Personal Assistants providing frontline support, which demonstrated significant improvements in attracting the highest quality candidates through the recruitment process. The review particularly noted "*direct support staff are valued, well trained, consistently competent, well-remunerated and well-supported".* ENABLE Scotland and UNISON have jointly commissioned independent research from the University of Strathclyde on the impact of reward strategy beyond the Scottish Living Wage on frontline keyworkers in social care.

   iv. The "PA Model" of delivery has been recognised as the foundation to the critical success of delivering responsive and highly personalised support throughout the transitions and ongoing service delivery. This model has provided the gateway to responsive and highly personalised transitions. The evaluation found that "*individual service design was fully aligned with a detailed understanding of the person requiring support*". 100% of people supported now have an individualised outcome-based support plan in place based on the models of Self-Directed Support, achieved through the application of ENABLE Scotland's innovative "PA Model". **The "PA Model" is based entirely on principles of Option 2 under the Social Care (Self Directed Support) (Scotland) Act 2013 regardless of commissioning arrangements.**

Appendix 1: Additional Information:

ENABLE Scotland's social care model: ENABLE Scotland is one of the country's largest providers of community based social care services, and as a national and influential charity, is a strong advocate for the delivery of person centred care and support which facilitates independent living for all, and for an effective reward and skills strategy for the frontline workforce. 80% of ENABLE Scotland services are currently graded 5s and 6s by the Care Inspectorate. **The "PA Model" is based entirely on principles of Option 2 under the Social Care (Self Directed Support) (Scotland) Act 2013 regardless of commissioning arrangements.**

Since 2016, ENABLE Scotland has embedded its "PA Model" of delivery as standard across all social care service, which involved "partnership with UNISON to develop new contracts of employment…: clearly designating the organisation as the employer; but stating unambiguously that the employee has been recruited to work directly for a specified individual. This step is integral to the achievement of … dedicated teams for individual people - enabling the person to have more choice, control and consistency of support whilst the organisation continues to assume responsibility for staff employment. This way of working in partnership with trade unions to develop creative contractual arrangements, embracing the values and principles of self-directed support, demands determined strategic leadership. It demonstrates the ability of a large organisation to act nimbly towards the goals of personalisation and is an example of good practice to be shared nationally." (Radical Visions Evaluation Report, June 2020)

Over the past four years, the organisation has also advocated for structural reform of adult social care to maximise the investment in frontline staff in order to attract and retain the best quality staff to deliver the highest quality care as part of consistent teams, recruited by and with the individual. The charity has invested in frontline workforce and specialist infrastructure to provide the best person centred care and support to all citizens, with a particular focus on those individuals who are in delayed discharge or at risk of admission as a result of provider failure or breakdown.

Sector Analysis: Post 1990s, Scotland delivered an effective, and rapid, hospital closure programme which resulted in 100s of individuals being moved out of long stay institutions and into a home of their own. Many of these individuals still live in Scotland's communities, and many are supported by ENABLE Scotland. Sadly, many of those individuals also featured in the Coming Home report as a result of provider and/or market failure.

The stability of community social care support in recent years for this group of vulnerable citizens has suffered as the delivery of social care provision in Scotland has faced enormous challenges. Whilst it is considered an essential public service and increasingly a partner of the NHS to keep people well in the community of their choice, it has to date also suffered from a fragmented commissioning and provider landscape, which has ultimately resulted in the most fragile workforce with fragmented terms and conditions, supporting the most vulnerable citizens.

- Over 200,000 people are employed in social care
- 31% of the social care workforce are employed in the voluntary sector; 43% private, and 25% public
- The social care sector contributes £3.1 billion to the Scottish economy
- There are over 1,000 different providers of social care in Scotland, with a mixture of third sector and private sector commissioned providers
- 42% of Scottish charities reported using reserves due to a deficit position in 2018
- 354 providers of social care for people who have learning disabilities

All social care providers (until 1st April 2020) negotiate commissioned rates within a competitive tendering landscape. The fragmentation of the current social care system can lead to different approaches to investment in quality of care.

Increasingly across the social care landscape, the sector is experiencing market failure at an alarming rate, with some providers unable to continue to deliver good quality care and support within this market context. Where this happens, vulnerable citizens are at the sharpest end, experiencing disruption and change in their lives which they have not chosen. This is the context for many of the individuals identified in the Coming Home report. Whilst not stated, we know the majority of residential, in-patient units for people who have learning disabilities and autism, are delivered by the private sector.

A recent investigation into the position of private equity backed care providers across the UK reported that £1.5 billion (half of Scotland's total social care budget) is considered as 'leakage' out of the system as profit[1]. Whilst there is no estimated equivalent figure for Scotland, we can extrapolate that at least 10% of that amount – approximately £150 million – is lost to the Scottish social care economy in this way. ENABLE Scotland's experience in supporting people to be welcomed in to a home of their own demonstrates the impact of third sector social care investment back in to improving frontline service delivery and outcomes for citizens, as opposed to leaving the system for profit.

[1] https://news.stv.tv/scotland/concerns-over-offshore-ownership-of-scotlands-care-homes?top

Appendix 2: About ENABLE Scotland

ENABLE Scotland is a leading campaigning charity in Scotland, one of the country's key commissioned social care providers and one of Scotland's five largest third sector employers. Over the last five years, it has grown to employ 2,200 staff delivering social care, employability and charitable services, on an income of £50m, as follows:

ENABLE All delivers personalised care and support services to over 1,000 people, many of whom have a learning disability alongside underlying health conditions and complex needs. The charity upholds the human rights of all people to live in the community of their choice, and is developing specialism in supporting individuals who have complex health and social care support needs out of hospitals and long stay institutions and into a home of their own.

ENABLE Works delivers training for employers and employability support to 1,489 people who have disabilities, supporting approximately 400 people into paid employment every year.

ENABLE Scotland Charity supports 897 adults and children who have a learning disability through a combination of local groups, membership support, and charitable projects, including campaigning and activism.

ENABLE Scotland - Self-Directed Social Care - A National Model

Self-Directed Social Care - a National Model

16 December 2020

Executive Summary

ENABLE Scotland's initial submission to the Independent Review of Adult Social Care ("the Review") outlined key principles and priority areas for the Review to consider, offering demonstrable solutions that could be rolled out nationally to deliver a self-directed, sustainable social care sector. This addendum identifies the specific interventions required to raise the current bar of quality and aspiration for those who have a need to access social care services, offering proactive and pragmatic solutions that can be adopted nationally to ensure de minimis standards of excellence in consistency through the delivery of human rights drive self-directed support at scale.

This addendum is focussed on proposals which can be delivered within current legislative and delivery frameworks, with no need to adopt a different statutory mechanism to deliver social care. The paper demonstrates an approach to delivering, with pace, higher quality self-directed social care, accessible to all citizens who require it on a national basis, regardless of their disability or additional support need. We are, however, clear there are other organisations who work to similar standards achieving great outcomes for people, notably organisations such as Thera Scotland, C-Change and the work of the independent living centres which are rooted in similar foundations. Should the Review recommend the establishment of a National Care Service, we anticipate that this would require more intensive and radical change at both a delivery and legislative level. ENABLE Scotland, as an organisation, is open to the possibility of a move away from the current delivery landscape in which we operate, where any change will assure that people get better lives. The organisation would be supportive in shaping the development of this work, regardless of whether we are positioned to deliver the solution moving forward.

This submission focusses on our internal evidence base, demonstration programmes and independent reviews of our work, informing three initial interventions necessary to ***"provide consistently excellent social care support for people who use these services, as well as their carers and their families",*** offering tested, transferable and scalable solutions in addressing the fundamental changes summarised herein.

The policy objectives of the Social Care (Self-Directed Support) (Scotland) Act 2013 ("the 2013 Act") remain a solid foundation for a consistent, human rights-based approach to social care and support across Scotland, however, deep focussed interventions are necessary in achieving better nationwide implementation of this legislation, both legally and in the spirit of the Act. Of the £1.3bn spend on social care annual across Scotland, only £111m of this was spent on was delivering SDS via Option 1[1].; £88m via Option 2; and £339m via Option 3. In line with this data, it is ENABLE Scotland's experience as a service provider that the 'default' commissioning position all too often falls to Option 3, which offers the least formal control to an individual of all SDS Options. Our tested model, as outlined within this addendum, demonstrates the ability to deliver the flexibility of Option 1, without the added complexities this can put on an individual to become an employer, regardless of the SDS commissioning route. This model is shared as an example of what could be achieved universally across Scotland if a consistent approach to human-rights driven self-directed support was adopted sector wide.

With over 1,000 social care providers across Scotland[2], there is a significant level of duplication on those core infrastructure functions and associated costs common to all providers; many of which are created through repetition of siloed delivery, where organisations deliver support services solely to single care groups. Addressing the associated inefficiencies and enhanced costs would offer savings to the sector that could be redirected into frontline delivery, promoting a thriving and sustainable provider landscape focussed on quality of frontline delivery. This addendum outlines the need for a nationally-led incentivised solution to support effective collaboration across providers that will reduce the indirect cost of delivering social care, releasing more efficiencies of public spend back into achieving high-quality frontline support.

There has been little of this collaboration work undertaken in Scotland to date, however, more widely across the UK in particular, it is noted that both East Side Primetimers and SeaChange Capital Partners are undertaking interesting work in this space. London thinktank NPC is similarly active on this work, however the limitations of active and successful collaborations across the third sector as a whole are recognised and noted. Internationally, there has been a strong focus on creating the space for demonstrating by doing in the US, with research highlighting how not-for-profit organisations can come together produced through support from the San Francisco Foundation. A further study by the Stanford Social Innovation Review into what drives successful mergers and suggests that more non-profit organisations should consider mergers as a useful tool to increase impact.

It is essential that good practice in the delivery of self-directed, human rights driven support has a platform from which to flourish, whilst tolerance for non-demonstration of continuous improvement and excellence is challenged, with necessary consequences enforced to eradicate failures to recognise human rights. These actions, underpinned by the strength and consistency of a proactive regulator, with a low tolerance for sustained mediocracy in the delivery of social care outcomes for people accessing services, dedicate the focus on continuous improvement and enhanced delivery, as core principles to demonstrate compliance.

[1] Scottish Government, *Self-Directed Support, Scotland, 2016/17*, August 2018
[2] Fair Work Convention, *Fair Work in Scotland's Social Care Sector 2019*, February 2019

Beyond these three vital building blocks, we have identified four further interventions required to improve the overall effectiveness of social care delivered nationally. These can be built using a 'Once for Scotland' approach to creating a path to improve the lives of Scottish citizens who require social care, whilst providing a potential solution to some of the persistent sectoral barriers to the implementation of human rights-based self-directed support, at scale, nationally.

A number of these further interventions are informed by ENABLE Scotland's evidence base, gathered though its approach of 'demonstrating by doing'. The charity has identified a number of key sectorial challenges, leading to an organisational response which has delivered positive results, that if applied more broadly across the sector, could transform the existing landscape of delivery. Such interventions are in relation to the sector's current challenges with recruitment and retention, as well as the need to deliver the recommendations of the "Coming home: complex care needs and out of area placements 2018", known as the "Coming Home Report".

Beyond this, we formally ask the Review to address and make specific digital and technology-based recommendations to further improve the current issues that a lack of streamed digital connectivity highlights across the 1000+ social care organisations, 14 NHS Boards, 31 Health and Social Care Partnerships (HSCPs) and 32 local authorities. With a clear and continuing societal shift towards workforce based digital solutions, the sector must keep pace with this transformation and seek to advance its effectiveness through digital connectivity. Digital solutions could reduce the administrative burden and duplication costs associated with a multi-commissioner landscape, with the significant return in investment delivered back into the social care system, to be redistributed towards further frontline delivery priorities.

Finally, we ask the Review recommend implementing a policy change that would create a universally accessible, national approach to social care which is free at the point of need. Based on the principles of the NHS, any citizen who requires social care support should have access to an equal and equitable assessment process, that does not rely on personal contributions of individuals to fund de minimis standard levels of care.

The table overleaf outlines each intervention identified, with a proposed evidence to inform the solution, based on ENABLE Scotland's experience, evidence base and informed judgement as the most impactful social care provider of community based social care services in Scotland.

The Review should not that this submission is drawn from ENABLE Scotland's evidence base as Scotland's largest member-led charity run by, for and with people who have a learning disability and long-term health conditions. Our charity's governance structure ensures our members – most of whom do not access our social care services, but are self-advocates and activists within the disability community – inform not only our vision, but our delivery practice on a day to day basis.

Furthermore, whilst we recognise the PA Model is unique to ENABLE Scotland in its interpretation and implementation of the SDS legislation, it is built on the shoulders of some exceptional small, human rights-led organisations and campaigns that have influenced and helped shape the thinking around the SDS agenda, and have supported our efforts to make our members' vision a reality. Although our PA Model was designed and developed to enable the rights and chosen outcomes of people who have a learning disability, it has proven transferable across wider care groups with a range of needs, for whom it has been demonstrably successful in practice.

We would particularly like to thank a number of individuals whose contribution to this agenda has been critical to its development:

- ***Dr Simon Duffy*** founder of Inclusion Glasgow, which supported people out of institutional care (especially at Lennox Castle), and now Director of the Centre for Welfare Reform;
- ***Frances Brown*** former Director of Inclusion Glasgow, and now Founding Partner of Radical Visions;
- ***John Dalrymple*** a sector thought leader on human rights and SDS across a range of organisations, including Neighbourhood Networks, InControl Scotland, Values Into Action Scotland and Radical Visions;
- ***Beth Morrison*** a tireless campaigner for the rights of people who have a learning disability recognised by Amnesty International, and a devoted mum to her son Calum; and
- ***Morag Dendy*** Head of Performance, Planning and Quality at North Lanarkshire Council, who has been a real trailblazer in the early adoption and demonstration of SDS in practice.

We also express our gratitude to UNISON, who have constructively engaged with and supported the implementation of the PA Model across our services, and to countless other individual members who have a learning disability who have helped us continuously improve the PA Model over the last 5 years.

Essential interventions required to deliver self-directed social care at a national scale:

1. ***A nationally consistent social care delivery model predicated on human rights-driven, self-directed support.***
The existing legislative framework for self-directed support across Scotland – the Social Care (Self Directed Support) (Scotland) Act 2013 – has been in force since 2014. It is, however, widely recognised that the number of people genuinely exercising their options under the Act has been persistently low, with limited apparent progress towards making self-directed support the default for people accessing social care and support in Scotland. ENABLE Scotland's **PA Model** offers a solution to the challenge of embedding SDS and delivers on the benefits of SDS Options 1 and 2, regardless of the commissioning route. Whilst there are other examples of delivery models in the sector, the PA Model, in our judgement, is a uniquely accessible, scalable and transferable model of human rights-driven self-directed social care, delivered organisationally on a national scale, and which could be delivered comprehensively and universally across Scotland.

2. ***An efficient and effective, digitally enabled infrastructure that reduces costs and redirects spend to the frontline.***
The delivery of social care operates in a complex regulatory and now technology-driven landscape that requires a modern, fit-for-purpose core infrastructure to deliver efficiently and effectively for the frontline. Rather than design and invest in duplicating the same back office infrastructure more than 1,000 times for each social care provider, ENABLE Scotland offers its experience in working successfully within a **Consortia Model**, whilst highlighting further benefits of the enhanced **Lead Provider Integrated Model** in offering practical and accessible infrastructure solutions to access best in class Finance, People and ICT functions.

3. ***Strong and proactive regulator(s) focussed on improvement and excellence***
The social care sector requires a regulatory approach which is proactive and interventionist, ensuring timely and robust action and consequences in response to providers' failure to meet de minimis standards of excellence. Such an approach is essential to the fundamental human rights of people who access care, and to challenge persistent mediocrity in operational performance, where there is no evidence of improvement to the experience of the people to whom they deliver care. ENABLE Scotland offers its experience in providing a **safe harbour** to address failing provision, having supported HSCPs through successful large scale **service transfers** following protracted periods of failure to deliver excellence as de minimis standards of care and support.

Further improvements, delivered as 'Once for Scotland' to enhance impact and build a stronger sector:

4. ***A nationally applied reward structure, creating parity of esteem with the NHS; recognising social care as a skilled profession.***
Attracting and retaining a valued frontline workforce is a fundamental requirement of a sustainable social care sector. This requires an appropriate reward strategy which remunerates social care as a skilled profession, recognising its value to society through reward beyond the Scottish Living Wage (SLW) as standard. This will achieve and sustain a high quality, stable workforce, as demonstrated through ENABLE Scotland's '**Reward to Retain'** model, which has demonstrated the positive impact of enhanced pay on recruitment and retention levels in challenging geographical areas and complex services.

5. ***A national Programme Board to expedite existing discharges and prevent future failings linked to supporting people to live at home in communities (referred to as delayed complex hospital discharge).***
The *Coming Home* report identified more than 700 individuals from Scotland who were affected by delayed hospital discharge or out of area placements which they did not choose. Around half of those individuals had been in that situation for more than a decade. The development of tripartite agreements implementing equal partnership roles across NHS, HSCP and provider partners would create the necessary framework to address this urgent human rights priority. It is our judgement that a small group of providers with the necessary infrastructure, reach and human rights-driven, self-directed delivery model could be commissioned to work with a single national Programme Board to scope, plan and deliver on a national basis the recommendations of the Coming Home report. This group would be tasked to 'demonstrate by doing', and would be a practical and pragmatic step to support those individuals currently living in institutional settings to return to their community of choice as active citizens.

   ENABLE Scotland offers its experience of strong and successful partnership working with the NHS, HSCPs and local authorities in successfully commissioning, planning, transitioning and delivering **complex hospital discharges**. The findings of the independent review (commissioned by ENABLE Scotland) assessing the successful and collaborative transitions of three complex hospital discharges into sustained community-based living could inform a baseline blueprint for this national approach.

6. ***A sector-wide digital platform seamlessly connecting providers and commissioners.***
As society continues to become increasingly digitally connected, the sector must keep pace with this transformation and seek to advance its effectiveness through digital connectivity. ENABLE Scotland highlights the need to introduce a modern, centralised, **digital platform** which will enhance and streamline contract reporting across a multi-commissioning landscape, creating a more efficient, digitally enabled sector. Thereafter, the sector should be supported by an informed and accessible digital approach which either connects providers and commissioners across their existing systems, or through development and implementation of a single system solution.

7. ***A universally accessible national approach to social care which is free at the point of need.***
Currently, access to social care services is predicated on a lengthy and complex assessment of need process, for which funding routes are typically inconsistently applied across different geographical authorities, with some requiring personal contributions under a charging policy in order to fully meet individuals' needs. ENABLE Scotland recognises the need to introduce **equal and equitable access to social care for all** based on the principles of the NHS – free at the point of need, and not predicated on geographical circumstances or the prevailing local authority financial position.

1. A nationally consistent social care delivery model predicated on human rights driven, self-directed support.

A national approach to delivery of human rights driven, self-directed social care for every citizen requires a model which enables this by purposeful design as well as by values and culture. ENABLE Scotland's PA Model is a scalable, transferable and tested model of human rights driven, self-directed social care, delivered through a valued, skilled, well represented and well remunerated workforce, contracted directly to the person supported.

The model was intentionally built and designed by ENABLE Scotland in response to the 2013 Act as a mechanism to deliver both the ***spirit*** and the objectives of the legislation for all people supported by the charity. The systems, budgetary[3] and contractual architecture of the PA Model were designed to achieve the benefits of Option 1 without the additional burden on individuals becoming employers. ENABLE Scotland's social care is delivered, at scale, for all people supported with the flexibility of Option 1, and the practicalities of Option 2, regardless of the commissioning framework. The construct of the PA Model prevents the shaping of support being imposed on an individual without taking into account their personal choice, control and human rights.

The PA Model, as the core operating standard for one of Scotland's largest social care providers, supports 1,800 frontline Personal Assistants directly contracted to support 1,000 individuals in 27 local authority areas, demonstrating scalability and transferability. The ***innovative contract***, designed around the individual, was developed in partnership with UNISON to provide maximum flexibility, choice and control to each person receiving support, whilst offering the stability of ENABLE Scotland as an employer of choice to the staff member.

Over the last 5 years, the charity has ***increased its impact by 75%*** with more people choosing to move their support to ENABLE Scotland, as a direct result of the PA Model. This impact is demonstrated in Appendix A, which outlines how the PA Model has successfully transformed the life of a young person we support.

Detailed Service Design	• The architecture of an individual's chosen support • Describes what support the individual needs to live a full life and the outcomes they wish to achieve • Self-directed by the individual, identifying their chosen outcomes • Involves key stakeholders and relevant professionals • Is continuously updated to ensure we are meeting the changing circumstances and aspirations of the individual.
Self-Directed Support Strategics	• Describes how the individual should be supported to achieve their identified aspirations and outcomes. • Provides detailed strategies for each individual component of the support outlined within the Service Design • Acts as a guide to the bespoke team, demonstrating how best to support the individuals in a way that works for them and that they have chosen • Is continuously refined to reflect any evolving change in circumstance or preferences in relation to the individual being supported
Bespoke Team of Personal Assistants	• Planning process informs the creation of a person specification, including profile, skills and attributes, of Personal Assistant (PA) required to work within the individuals service team • A bespoke recruitment campaign is launched to identify suitable candidates that meet the person specification requirements identified by the individual • Each PA is directly contracted to the people they support, with ENABLE Scotland becoming the employer on the individual's behalf.
Individual Service Fund	• Every individual supported has their own Individual Service Fund (ISF), regardless of the legal commissioning framework under which the service is contracted • The ISF is used to manage the funding requirements of each individual service • Each individual chooses to utilise their ISF in a way that meets their chosen outcomes • Each ISF is bespoke to an individual, with full transparency of budget spend and funding availability

The Review should note that whilst the PA Model, as founded in the principles of the spirit of the legislation of the 2013 Act, is used to deliver all self-directed social care services at ENABLE Scotland, which encompasses multiple care group, such as learning disability, physical disability, acquired brain injury, mental health conditions and autism. The 75% growth of impact is reflective of more people choosing access this rights-drive support model, regardless of their care label. This evolution of care need delivery has resulted in the creation of our internally branded service delivery division: ENABLE All. The purpose of encompassing 'All' into this title is to intentionally reflect the organises ability and commitment to provide human rights drive self-directed support to every individual who wishes to access this support, regardless of any such care label or barrier.

Revolutionising the traditional HR recruitment approach in social care, the model is further supported by an internal recruitment agency, ENABLE Recruits. This team of skilled recruitment consultants develop a bespoke recruitment campaign with each individual we support, and lead the end-to-end recruitment and onboarding processes. The PA Model works to a principle of over-recruitment, filling 105% of commissioned hours in order to manage relief costs and eradicate impersonal and expensive agency staff. In the era of COVID-19, this model has also proven critical in controlling risk of infection and enabling consistent hours of support to continue.

Adopting a nationally consistent social care **delivery model** accessible to all, predicated on human rights driven, self-directed support, such as the PA Model, would create an opportunity to enhance access to truly self-directed support, in achievement the aims of this Review.

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[3] Each individual has an internal ISF. Of the 1,000 people supported, only 5 have support commissioned as 'Option 2'. These individuals have their own dedicated bank account for their IFS. All other individuals have the same ISF reporting mechanisms available as formally commissioned Option 2 services

2. An efficient and effective, digitally enabled infrastructure that reduces costs and redirects spend to the frontline.

Scotland has a thriving charity sector, which COVID-19 has demonstrated is never more needed in communities across the country. Beyond recognising the critical strategic partnership role of commissioned social care providers, a national approach must deliver a modern, vibrant and sustainable social care sector, focussed on individuals rooted in communities of their choice, regardless of labels or conditions.

There are 1,000+ social care providers in Scotland delivering services which are negotiated, implemented and regulated across 14 NHS Boards, 31 HSCPs and 32 local authorities. To support streamlining costs and inefficiencies, the Review should consider how to support and incentivise providers to work more collaboratively, to share costs and modernise processes that will seamlessly connect directly into the commissioning and regulatory landscape.

A consideration in progressing this agenda could be supporting development of the Consortia Model. ENABLE Scotland has demonstrated the effectiveness in delivering consortia contracts within its employability division, ENABLE Works. Over the last five years, ENABLE Works has delivered multiple contracts that have been commissioned directly to ENABLE Scotland as the consortium lead commissioning partner. Delivery of the contract is achieved through a collective partnership, recognising the wider contributions, experience and resource capacity available through joint working.

An example of this is with 'All in Dundee', a consortium bringing together seven independent organisations to collectively deliver specialist employability services to people who have disabilities and mental health conditions. The contract has been commissioned directly to ENABLE Scotland, with all delivery partners working as part of the consortium to reach more people than any one organisation could provide alone. This single commissioning route provides more flexibility and efficiency to the commissioning authority, by engaging directly with the consortium lead partner only. The consortium lead partner is responsible for ensuring all contract and compliance requirements and met and delivered. Operational delivery is achieved through the proportionate distribution and reconciliation of workload, linked to the skills and expertise of each partner, whilst providing streamlined reporting and consortium representation to the commissioning authority. This approach offers a further economic benefit with only one organisation requiring the necessary resources to provide the overall contract management and compliance role, as opposed to individually commissioned contracts requiring this role and functionality across all delivery partners.

As demonstrated, this route could support the sector with reducing operating costs and streamlining commissioned service delivery, however, additional efficiencies and benefits could be achieved by taking the consortia model further and developing the **Lead Provider Integrated Model**. In this model, the lead provider not only delivers the commissioning and compliance components of the consortia model, but also provides the core infrastructure platform for other charities to access.

This model offers a scalable and transferable, tested solution which ensures efficient, effective and consistent shared infrastructure in business-critical areas common to all provision, including HR, Finance and ICT. It promotes a thriving and sustainable provider landscape focussed on quality of frontline delivery and provides a foundation where all provision can be more economically delivered, allowing reinvestment into the frontline through spending less on the cost of supporting delivery.

The success of this model has been demonstrated as part of a group structure by UK based charity Thera Trust. In this model, as outlined in the diagram below, each charity retains its own brand identity and charitable purpose. Full choice and control for people choosing their preferred support provider is maintained under this model, whilst indirect costs of delivery are reduced.

At scale, a shared common infrastructure across the provider landscape could substantially reduce the volume of back office support roles and systems procurement; not only achieving systems efficiency and security, but also reducing duplication of spend. Notwithstanding the fiscal benefits, the experience of ENABLE Scotland has demonstrated that formal partnership approaches within the sector are difficult to achieve without the support of Scottish Government and encouragement of commissioners. Having sought to develop the lead provider model previously without government support, it is clear that whilst the model itself is valid and beneficial to the wider sector, Scottish Government must take a proactive role in creating the environment in which the model has the opportunity to succeed.

Establishing a nationwide network of lead providers through a nationally directed approach to deliver infrastructure services to multiple local providers allows for the implementation of integrated, connected digital infrastructure. Akin to NHS National Services Scotland, this would support and streamline not only infrastructure support but also frontline delivery.

3. Strong and proactive regulator(s) focussed on improvement and excellence – Care Inspectorate and Scottish Social Services Council

The role of regulators in social care should be principally focussed on protecting the human rights of individuals receiving support. An enhanced regulatory framework must identify failure to deliver human rights based self-directed support, together with sustained mediocre delivery in operational performance, as key indicators of provider failure. Regulators should proactively intervene to address such failure where there is a recognised failing in meeting fundamental human rights. They should apply commissioning interventions to eradicate provider failure, and assess the requirement to transfer services to providers with proven track records of meeting human rights and delivering high quality support, and who can provide safe harbour. Persistent and prolonged failure to meet de minimis standards must be addressed through a proactive, strong and interventionist regulatory response, with appropriate consequences imposed to prevent reoccurrence of failings.

The expanded regulatory framework must also monitor and oversee the reduction in use of agency staff in order to deliver effective, self-directed support with dignity. The use of agency staff must only be accepted in extremis, and on a reducing trajectory.

It is recognised that the achievement of an enhanced regulator is a medium-term objective. In the meantime, a human-rights based national approach to social care should improve access to self-directed support. This will give people accessing it choice and control over who provides their support and how they use it; enabling the system to better achieve human rights, equal citizenship and independent living for all. This must be accompanied by an investment in the availability of independent advocacy services for people to access in order to support them to access the social care that will enable them to live the life they choose.

There is clear evidence that working to eradicate failing service provision has a direct impact on the quality of support available to individuals. ENABLE Scotland has significant experience of supporting the move from falling provision to a human rights, self-directed based support delivered under the PA Model, and in doing so, providing safe harbour for those individuals supported, and for their commissioned support.

An example of this is in ENABLE Scotland being commissioned in East Lothian to take over delivery of failing services, following a sustained failure to deliver fundamental human rights to the individuals supported over a protracted period. The services had received Grade 2s from the regulator in the four most recent inspections. An enhanced regulatory framework in recognising human rights failings as requiring a regulatory intervention, and with a low tolerance for mediocracy, could prevent such extended periods of failing support from occurring. This service transfer raised the bar of social care support for the individuals supported in the area and provided a consistent, nationally applied approach to their support.

Since the services transferred to the charity, significant progress and improvements have been delivered in all aspects of service delivery and quality, as well as staff recruitment and retention. ENABLE Scotland, as a national third sector provider at scale, has invested considerable financial and operational resources to achieve the following improvements:-

1. Recruitment levels increased from below 80% to 100% in 8 weeks;
2. Turnover dropped from 37% to 8% in 6 months; and
3. Quality grades from the regulator increased from Grades 2 to Grades 4 in just 18 months.

In addition to this, ENABLE Scotland:-

1. Moved on 30% of the inherited workforce due to lack of compliance with ENABLE Scotland standard recruitment and vetting procedures;
2. Put in place an individualised outcome-based support plan in place based on the models of Self-Directed Support, achieved through the application of ENABLE Scotland's innovative PA Model for 100% of people supported;
3. CEO of ENABLE Scotland proactively met with CEO of Care Inspectorate to ensure a transparent and open partnership approach on the complex turnaround of key regulatory inspection criteria;
4. Provided consistent, enhanced and effective leadership at local, regional, and national level;
5. Developed and invested in an innovative recruitment agency: ENABLE Recruits. This acts as an independent recruitment resources for people who chose to be supported by ENABLE Scotland. It supports the person to act as the customer in building and recruiting the team of PA's around them. In the same way the customer would have the power and control ina commercial transaction, the customer has the power amnd contratol for recruiting interviewing and selecting the people they wish to be involved in providing their self directed support.

4. A nationally applied reward structure recognising social care as a professional career path

A national approach to social care must recognise and nurture the unique relationships, values and commitment of a frontline social care worker and the person they support, who they let into their lives and homes on a day-to-day basis. This is a deeply personal, relational element of social care and all reward levers should be available to providers in order to maintain consistency of support. Attracting, recruiting and retaining the right person to work alongside another person to achieve their human rights is the only outcome that matters, and retaining flexibility in the system to reward appropriately is a key element of a thriving and successful third sector provider landscape.

A national approach to reward must deliver appropriate and universal terms and conditions at a de minimis rate, whilst not locking providers into a specific pay point, and recognising social care as a skilled profession. This approach, rather than a pay scale model for the provision of social care, more accurately reflects the value and impact of care in an integrated health and social care workforce. Predicated on an efficient and effective remuneration strategy, this national approach would see pay annually negotiated in a single negotiation process, from a baseline position above SLW, and thereafter cascaded across the sector in a single transaction.

Whist reward is not the only answer, we believe that this approach is key to achieving reciprocity of dignity – the application of Maslow's Hierarchy of Need suggests if you take care of the financial security of individuals in social care you will allow their values and commitment for the person they support to flourish, which will significantly reduce the persistently high turnover levels and recruitment challenges faced by the sector. Furthermore, it is known that in Scotland alone, 17% of the population are living in in-work poverty, and 60% of working age adults in poverty – some 310,000 people – live in households where someone is in paid employment.[4] The Joseph Rowntree Foundation report that 12.9% of the UK workforce experienced in-work poverty in 2018[5], and based on known pay levels in the sector, it is assumed that the proportion of the social care workforce experiencing in-work poverty will be even higher. Appropriate reward is therefore a significant consideration for a national approach to social care, together with a well-represented and effective employee voice.

ENABLE Scotland has been able to demonstrate the impact of enhanced frontline reward through our 'Reward to Retain' model, implemented in partnership with our recognised trade union partner, UNISON. It has resulted in a significant reduction in turnover in demonstration areas through the application of a reward strategy at an enhanced rate beyond the SLW. Put simply, we will keep good people in the system if we reward them enough in order that they do not transition to other sectors. The impact of 'Reward to Retain' has been significant in the demonstration sites has reduced from 55% to 10%, more specifically:-

	Current Turnover	Pre-Demonstration	Variance
East Lothian	8%	37%	-29%
Edinburgh	11%	57%	-46%
Orkney	8%	66%	-58%

This de minimis practice on reward structure must be nationally negotiated and consistently applied, at whatever level you enter the social care workforce. However, a national approach must go beyond simply adopting the same principles as the NHS terms and conditions. As a core principle, it must also retain flexibility in the system to reward beyond the de minimis rate as required by the individual and the community in which they live.

It should be noted that whilst we appreciate the legal barriers surrounding of enforced trade union recognition, all of ENABLE Scotland's organismal interventions described have been worked on in conjunctions with and supported by our recognised trade union partner UNISON.

5. A national Programme Board to expedite existing, and prevent future failings linked to supporting people to live at home in communities (referred to as delayed complex hospital discharge).

A key priority for a national approach to social care must be the implementation of a national programme to eradicate and prevent delayed complex hospital discharge, on a 'Once for Scotland' basis.

Post 1990s, Scotland delivered an effective, and rapid, hospital closure programme which resulted in hundreds of individuals being moved out of long stay institutions and into a home of their own. Many of these individuals still live in Scotland's communities, and many are supported by ENABLE Scotland. Other individuals, identified in the December 2018 Scottish Government Coming Home report remain in institutional settings miles from their own local communities. Many of these individuals are considered to have complex support needs that has resulted in them being caught between health and social care agencies, highlighting a lack of streamlined funding and accountability to expedite the transition home for these people.

Increasingly across the social care landscape, the sector is experiencing market failure at an alarming rate, with some providers unable to continue to deliver good quality care and support within this market context. Where this happens, vulnerable citizens are at the sharpest end, experiencing disruption and change in their lives which they have not chosen. This is the context for many of the individuals identified in the Coming Home report. Whilst not stated in that report, it is acknowledged that the majority of residential, in-patient units for people who have learning disabilities and autism, are delivered by the private sector.

ENABLE Scotland has demonstrated that it is possible for a commissioned third sector provider to achieve transformational change for these individuals in the immediate term, without unnecessary delays, and commissioned an independent evaluation of our work to capture the key learning. This has been shared with the Short Life Working Group tasked with making recommendations to this Review, and of which ENABLE Scotland is proud to be part.

Beyond the strategic interventions introduced by ENABLE Scotland at an organisational level, which were identified within the independent evaluation as significantly influencing the success of each transition; the evaluation recognises the founding critical success factor of these positive transitions as the strong and equal partnership between NHS Health Boards, HSCPs and ENABLE Scotland as the service provider.

To replicate this successful approach on a national scale when commissioning, planning, transitioning and delivering complex hospital discharges, the Review should consider introducing tripartite agreement of equals across NHS, HSCP and provider partners. It should be further recognised that not all providers would have the necessary infrastructure reach and human rights driven, self-directed delivery model required to meet the full extend of the delivery solution required. The Review is, therefore, encouraged to consider restricting the number of providers eligible to form part of this partnership, based on demonstrating the necessary eligibility criteria essential in the form of a track record of delivery together with the requisite scale and reach to support and achieve delivery.

[4] Scottish Government, *Poverty and Income Inequality in Scotland 2016-19*, March 2020
[5] The Guardian, *Number of people in poverty in working families hits record high*, 7 February 2020

Facilitation of this partnership could be commissioned through a single national Programme Board to scope, plan and deliver on a national basis the recommendations of the Coming Home report. In progressing the change required to secure nationwide moves out of hospitals, and other institutional settings, for every person identified within the Coming Home report a national body must be created; and the programme must be time limited, to be delivered within two years of the date of implementation. In addition, this body must take ownership of monitoring on an ongoing basis, and lead a preventative agenda across all HSCPs. In order to achieve this, it will require:

- A robust funding model that fully supports the critical transition costs required to adequately resource and sustain the transition and, critically, ongoing delivery through specialist resources at provider level, closest to the individual;
- A dynamic register of individuals in a delayed discharge position, or at risk of delayed discharge or re-admission;
- Develop a stronger regulatory environment to eradicate delayed complex hospital discharges, including a defined role for clinical governance and the Mental Welfare Commission, and leadership of a tripartite partnership of equals across the NHS, local authority social work and Provider.

This will inform monitoring and resource planning in the long term, but critically in the immediate term, achieve the human rights of some of Scotland's most vulnerable citizens to live in the community of their choice supported by the people they choose, to live the life they choose to live.

6. A sector-wide digital platform seamlessly connecting providers and commissioners

With over 1,000 social care providers across Scotland, working across 14 NHS Boards, 31 HSCPs and 32 local authorities, there is a huge level of duplication of need across system capabilities and dependencies. The current non-standardised approach to system development and integration adds layers of cost and complication between providers and commissioners, with multiple manual processes required to demonstrate contract compliance and validate financial returns.

To support streamlining these costs and inefficiencies, the Review should consider how to support the funding and development of a modern, centralised, digital platform which will enhance and streamline contract reporting across a multi-commissioning landscape. This could be delivered through a standard digital portal, accessible to all support providers that ensures standardised reporting and reduces the complexities associated with inconsistent localised contract monitoring requirements. Such an intervention would not only be creating a more efficient, digitally enabled sector, but would reduce the cost of administration which could offer savings back into the sector that could be reinvested in frontline delivery.

Beyond this, the sector would benefit from introducing a consistent digital infrastructure solution, on the basis of 'build once and deploy many times'. This could be delivered as a bespoke solution available to the entire sector, or as an platform that supports a 'plug and play' direct integration with providers' existing platforms. This would generate and secure further efficiencies for the sector as a whole, streamlining engagement and partnership working with commissioners, NHS Boards and HSCPs; and creating further potential for a digitally enabled workforce and citizens through scalable procurement linked to the digital healthcare agenda. We ask the Review to consider the mechanisms available to support this much required digitally focussed approach, whilst recognising the significant return in investment that such a transformational approach would deliver.

7. A universally accessible national approach to social care which is free at the point of need

A national approach to social care must have enshrined as its founding principle that it is delivered free at the point of need, and is accessible universally to all citizens who need it.

We note in COSLA's response that "***To date, there has not been fundamental consideration of how much it costs to provide high quality social care in Scotland."*** An urgent priority in considering a national approach to social care is to undertake scoping work to quantify the cost and therefore inform the scale of economic levers required. Whilst more investment will be required, it is noted that the repurposing of existing NHS acute spend and sectoral reform of infrastructure efficiencies, as outlined within this submission, could be part of the solution.

More immediately, in order to address the widespread inequalities witnessed during the pandemic in community based social care, we recommend that the Review considers the option to re-open the ILF to new applicants as an urgent priority to direct more funding into the social care system of support available to disabled people to assist them in accessing their rights as equal citizens. The ILF provides additionality funding, over and above the commissioned statutory support. Local authorities, under the Social Work (Scotland) Act 1968, complete individual assessments to determine if social care support should be commissioned for that individual. This is fundamentally a resourced-led approach to assessing and meeting social care needs across Scottish communities, which may ultimately disguise the true extent of nationwide unmet need as a result of high eligibility thresholds.

It is therefore proposed that through re-opening the ILF, consideration could be given to expanding the remit of the ILF by introducing a financial cap to local authority social care funding, with the balancing sum met through additional ILF funding directed into the social care system. It is anticipated that such an approach would enhance each local authority's ability to undertake further assessments of need and to provide further assistance to those individuals who do not currently meet the existing eligibility thresholds. It is recognised that this proposed expansion of the ILF's remit could be achieved through a policy change to expedite implementation and provide a universally accessible national approach to social care.

Charging policy must also be urgently addressed. Currently, COSLA produces annual charging guidance for care and support with the aim of achieving consistency across the country, and that the payment structure varies across commissioned social care and personal contributions. We note that no such charging guidance is required to access health services – these are free at the point of need. We contend that support to access basic, fundamental rights should never be a matter of 'local priorities', and neither should people have to pay just to be able to exercise those rights; this applies across both statutory social care and that through the ILF. **Charging policy should end immediately for the provision of all care**. Consideration must be given to accommodation costs separately

Appendix A: PA Model Case Study

Introduction

N is a 26 year old man who lives independently in his own flat with support from ENABLE Scotland. N is a chatty, confident young man who leads an active life, working in his chosen vocation at a smallholding, volunteering and regularly playing football.

This is not how life has always been for N.

When ENABLE Scotland first met N in 2014, he lived at home with his mum and three younger siblings. N has a moderate learning disability and inflammatory bowel disease (IBS). He was allocated a small short-break budget of a few hours a week to afford his mum some respite. N had never had support before and was very shy and anxious. At initial meetings with ENABLE Scotland, N could not make eye contact, have a conversation or stay in the room to participate and interact with anyone outwith his family.

PA Model

Due to his nervousness, N wanted to include his mum in the recruitment process. Together, ENABLE Scotland Services Manager, N and his mum developed a PA recruitment profile to attract, identify and select people with common interests, who could strike a connection and help N feel comfortable and positively engage in support. It was very important to N, and his mum, that his PAs were more like peers so that it was not obvious that he was receiving paid support. N wanted to appear as any other young man, out and about with friends; this was the foundation of the person specification launched as part of N's bespoke team recruitment campaign.

N's PAs, once recruited and trained, started to get to know N at a pace that suited him. Over several weeks of short sessions, PAs spent time with N in and around his home, gradually building up to going out in the community and taking part in activities such as bowling and playing pool. N's PAs have, over time, supported him to develop his skills, including independent travel, attending college and sourcing employment. These are outcomes that exceeded N's own initial expectations, but which have evolved over time as he has become more confident. N's confidence has helped him to continue to refine and self-directed the progression of his own support plan over this time.

In 2019, N chose to move out of his family home into his own tenancy. He worked alongside his support team at ENABLE Scotland to bring his aspirations to life. Having supported N to navigate through the statutory budget review process with social work, ENABLE Scotland has since worked with him to design his new support plan, which has enabled him to successfully live independently.

N's support has been commissioned as an SDS Option 3, however, ENABLE Scotland delivers his support consistent with a typical Option 2 approach, with an allocated ISF, bespoke team of PAs, self-directed service design and detailed support strategies – all delivered through the PA Model.

Whilst ENABLE Scotland manages N's budgets within his own ISF, the drawback of his Option 3 commissioning route is that his support assessment and associated budget has been calculated solely on 'hours of support'. N's ambitions extend well beyond those that 'hours of support' can deliver, so ENABLE Scotland are continuing to support N to consider how to he can access a more flexible support package, as he continues to shape his future path and ambitions.

Should the flexibility have been available at the outset of N's support package being commissioned, these restrictions would likely be far less of an issue. In the meantime, we will continue to celebrate the many achievements N has had in his life to date and will continue to work with N to self-direct his support and live the life he chooses.

Flexible use of SDS Budget

North Lanarkshire HSCP has been at the forefront of commissioning self-directed support based on flexible ISFs since the introduction of the 2013 Act. When commissioning support, North Lanarkshire HSCP does so based on an annual budget value, and not as hours of support. This approach has allowed many individuals to achieve outcomes beyond those that 'hours of support' can deliver. One such individual is G.

G is a young man who has autism. His mother is originally from South East Asia, where their extended family live; family and culture are very important to G. His family do not have the financial resources to travel to see family; however, G articulated the importance to him of visiting his family to help him fully embrace and understand his culture. G has chosen to utilise his budget to visit South East Asia annually with his mother and brother, which not only enables him to meet his chosen cultural outcome, but has also been a positive influence in reducing G's anxiety levels and building his confidence.

This improvement in G's quality of life has been realised as direct result of the flexible ISF underpinning his commissioned self-directed support.

ENRICH Scotland

ENRICH SCOTLAND
enabling research in care homes

Mr Derek Feeley
National Care Review

5th November 2020

Dear Mr Feeley

Re: Representation to the National Care Review

We thank you for the opportunity to make representation to the National Care Review. We would like to draw attention to the need for embedding a strategy for supporting the conduct of research to inform evidence-based practice in social care, and in particular in care homes.

This can be ensured by support for **ENRICH (enabling research in care homes) (Scotland) – see attached document:** we are currently in discussion with the CSO and Scottish Government about the appropriate mechanisms for supporting and funding care home, and social care, research in Scotland, which is now required as a matter of urgency.

The review of adult social care provides an ideal opportunity to ensure that Adult Social Care is, as far as possible, evidence based, and continually learning to provide the highest quality of care to all people requiring social care. This requires explicit integration of research participation and implementation of evidence in any future plan. With co-production principles being in the heart of the National Care Review programme, the similar participatory approach to research would allow for the evidence informed social care practice to be supported.

The provision of best quality care to Care Home residents, and supporting staff, is a Scottish Government Priority, and this requires high quality evidence. We believe ENRICH Scotland can become a hub for Care Home research and over time for social care research.

We would be very happy to discuss this further,

Yours sincerely,

Dr Emma Law
Co-Chair ENRICH Scotland
NRS NDN network manager

Dr Susan Shenkin
Co-Chair ENRICH Scotland
Reader, Geriatric Medicine,
University of Edinburgh

Irina McLean
NHS Research Scotland
Project Lead

Paper to inform the Independent Review of Adult Social Care

Enabling Research In Care Homes (ENRICH) Scotland

Background

The review of adult social care provides an ideal opportunity to ensure that Adult Social Care is, as far as possible, evidence based, and continually learning to provide the highest quality of care to all people requiring social care. This requires explicit integration of research participation and implementation of evidence in any future plan.

One important area where research can inform social care is in Care Home research. Incredibly, research which involves social care is not recorded centrally by the Scottish Government so the amount of research in Social Care in Scotland is unknown.

The provision of best quality care to Care Home residents, and supporting staff, is a Scottish Government Priority, and this requires high quality evidence. **We believe ENRICH Scotland can become a hub for Care Home research and over time for social care research.**

ENRICH Scotland has been has been supporting a programme of work within the NIHR Enabling Research in Care Homes (ENRICH) framework since November 2012 via the management and chairing of the group by Emma Law of the Scottish Dementia and Neuroprogressive diseases network. Emma was joined by Dr Susan Shenkin, lead for the NRS Ageing speciality, as co-chair of the group in 2017. Irina McLean, (Project Lead) joined the group in 2019.

What progress has been made in the past 2 years

ENRICH Scotland have helped to facilitate the development of Care Home research interest and capability within Scotland.

1) By bringing together a **multidisciplinary group** of ~40 people interested in Care Home research including Care Home and NHS staff, academics from a wide range of universities and disciplines (medical, nursing, AHP, sociology) in Scotland, Scottish Care, the Care Inspectorate, all of whom collectively are assisting in gathering and sharing the evidence base required to advance care Home practice in Scotland.

2) By **raising the profile** of Care Home research in Scotland via the ENRICH Forum and with the help of the NRS communication team.

3) By acting as **advocates** and promoting the Care Home research agenda with appropriate stakeholders including care-Home managers, NHS and academic partners, policy makers and research funders.

4) By building on the NIHR ENRICH network of Care Homes and making this uniquely fit for Scottish care Homes to join, establishing which Homes are '**Research Ready'**.

5) With support from the NRS communication team, established a new **website**, including a new **logo**, developed an **information leaflet**, and gained **endorsement from the Care Inspectorate (to be confirmed)** for 'Research Ready' certificates for care Homes

There currently are 54 care Homes on the ENRICH 'Research Ready' register. The register needs to be updated regularly as care Home managers' move, and Care Homes may change ownership or purpose.

All this has been achieved using current resources of a network manager and a specialty group lead whenever time allows and by working out with hours because both believe this is a vision worth investing personal time in.

Rights based approach

We want to ensure that a rights-based approach is used for involving people in Care Homes, their families and the staff. We believe it is about improving what is in place using a rights based approach as the underpinning ethos. This would enable us to:

1. Support the message that people living in Care Homes are first and foremost equal persons with human rights, supported by their families and the staff who care for them.
2. Support Care Home staff in meeting their professional ethical obligations
3. Improve and enhance the quality and effectiveness of the health and well-being of Care Home residents by enabling people to be involved in decision making processes around involvement in research.
4. Have more meaningful participation in the research process and having access to opportunities available to others who are not living in a Care Home and therefore promoting equity to access.

Potential impact of ENRICH Scotland

We can build on the work already completed using the rights based approach outlined. We have reached a stage in the genesis of ENRICH Scotland whereby the level of interest has increased enormously due to the pressures on Care Homes in the light of Covid-19.

There are opportunities to have an impactful presence in Scotland including:

- ENRICH Scotland being an **evidenced based hub** as a joint national group for anyone with an interest in Care Home research to receive guidance and

feedback on study design and ethical approvals. We can aim to **involve** residents and their relatives in this process.

- Bringing different disciplines and organisations together to allow meaningful and impactful **collaborations**.
- **National database** for Care Home and in time, social care research.
- Signposted entry of access to **research ready Care Homes** for Care Home researchers in Scotland.
- **Scotland-wide** involvement and inclusion of all stakeholders
- ENRICH Scotland enhances and informs the rapid action groups and clinical professional advisory groups within **Scottish Government**
- Can link to other Scottish **government strategies and priorities** such as Care at Home, health inequalities etc.

In summary

Using a rights based approach as our underpinning ethos, ENRICH Scotland is a natural conduit to the current Scottish Government priory of improving care and outcomes for Care Home residents, and supporting Care Home staff, during the COVID-19 crisis and beyond.

Carers and family members who play a pivotal role in supporting their loved ones in care homes deserve equal recognition and involvement too. Their valuable expertise and experience could provide opportunities via participatory research involvement. This would provide positive evidence for person-centred practice in care homes in Scotland.

Research plays important role in promoting the nation's wellbeing, it also provides a scientific foundation to successfully developing social care services. On the other hand, research can present certain elements of risks associated with the safety and wellbeing of participants. All of these might raise legal/ethical disputes and therefore call for arrangements to identify and manage risks related to participants and their rights. By establishing the structured support for ENRICH Scotland, the sound principles of research are going to be supported. Additionally, creating a learning culture within a large community of care homes would support a much needed capacity building for staff, where evaluating existing data and measuring the outcomes would contribute to the ongoing objectives of the Public Bodies (Joint Working) (Scotland) Act 2014 implementation with co-production in the heart of it.

What we need now

Participation in research, and the implementation of evidence-based practice should be central to any new Adult Social Care framework.

We need **ENRICH Scotland to be funded and established as part of an NRS Social Care Network/specialty group with the attached dedication of clinical lead time and administrative support.**

ENRICH Scotland, if provided with adequate clinical lead and administrative support, could provide the framework for this, initially in care homes, and if appropriately resourced, expanding to involve more aspects of social care. This would enable Health and Social Care to be truly integrated, person-centred, and enable Scotland to lead the way in evidence-based interdisciplinary care of the most vulnerable in our society.

This will allow us to:

- Establish Scotland as a research leader in interdisciplinary Care Home research
- Provide a platform for collaboration to apply for large research grants
- Engage a wider range of Care Homes in Scotland to become research and teaching active (both for health and social care sectors).
- Promote a more holistic approach to Care Home research in Scotland through offering guidance, governance and networking to colleagues from both health and social care research community.
- To contribute to the analysis of the national integration of health and social care, set by the Public Bodies (Joint Working) (Scotland) Act 2014
- To contribute towards Scotland's Digital Health and Care Strategy;
- To feed into the Adult Social Care Reform priorities set by SG and COSLA

First do no harm (Valproate) Scotland

Derek,

I have an adopted daughter who suffers from Foetal Valproate Spectrum Disorder and as result I am a member of the **First do no harm (Valproate) Scotland** group who are campaigning to ensure that the Scottish Government fully implement the Cumberlege Review recommendations. I represent the group on both the Patient Reference Group and the Specialist Reference Group advising the Scottish Government on proposals for the Patient safety Commissioner.

I would like to provide input to your review regarding people impacted by **Sodium Valproate (Epilim)** and would also ask if you would meet with some of the parents of Adults who have been experiencing a poor service for the adult current care services (perhaps this could be jointly with Mesh and Primados sufferers who have similar experiences)

The Cumberlege Review identifies major issues with the way that the drugs and medical devices were licenced and the way safety concerns were then responded to but the ongoing long term care and support for people suffering as a result of this "avoidable harm" added significantly to what Baroness Cumberlege described as the "harrowing experiences" of the families impacted.

FVSD is caused when the foetus is exposed to the drug Sodium Valproate (Epilim) in the womb. This results in a range of both physical and mental disabilities in around 40% of the children exposed. The drug has been proscribed since 1973 and there are estimated to be several thousand affected people in Scotland, with the number still increasing as babies are still being exposed to this drug with around 1000 prescriptions per month being issued by NHS Scotland to women of childbearing age.

The report described how for years the families of sufferers have had what Baroness Cumberlege described as a **"woeful lack of support and help".** This has been from the NHS, Education and Social care.

I believe that much is this is down to both a lack of knowledge and experience (FVSD is classed as a rare "disease" by the medical establishment) and a failure of the medical establishment to recognise, accept and take responsibility for the "avoidable harm" that they have created.

Going forward we need both a heath and social care system that can provide the care and support that the Valproate, Primados & Mesh victims need and deserve. As these conditions have now been classified as "avoidable harm" that was caused by the healthcare system any National Care service, we believe that the government should provide an exceptional level of care to the victims and their families and not just at a bare minimum level.

Two of the Cumberlege review recommended that are particularly relevant are:

> "schemes should be set up for Hormone Pregnancy Tests, valproate and pelvic mesh to meet the cost of providing additional care and support to those who have experienced avoidable harm "

And

> "**t**he establishment of two types of **specialist centres** – one for mesh, and another for those affected by medications taken during pregnancy. They will be located regionally. As well as meeting clinical needs, these centres should act as a one stop shop, able to signpost and refer patients to other services.

The current local authority managed care provision does not serve the adult victims of these conditions well. I feel that a national care service would benefit the care of people suffering from FVSD and the other conditions covered by the Cumberlege review by:

a/ allowing a consistent approach to support services across Scotland. We know that response to the condition varies enormously between authorities.

b/ allowing specialist social work teams to become experts in “rare” conditions and so offer a country wide service for assessments and reviews

c/ provide a Scotland wide approach to funding of services which are to meet the resulting long term implications of “avoidable harm” cases

To meet the recommendations of the Cumberlege review I also think that a National care service needs to be an integral part of the recommended specialise centres with both Health and education as it is in Education and Social care where the long term needs are greatest.

Baroness Cumberlege stated that
“Our recommendations will improve the lives of people who have been harmed and make the system safer in the future. This report must not be left on a shelf to gather dust. Implementation needs to be approached with a new urgency and determination, founded on the guiding principle that our healthcare system ……must ……..first ……do no harm.”

My view is that the greatest impact on the lives of those impacted by Sodium Valpraote will be by our response to the provision of long term care. I hope that your review will address the issues that the Valproate, Primados and Mesh victims are experiencing on a daily basis.

Regards
Charlie Bethune
Co founder, First do no harm (Valproate) Scotland

Glasgow Centre for Inclusive Living

Glasgow Centre for Inclusive Living's Submission to the Independent Review of Adult Social Care

December 2020

GCIL's Submission to the Independent Review of Adult Social Care

Introduction

Glasgow Centre for Inclusive Living (GCIL) is run by and for disabled people (ie a Disabled People's Organisation). We provide a range of services which aim to help disabled people challenge the barriers to independent living. These include employment programmes, housing information and advocacy, training, help managing self-directed support (SDS) funding, payroll, and consultancy services.

GCIL welcomes the opportunity to respond to this Review. Like others, however, we have made submissions to numerous consultations and reviews on social care support during the past 25 years (without, it has to be said, seeing much in the way of tangible, positive impact on disabled people's quality of life). Rather than repeat the arguments set out in these responses in detail, and given the volume of submissions the Review has already received from different sectors, we will be brief and simply:

a) endorse the Recommendations made in the response of Inclusion Scotland, of which GCIL is a member;
b) attach for information a copy of our recent submission to the Health and Sport Committee's Enquiry on Social Care from February 2020 (Appendix 1);
c) limit ourselves to setting out an abbreviated summary of key points and themes which we have identified as being fundamental to the current Review.

Key Problems with the Current System

Covid-19 – There is clear evidence that that many disabled people who rely on social care support were **badly let down by statutory services** during the Covid pandemic, with significant numbers being left without essential support. **This must never happen again.**

Purpose of social care support - There is a need for a **shared understanding** of the purpose of social care support based on **participative citizenship** and **human rights.**

Health and social care support – Social care support must not be considered as a merely the **'handmaiden' of health care**: in other words, it must be recognised as a key tool that many disabled people rely on to **live as equal citizens**, not just a way to keep people out of hospital or residential care, and safe and warm in their own homes.

Self-directed support - Despite some positive experiences and pockets of good practice, overall, the current system of **SDS has not delivered** the level of **choice** and **control** required.

Social care resources - The current system is **chronically underfunded** at a time of rising demand.

Assessment – Assessment for social care support is budget-driven and HSCPs manage demand by increasing **eligibility criteria** and / or **charges.**

Inequity - The current system is a post code lottery: it is fundamentally **unfair**, with **arbitrary variations in provision** both within and between local authorities.

Charging – Charging for social care support (**the Care Tax**) is fundamentally unjust and should end for **social** care support as well as for **personal** care. No-one should have to pay to exercise their basic human rights as set out in the UNCRPD.

The gap between policy and practice - There is a fundamental **disconnect** between the Scottish Government's **national policy** and **local practice**.

Coproduction - Meaningful **coproduction** on SDS at a local level is largely absent.

Personalisation - SDS is mostly implemented in the guise of '**personalisation'** which, although it focusses on the needs and preferences of the individual, pays insufficient regard to the benefits of **collective empowerment**, **peer support**, and **user-led support services.**

How can we fix it?

Purpose of social care support – Our shared understanding of the purpose and scope of social care support must be based on **participative citizenship** and **human rights**.

Accountability & scrutiny – The distinct purpose and importance of social care support must be accompanied by robust new systems for ensuring **accountability and transparency**. These must include developing **more appropriate, targets, outcomes, indicators, monitoring and evaluation metrics**.

Ringfencing the national social care support budget and holding politicians and others more **transparently accountable** for performance is fundamental.

UNCRPD - Incorporating the Rights set out in the **UNCRPD** into Scots law would provide a useful reference point to underpin a revised system of social care support based on **human rights budgeting.**

Enforcing rights – Rights that are not enforceable are not rights at all. For legislative rights to be enforceable, there must be **clear, accessible information** on what those rights are, **adequate independent advocacy**, and better **access to legal aid** for those who need it.

Minimum entitlements – Whilst we would welcome the introduction of **minimum entitlements** linked to Rights under the UNCRPD, any new system must prevent these becoming the **de facto maximum** support available.

Challenging decisions – If assessments continue to take place at a local level, new, **independent and accessible mechanisms** are needed to enable **effective challenge**, for example using **independent expert panels** similar to those used in social security appeals.

A Social Care Support Charter – Any new system of social care support must be underpinned by a **transparent coproduced Charter**.

Coproduction - We need a stronger **national scrutiny body co-produced in partnership with people with lived experience** of social care support. At the local level, social care support users must be meaningfully **represented at IJB level** and have **real power** including **voting rights**. To achieve meaningful **coproduction** and **accountability** is likely to require a national programme of **community development** and serious **investment in capacity building**.

Assessment – Assessment for social care support should determine what resources and support disabled people need to have genuine choice and control over their lives (Independent Living) and to enjoy their **equal citizenship and fulfil their human rights.** To do this, it is essential that **assessment is independent of budget management,** and that **data on any unmet rights** is recorded and used to **inform strategic planning and budgeting**.

Investing in social care support - There is growing evidence that the **return on investment** in social care support can make **economic sense** as well as meeting fundamental principles of **social justice**.

A National Care (Support) Service – A National Care Service has been identified as one way of providing a more equitable, accountable and portable service nationally. Ideally, we would prefer to see as truly national **service** along the lines of ILFS with national administration and delivery), rather than simply a modified, or enhanced **system** based on the current one with local delivery (albeit with clearer, enforceable entitlements etc). We remain highly sceptical of changing existing LA organisational cultures sufficiently to enable real change to take place.

ILF Scotland – ILF Scotland & NI is widely regarded as a model of good practice but is closed to new applicants. Given sufficient resources, it has the potential to **play a significant role** in any new landscape of social care support.

A phased approach – Given the scale of the transformation required to realise a national care support service capable of delivering Independent Living, we recognise that **a staged approach** would probably be required. We believe the **ILFS could play a key role** in such a staged approach.

Local support – Social care support users will always need access to **specialised, one-to-one support and advocacy,** including **'pre-assessment' advocacy**. Such support systems should ideally be **user-led** and should form an integral part of any new social care support landscape.

Funding social care support – We believe that social care support should be **free at the point of delivery** in the way most health services are, and funded through some form of **national taxation**, whether hypothecated or otherwise.

Appendix 1: GCIL's Response to the Health & Sport Committee's Enquiry on Social Care (February 2020)

Introduction

Glasgow Centre for Inclusive Living (GCIL) is run by and for disabled people (ie a Disabled People's Organisation). We provide a range of services which aim to help disabled people challenge the barriers to independent living. These include employment programmes, housing information and advocacy, training, help managing self-directed support (SDS) funding, payroll, and consultancy services. GCIL's way of working is informed by the social model of disability and we therefore work with people with a variety of impairments.

GCIL welcomes the opportunity to respond to this Review. This response draws on 4 different areas of our work:

a) Around 25 years' experience of working with and for disabled people to challenge the barriers we face to independent living, equality and human rights. This includes providing ongoing support for approximately 1,000 people using SDS in three local authority areas: Glasgow, East Dunbartonshire, and South Lanarkshire. We also provide payroll services to around 350 people using SDS Option 1 (direct payments) to fund personal assistants (PAs) and care agency providers.

b) Feedback from our SDS Development project funded by the Scottish Government's *Support in the Right Direction* programme. This has involved dozens of individual and collective awareness raising sessions with existing and potential SDS users, their supporters, and also with Care Managers.

c) A number of consultation events with SDS users and those who support them, including those who have used different forms of self-directed funding over the past 25 years.

d) A research project carried out in partnership with Stirling University on 'The costs and benefits of 'good' self-directed support' funded by the Big Lottery's DRILL programme.

NB: The term 'disabled people' is used throughout this paper for convenience. Where appropriate, however, this may also be taken as

including older people with support or access needs, or people with long term health conditions.

The Purpose of Social Care

We believe any meaningful reform of social care must begin with developing a shared understanding and agreement about its purpose.

Despite decades of reforming legislation and more recent attempts to make it more empowering, we believe social care still bears some of the hallmarks of its historical roots. Today's provision may not be as harsh as the parish workhouse, nor as paternalistic as the alms-houses of the 19th century, but many disabled people still describe their experience of their engagement with social work as humiliating or stigmatising, with the threat of being forcibly institutionalised never far away.

A persistent feature of the current system is its localisation – its dependence on local decisions, local resources, and locally perceived priorities. Indeed, this has been argued to be its strength in that it enables local Health & Social Care Partnerships (HSCPs) to respond differently according to the individual conditions, needs or concerns in their area.

We disagree. GCIL believe that people with impairments are disabled (ie disadvantaged) by often avoidable barriers to their full inclusion in society. The absence of, or lack of sufficient, social care is a major avoidable barrier to inclusion for many disabled people. As such, access to adequate social care is very clearly a human rights and equalities issue. Only when those who need it have access to adequate, appropriate, flexible forms of social care can they enjoy their full human rights and function as equal citizens (see, for example, the UN Convention on the Rights of Disabled People[1]).

And yet, no other group identified as having a 'protected characteristic' in the Equality Act 2010[2], has to rely so much on factors which are determined at a local level to exercise their equal citizenship and human rights. For most protected characteristics, it is considered appropriate that legislation, policy and practice apply nationally. For example, whether women should receive equal pay to men for doing the same job

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1 https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

2 http://www.legislation.gov.uk/ukpga/2010/15/pdfs/ukpga_20100015_en.pdf

is not considered to be a matter that can be decided differently in Dundee than in Aberdeen.

And yet access to adequate social care support may be hugely dependent on where that person lives, the nature of their impairment, their age, their means and even their personal or family circumstances. Geographical variations in eligibility criteria, charging policies, available service providers, and independent support services all add up to a true post code lottery.

GCIL considers social care to be fundamentally an equality and human rights issue. As such, we believe that any system of social care fit for the 21st century must be underpinned by nationally enforceable, transparent, minimum entitlements and should be aiming to facilitate genuine independent living ie enabling people to have control over their own lives and make the kind of day to day choices that most non-disabled people take for granted.

This fundamentally different approach to social care is encapsulated in the 'Ten Principles of a Constitution for Social Care' attached as Appendix A[3]. It has also been articulated in the Independent Living in Scotland (ILiS) document 'Our shared ambition for the future of social care support in Scotland' to which GCIL contributed:

> **'Our ambition is for sustained public investment in the development of a modern, nationwide infrastructure of social care support.**
>
> The social care support we envision will be an instrument of transformative social change. It will protect, promote and ensure human rights and tackle inequalities for disabled people and carers. We believe that this nationwide infrastructure will play a critical role in building and sustaining Scotland's social and economic prosperity as an integral part of the country's wider national infrastructure.
>
> This infrastructure should facilitate the delivery of a statutory framework of common outcomes, underpinned by clear and consistent nationwide rights and entitlements.'[4]

We have spent some time emphasising this key issue because we believe that currently, a well-intentioned national SDS strategy is being

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[3] Bartlett, J and Guglielmi, S (2009) A constitution for social care, Demos, London

[4] www.socialcareambition.co.uk

thwarted by a local delivery mechanism which is struggling to meet even basic demands, let alone deliver disabled people's vision of independent living.

We believe that a social care system founded on human rights and capable of realising independent living involves a radical transformation of the current system and requires re-aligning legislation, guidance, funding, assessment, outcomes monitoring, and training with key equality and human rights principles.

A similar vision was required in establishing Social Security Scotland to manage the benefits devolved from the DWP. To its great credit, the Scottish Government has shown that, by co-producing both the key values and principles which will underpin the new agency (dignity, fairness, respect), and the Charter and Commission which will oversee it, it may be possible to radically change our relationship with public institutions.

GCIL believes we need a comparable transformation in social care. We need a national social care support service based on transparent principles and entitlements which is adequately funded to enable independent living, is free at the point of delivery (like most health care), and which is genuinely able to emancipate disabled and older people. Investing is such a system would not only release the potential of thousands of disabled people, we are confident it would be beneficial to the nation as a whole.

Experiences of social care in Scotland

Although we believe there are significant problems with the current system, it is important to note that, even in its present form, SDS does enable some disabled and older people to live more independent, active lives and, in some instances has proved transformative in increasing choice and control and improving quality of life.

This is more likely where the budget awarded is sufficient (especially, perhaps, where the person is in receipt of additional funding from the Independent Living Fund Scotland). It may also depend on the individual either requiring little independent support to manage their funding, or having access to the kind of independent support that enables them to exercise maximum choice and control. These examples serve to illustrate what could also be a reality for the majority if adequate funding and best practice were to become the norm rather than the exception.

Unfortunately, in reality, there is much unmet need and little preventative support. Many people are left physically and mentally vulnerable and totally alienated from the decision-making around their own well-being and future prospects.

We would therefore like to see an explicit recognition of 3 key issues:

1) there is not currently enough funding in the system to make any form of SDS work as effectively as it should for everyone who needs it;
2) disabled and older people's rights to adequate social care support are not sufficiently explicit from a legislative point of view, nor can they be enforced effectively through existing forms of redress; and
3) however good national policy and guidelines on SDS are, the current relationship and accountability mechanisms between the Scottish Government and local authorities are unable to guarantee that the strategy will be realised at the local level.

What people would change about their experience of social care?

The following issues have all been cited by disabled people as problems with the current system.

Social care funding – Although it is far from being the only important issue, it is now widely recognised that we are experiencing a crisis in social care funding and this is often the key factor in determining people's experiences of social care support. Many disabled people have had their support budgets much reduced, with eligibility and resources increasingly targeted only on meeting essential personal care needs (defined as 'critical and substantial' needs) rather than what is needed to live an active and meaningful life. More than once we have heard senior social work managers admit 'social work cannot possibly fund independent living on its own'. This situation is made worse by benefits cuts, rising local authority charges and increasing support costs.

Charging – GCIL welcomed the recent extension of Free Personal Care to people under 65. However, it is clear that only around a half of third of those intended to benefit saw any reduction in their charges and that the intentions of the policy were therefore not fully realised[5]. Many disabled people are still having to pay for essential social care support - in other words, they are paying simply to enjoy their rights to participate

[5] http://www.scotlandagainstthecaretax.co.uk/

in the community as equal citizens. GCIL supports the view that charges for most non-residential community care services (the so-called 'Care Tax') should be scrapped and that both social care and personal care, like health care, should be free at the point of need regardless of age.

Social vs personal care – The inconsistent implementation of the recent extension of Free Personal Care to people under 65 is perhaps not surprising given the confusion over the precise definitions of social vs personal care. For most disabled people, the distinction between the two is, at best, unclear and, at worst, simply contrived to manage budgets. In reality, people do not live their lives by labelling each day to day activity according to arbitrary criteria. For example, in what way is help getting dressed in the morning different from help needed to adjust clothing at a football match? (The former is likely to be regarded as personal care, whilst the latter may be considered social.)

Nor has the integration of health and social care helped in this regard. Social care support continues to be seen as the poor relation of health care, its role being primarily to prevent people relying on overstretched health services, or to speed earlier discharge from hospital.

Eligibility criteria – In addition to increasing charges for services, HSCPs also manage demand by tightening eligibility criteria to the minimum required to meet legal responsibilities. Setting eligibility criteria to 'substantial' and 'critical' is increasingly excluding people from accessing low level, preventative services which could avoid crises and additional later public expenditure. This is a medical model vision of social care support which bears little resemblance to disabled people's own aspirations for independent living.

Choice & control – The current system of social care provision is intended to offer real choice to disabled people about how they wish to manage the resources they are eligible to receive. However, we are concerned that many disabled people are not being properly enabled to access all the options available under SDS. In particular, there are indications that there is a disproportionately low take up of Option 1, a direct payment and too many people are still using Option 3, which represents no tangible benefit from the traditional form of 'top down' service provision. We believe this may be because:

a) people are being steered towards what are seen as more risk-free options which are simpler to administrate for funders; and / or

b) that there is not enough independent support and advice available throughout Scotland, especially in the form of user-led support organisations, which know how to make the most of the SDS options to empower disabled people themselves.

We believe the Scottish Government should be collecting quantitative and qualitative data which would enable it to look closely at the relative take up of the four SDS options, the reasons for any significant differences between local authorities, and the impact on individuals in relation to outcomes and choice and control.

Individual Service Funds - Option 2, Individual Service Funds (ISFs), also require close monitoring to see if they are genuinely empowering in practice. Key indicators could include: the range of providers available under this option; the number of people who switch providers after choosing an ISF; or the extent to which each individual's ISF budget varies in response to changing need / individual choice.

Assessment – Many disabled people's experience of assessment is regrettably quite negative. Typical concerns are that:

- it can take a very long time for an assessment to take place
- some people are being told they are ineligible for SDS by unqualified staff without a formal assessment having been carried out
- they are not able to access independent help or advocacy prior to being assessed
- they are not able to have sufficient say in the process and may not even receive a copy of their assessment before it is submitted for funding decisions to be made
- the assessment proposal based on their agreed needs is overturned and the budget reduced without explanation (suggesting it is more based on financial considerations than the actual needs of the individual)
- some people say they are made to feel they are 'trying it on' ie asking for something unreasonable rather than simply what they need to live a meaningful life – this can make the assessment procedure feel humiliating.

GCIL believes assessment should be needs driven and based on clear entitlements. Furthermore, it is vital that unmet need must be recorded systematically and fed back into the planning cycle. At present unmet need effectively 'evaporates' since the only need recognised and recorded is that which is funded.

Prepaid cards - A further cause for concern in some areas is the introduction of prepaid card schemes. This is where all those who choose to receive their funding in the form of a direct payment must use a card which is issued by the HSCP and which enables it to monitor expenditure (and also recover underspent funds more easily). In our experience, card schemes may be welcomed by some SDS uses as they require less paperwork and monitoring. However, for others, they are regarded as less accessible, over-intrusive and against the spirit, if not the legislation, underpinning SDS. GCIL believes that anyone choosing SDS Option 1, a direct payment, should be able to choose whether or not to use a prepaid card.

Challenging decisions - We believe that existing assessment processes, especially those using Resource Allocation Systems, have become discredited and disabled people have little confidence in them as a fair and transparent means of assessing real need. We acknowledge that risk management is an important consideration, but we believe it has assumed a disproportionate role in the assessment process in some parts of Scotland. Too often the assessment process is not genuinely co-productive and, despite the best intentions of many social work professionals, is driven primarily by resources.

More specifically, we believe a more independent and transparent mechanism is needed for disabled people and their families to challenge decisions around assessment, funding or service provision. An appeal mechanism which is entirely independent of the local authority is required in the short term and, in the longer term, a more robust legal framework for challenging decisions in law backed up by affordable legal advice and representation.

Workforce issues – It is widely recognised that there is currently a severe shortage of staff available to provide high quality support, either as personal assistants, as care agency staff, or indeed in residential care homes. This remains so despite recent efforts to increase minimum hourly pay rates. There is still work to be done to raise the status of this vital work and to ensure it is appropriately remunerated.

A further workforce issue concerns the role of professional social work staff. Some social work professionals feel they have been de-skilled and disempowered by assessment systems that prioritise financial expediency at the expense of professional judgement. Indeed, many have left the profession because they feel unable to act in accordance

with their professional ethical principles to always act in the interests of the client.

In summary, despite pockets of good practice, the current system struggles to offer people real support and control, and too often simply requires them to make difficult choices about rationing their own support budgets.

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

Genuine high value co-production means sharing decisions at the objective setting stage, not just rubber stamping decisions already made elsewhere. There should be opportunities for people to be involved, if they so choose, at every level including at the individual, operational and strategic levels. Co-production is ultimately about how power is distributed between the powerful and the disempowered. Good co-production, in this context, is where commissioners, funders, assessors, and providers share as much power as they can with the person requiring support.

Individual co-production starts with enabling the disabled person to have as much say as possible in the assessment process. This may include providing independent support to:

- self-assess needs, aims and personal outcomes
- obtain unbiased information about available options and make an informed choice
- understand their rights and any support available to exercise those rights
- choose an option which enables them to assume maximum choice and control

It should be noted that although providing 'person centred planning' may be a necessary part of good individual co-production, it may not be sufficient to guarantee it. Person centred planning may still involve a large number of professionals effectively assessing an isolated individual, setting an inadequate budget (which cannot be meaningfully challenged), forcing the person to effectively ration their own support within the resources provided, and then offering few opportunities for the person to change the way support is provided.

Person **controlled** planning is the only way to ensure that the individual has some control over the **process** as well as the **outcome** of the assessment. Person controlled planning means treating the person as an equal participant in the process rather than simply a commodity in the

'care industry'. It should involve ensuring that the infrastructure enabling support preserves the dignity and autonomy of the individual at all times, and recognises the need for flexibility in the way funding is used as long as broader agreed outcomes are met. It must facilitate genuine choice and control by people with a wider range of support needs, and offer the opportunity to change from one option to another more easily. In short, it should ensure that the person remains as far as possible in the driving seat concerning their own support needs. Meeting those needs should feel more like engaging with a public amenity (such as a library or a law centre) and less like asking for a hand-out from the local parish.

Collective co-production - Enabling individuals to get involved in operational or strategic coproduction is likely to be easier when disabled and older people share peer support and have the opportunity to build their collective capacity to engage as a community of interest. This means helping them to create their own representative organisations and resourcing them to become involved in planning, service provision, and evaluation if they choose to.

Unfortunately, 'personalisation' is seen only as an individual concern, not one of collective empowerment. Few new DPOs are being developed, and the community development services required to achieve this have largely been superseded by budget driven managerialism. In the meantime, support service procurement exercises favour larger, well-resourced, non-user-led organisations and undervalue lived experience, self-help and peer support.

Consulting more widely - When public bodies consult the general public as well as those with more direct experience of using services, it should be noted that their views are likely to differ from disabled and older people's own lived experience. It is important to take this into account in interpreting public conversations about social care. Traditional attitudes about 'care' may not be consistent with the perspective of those with lived experience as seen through the lens of 'independent living'.

At the strategic level, Integration Joint Boards (IJB) need to be more accountable to people with lived experience of using services. They need effective links between policy forums which include significant representation from Disabled People's Organisations and other stakeholder representatives, and meaningful representation from these bodies at IJB level. IJBs must carry out **meaningful** Equality Impact Assessments and must **act on their findings** before major changes to services are implemented. There may also be a useful potential role for

'Citizen Juries', where stakeholders control the agenda and invite funders, commissioners, providers etc to give evidence.

For further information on good practice in coproduction see ILiS's Co-production Toolkit, part of which is attached as Appendix B[6].

How should integration authorities commission and procure social care to ensure it is person-centred?

As noted above, we would favour establishing a new national body to co-ordinate and fund social care on an equitable basis. To the extent that commissioning and procurement bodies may be required to play a role in delivery, they should do on a genuinely co-productive basis as outlined above.

At the individual level, we need to increase the proportion of people managing their own support. We should treat this in the same way that we encourage people to take more responsibility for their own health care. A high profile national campaign might be one way forward. Empowering service users needs to be a key aim of professionals – targets for doing so should be set and monitored through performance management systems

At the collective level, HSCPs and IJBs need to work with representative groups to agree how social care can best promote real independent living. User representatives can participate in joint commissioning processes, as well as joint monitoring and evaluation of providers.

Procurement procedures should recognise the added value that user-led support services offer. This may mean supporting user-led groups to develop and grow so they can provide their own information, support, advocacy and other services.

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

The key elements in an ideal model have mostly been detailed above. However, to summarise, we must:

- develop a shared understanding of the purpose of social care in the context of independent living, citizenship and human rights
- plan, commission, deliver and evaluate co-productively
- deploy sufficient resources to make a difference
- resource user-led (peer support) organisations

[6] http://www.ilis.co.uk/get-active/publications/co-production-toolkit

- involve people with lived experience of using services in professional education
- enable disabled people to have more control over the process of defining their own needs and designing their own services
- co-produce standards and define outcomes in policy and practice
- involve people with lived experience of using services in monitoring and evaluating provision (and act on their findings)

Housing – The process of separating the provision of housing from support is the right way forward and must continue. Disabled people should not be forced to live with other disabled people merely on the grounds of financial expediency, be this in small group homes, or in residential care homes.

Use of digital technology – Digital technology such as the use of prepaid cards to manage and monitor SDS funding, or Technology Enabled Care and Support Services (TECS) to supplement other forms of social care support, may have a part to play in 'modernising' services and making best use of limited resources. However, they may also exclude large groups of disabled people who are 'digitally excluded' and unable to use them to control their support.

At GCIL we estimate, based on a recent survey, that fewer than half the hundreds of people we support use computers or digital devices on a regular basis. Similarly, TECS systems may be seen as more cost effective by funders, but they also risk increasing the anxiety, reducing the flexibility to meet urgent need, and ultimately adding to the isolation from human contact that many disabled and older people are already more likely to experience. We would argue, therefore, that both options should be available if they are positive choices that enhance an individual's ability to control their own life; but neither should be imposed on a person purely out of financial or administrative expediency.

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

We propose establishing a national social care support service for Scotland which should encompass both 'personal care' and 'social care' (in so far as these are currently defined).

We support the proposal from Scotland Against the Care Tax that the service should be underpinned by the following principles:

1. National entitlements – eligibility criteria should be uniform throughout Scotland and should be set within a framework of national entitlements.

2. Free at the point of delivery – as with health care, eligible support should be free and based on need rather than the ability to pay.
3. Co-production - all aspects of planning, assessment, delivery, evaluation etc should include people and organisations with lived experience of using social care support.
4. Independent living – support should aim to maximise choice and control enabling people to maximise the control they have over their lives and their equal citizenship and human rights.
5. Unpaid support – the important contribution that families, unpaid carers and communities play in enabling people to realise their potential should be recognised, but should be a positive choice by all involved rather than the only option due to lack of alternatives.
6. Accessibility – information, processes (eg assessment), communication and documentation relating to support must be fully accessible to people with a wide range of access needs.
7. Independent support and advocacy – independent support and advocacy must be freely available to ensure that the person is able to make informed choices or challenge decisions.
8. Values led commissioning – commissioning should value providers with a social purpose in the not-for-profit or public sectors including Disabled People's Organisations.

A national service would be able to ensure geographical equity across Scotland more easily, avoiding a post code lottery and the problem of portability. The Independent Living Fund Scotland provides an example of how this might work in practice. Establishing a Charter for Social Care and a corresponding Commission to provide oversight and scrutiny would also help ensure that the key principles outlined translate into practice at the local level.

Finally, a new national social care support service may require a new system of funding. One way to do this would be through a new hypothecated tax so that all contribute according to their means. However, until more public funding is available, many of the real aims of social care will not be achievable. In the short term we need to develop a plan to address this, even if the full realisation of that plan takes several years. The importance of the issue, and the scale of the measures required to address it, are comparable to the national debate about pensions. This plan should set out how we aim to fund and deliver a system of social care support based on independent living principles in the medium to longer term. The corollary of the above, is that we also need to be much clearer about the economic and social benefits that investing in social care support generates.

In conclusion, although we recognise that the scale of the transformation required in realising these proposals, we believe that the current situation is unsustainable in the longer term. It may be possible to break the process down into more achievable stages, perhaps by taking advantage of the infrastructure provided by ILFS in the first instance, for example, by opening it up to new groups of users. However this is realised in practice, we firmly believe the direction of travel should be towards a national system.

Etienne d'Aboville
CEO, Glasgow Centre for Inclusive Living
February 2020

Website: www.gcil.org.uk

Appendix A

Ten Principles of a Constitution for Social Care

Bartlett, J and Guglielmi, S (2009) A constitution for social care, Demos, London

I Citizenship

Everyone has the right to live a full and active life. This means being in control of one's life, and having the opportunity to participate fully in family, community, cultural, political, social and economic activities. This is known as 'full and active citizenship'.

II Equality

Anyone who needs support to live a full and active life because of a disability, impairment or old age has the right to a sufficient level of support and care that gives them the opportunity to live this life, whether those needs are temporary or permanent. This includes families and friends who care for other people.

III Access and eligibility

No one will be denied this opportunity because they cannot afford to pay for the support they need. Some people might contribute to the cost of their own care, although it will not be done in a way that discourages people from working or saving, and any contributions made will not undermine people's full and active lives

IV Friends and family

Social care supports caring relationships. It is right that friends and family support each other when needed. However, friends and family members will not be expected to compromise their own full and active lives because they have chosen to support someone.

V Equity across the country

People's right to live a full and active life will not depend on where they live geographically, or whether they live at home or in an institutional setting.

VI Choice and control

Those who require social care support, together with their friends and family, have the right to control how their needs are met, and to decide how that support is managed and delivered. They have a right to be involved in decisions that might affect their lives.

VII Independence

Those who require social care support, together with their friends and family, have the right to control how their needs are met, and to decide how that support is managed and delivered. They have a right to be involved in decisions that might affect their lives.

VIII Meeting people's needs

Social care recognises that people face different and changing barriers to living a full and active life. Everyone will need something specific to their own life and circumstances. Therefore, the aim of the social care is not to provide a set service, but to achieve positive improvements in people's lives, however, that is best achieved. To know how far this is working, success will be measured against seven outcomes (as stated in the White Paper Our health, our care, our say: a new direction for community services, Department of Health 2006),

IX Openness

Social care is a public service and is accountable to the public, communities and the people who use its services. It is open and transparent in every aspect of its work.

X Responsibility

Leading a full and active life also depends in part on people playing an active role in making it happen, by making the best use of the resources they are given, and where possible sharing what they have learned with others.

Appendix B

It is suggested here that the principles and practices of co-production, ***if conducted in the manner outlined within the 'Co-production Toolkit'***, would overcome the following barriers to involving those with lived experience of services:

- **The power relationship** between professionals and their managers on the one hand and those with lived experience of services on the other
- **The power of words**: within the co-production process plain English is required and terminology explained. Acronyms are banned, or explained if they are easier to use
- **The danger of tokenism** is avoided, as those participating are normally accountable to their collectives, unless they represent themselves within situations regarding their own support system
- **Professionals and their managers**, from the top downwards are required to be committed to the process and outcome of the process
- **Resources, time, material, and human, must be provided** a) to the process itself, and b) to support, independently, those with lived experience to participate freely and openly
- **The process can be project based, but co-production should be seen as an on-going process**, rather than a series of one-off meetings. This will enable trust, rapport, and communication to develop. Personnel attending may differ according to the agenda, but the co-production process needs to be seen as a standard management practice[7]

7 http://www.ilis.co.uk/get-active/publications/co-production-toolkit

GMB

16 October 2020

For the attention of:
Independent Review of Adult Social Care
Derek Feeley
Chair

Dear Mr Derek Feeley,

Thank you for meeting recently regarding the Independent Review of Social Care in Scotland. I wanted to follow up in writing some of the points we discussed.

Firstly, thank you for offering to meet with our members as part of your review to hear their perspectives. We are in the process of finding dates and times that are suitable to a group of members and will be in touch on those as soon as we can.

We note that no other members will be added to the panel and the point was made that the gender balance of the panel is heavily in favour of men. We know the social care workforce is made up of 83% women and we believe that the panel should reflect the workforce.

There has been a significant amount of discussion around the prospective of a national care sector or whether care should be further integrated into the NHS. Our position is clear and that is that we require any future reform of social care to deliver a significant pay rise for those in the care sector of £15 an hour for carers and associated pay rises for other roles in social care. It must also mean a levelling up of terms and conditions across the sector and lastly recognise the value the social care sector brings to society. We know that investment in social care jobs is better for the economy, better for jobs, reduces the gender employment gap and that investment would be sustainable.

GMB are very vocal about our concerns with the NHS partnership model. Particularly in NHS Highland, but also in terms of poor pay awards for hard working staff. We do not support any partnership model that has all the best intentions but is overly bureaucratic and that does not allow each union to have an effective voice. An ineffective partnership model results in staff having little confidence in the system and leads to ineffective collective bargaining. We hope that any new social care model has a trade union voice at the top table where we can genuinely influence decisions in the best interests of our members on the ground.

Another important piece of work discussed was the Fair Work's 2019 paper on Scotland's social care sector. While there are many important points made in that paper, ultimately, we would likely not be having the discussions we are today had the recommendations of that paper been implemented. Therefore, we need assurances of how this current undertaking will result in more tangible outcomes for our members.

On your question around why people leave social care, we would refer back to the report GMB produced recently, Show You Care (Full Report - https://tinyurl.com/yyt6hdc2 and Executive Summary - https://tinyurl.com/y2ftrvcs). Further, I'm sure when you speak to our members they would be willing to discuss their experiences and the demands they face on the job day to day.

We look forward to our next meeting to discuss further ethical commissioning and requirements for national contracts.

Many thanks,

Megan Fisher
Women's Campaign Unit
GMB Scotland

GMB - Second Letter

28 October 2020

For the attention of:
Derek Feeley
Chair of Independent Review of Adult Social Care

Dear Mr Derek Feeley,

Further to my previous letter, GMB Scotland would now like to put on record a number of concerns in relation to the Independent Review of Adult Social Care.

We must be clear that we have yet to be reassured that this review will yield any timely, tangible change for our members in social care.

The Scottish Government has continued to forget, and too often ignored, the voice of the social care workforce throughout this pandemic. Not only in immediate issues such as inadequate and insufficient PPE and testing, which has only just been announced for home care workers, but also in how the government is planning for the future of social care by way of the review itself.

As we have said already, charging a panel, of which 5 of the 7 members are men, and none represent the workforce, to recommend changes to a sector in which the majority of both the workforce and service users are women, is not credible. Working women's voices must be heard and men with only managerial, if any, experience of the care sector, cannot represent those perspectives. If we are serious about the ambitions expressed within the Scottish Government's "Fair Work" agenda or of our own commitment to raising the value of women's work, then we are obliged to say that this panel are not the men to do it.

There have been recent reports around the growing pressure for the appointment of a Commissioner for Older People in Scotland which, given what has occurred over the past several months, is timely. Since March, GMB have called for the Scottish Government to establish an authority which can take practical decisions in partnership and respond to the crisis in social care with urgency. This offer to work with the Scottish Government has been continually rebuffed.

It has been very evident to us that social care is the forgotten, or easiest to ignore, workforce so far as the Scottish Government is concerned; platitudes are not partnership. For this reason we have supported the creation of a Chief Care Officer to advise ministers and champion the interests of care workers within government, whilst also bringing badly needed practical understanding of social care work to the table. Too often the existing senior officers have sought to take decisions or advise about the safety of our members without their input or buy-in. No other part of the health and care workforce is treated in such a consistently patronising way.

We are also seeking assurances that the Scottish Government and the review group actually recognise the significant investment that is required in the sector in order to simply ensure that dignified and compassionate care can be consistently delivered. GMB Scotland has exposed, in our Show You Care report, the recruitment and under-staffing crisis facing the sector. We have also highlighted the huge change that members have seen in their work over the past decade. Workers in the care sector are skilled and passionate workers who are being paid exploitatively low wages.

In order to recognise the value of this work and end the recruitment crisis, we want to see a £15/hour minimum wage for carers and pay rises for other jobs in the sector. If the review considers this to be too ambitious, then we hope it will explain why our members' work is worth less than average wages. Change on the scale we need requires significant investment from the Scottish Government, and not just talk, or even applause. Neither can we carry on putting the burden on over stretched and underfunded local authorities or struggling third sector employers.

Regards,

Megan Fisher

Megan Fisher

Women's Campaign Unit
GMB Scotland Trade Union

Hanover (Scotland) Housing Association

Scottish Government Review of Adult Social Care

1.0 Context

1.1 This is a longstanding challenge where numerous previous attempts to design, develop and deliver comprehensive solutions have been kicked into the long grass. This challenge will only grow over the next decade.
1.2 The Covid crisis not only makes delivering a solution more pressing but also provides opportunities to embed and further develop some of the initiatives that the crisis has released. Staff and agencies have been imaginative, enterprising and creative and initiatives have been accelerated, - this energy must be sustained beyond the Covid crisis.
1.3 There is a strong consensus around shared strategic objectives and policy goals with regard to Adult Social Care - the challenge is creating an infrastructure that facilitates rather than frustrates the delivery of agreed strategy and policy.
1.4 We have a good idea of what the solutions should look like. (see Reshaping Care for Older People) Taking these forward requires a determined effort to overcome the vested interests and suspicions that exist between individuals, agencies and professions.
1.5 Funding is and will remain a critical challenge, made more severe by the financial consequences of Covid - but a good, integrated, personalised care service will provide the best value and best outcomes and the funding options are few and whichever is chosen requires strong, clear political commitment to endorse and deliver.

2.0 Key components of a good Adult Care system and service

2.1 Our policy goals are clear and agreed - **To optimise the independence and wellbeing of older people and adults through the caring and efficient delivery of personalised care at home or in a homely setting.** This ambition has near universal support.
2.2 Our ability to deliver against these policy goals is severely compromised by the fragmented, competitive, disjointed financial, legal and organisational infrastructure within which care giving agencies and professionals are compelled to operate.
2.3 There have been positive and significant attempts to address the above deficiencies through the introduction of Integrated Joint Boards and the move to create joint budgets - but these are required to operate within a super-structure that remains fragmented, so only has limited impact.
2.4 To achieve integrated personal care on the ground it is essential that there are integrated arrangements from the top and throughout the care systems. This starts with the Scottish Government ensuring that legal, financial and bureaucratic arrangements are designed and organised to ensure the efficient and effective translation of Government policy goals into strategies that can be delivered with maximum efficiency. Too often the present arrangements inhibit and obstruct this endeavour.

2.5 Housing MUST be seen as a key participant within the integrated care arrangements. The core of the policy goal is to sustain older people in their **own home or a homely setting** - this can only be achieved if housing interests are an equal partner in the design, development and delivery of Adult Social Care and this has not been the case to date.
2.6 Integrated financial arrangements that avoid artificial distinctions between what is defined as Health or Social or Housing must be adopted. The Scottish government should determine the Adult Health, Housing and Social Care budget and allocate it to commissioning and delivery agencies as a single budget. Sustaining separate Departments within both Scottish Government and within Local Authorities, each with their own budgets, legal arrangements and bureaucracies fragments in multiple ways and makes integrated delivery at best inefficient and at worst impossible. The Scottish Government currently splits funding between NHS, Housing and Local Authorities then expects those agencies to re-join parts of those budgets for Adult Social Care. This is bizarre, the Government should, following consultation, determine the Adult Social, Health and Housing Care budget so it is a single budget from source to be allocated to local Commissioning bodies.
2.7 Flowing from above, the legal infrastructure needs to be reviewed and harmonised to ensure mutually reinforcing arrangements exist that provide the powers and duties for the enabling/commissioning authority to design and deliver the physical and service components for a dynamic, integrated care system. At present Integrated Joint Boards are not distinct legal entities, they are accountable to local authorities and health boards that each have their own legal and financial powers and responsibilities. It creates a classic case where everyone and no-one is responsible and accountable.
2.8 Each organisation and agency involved in care provision has its own infrastructure and these are not harmonised either in terms of meeting legal and financial requirements or meeting internal bureaucratic obligations. Inefficiency, delays and duplication are built into the system as staff at all levels attempt to work their way through the care maize. It saps energy and enthusiasm, stifles innovation and protects the inefficient. The Covid emergency has necessitated the relaxing and even ignoring of some of the normal bureaucracy and this has been liberating for staff and enabled rapid and effective responses - surely there is an important lesson from this experience?
2.9 Fragmented structures compounded by distinct and sometimes conflicting legal, financial and bureaucratic systems ensure that the integrated arrangements necessary to deliver the policy goals cannot be achieved.

3.0 What is possible?

3.1 The core of achieving success in delivering the policy goals lies with a great care at home service that combines nursing care , personal care, home care and housing support along with physio and occupational therapists into an integrated service that has a well trained, well paid compassionate workforce with good career development opportunities. This is not rocket science and should be easily achieved within an integrated system. The fact that such a service does not exist anywhere in Scotland at present speaks volumes for our present fragmented system where

nursing, social and housing care and support are funded, organised and regulated through a variety of distinct bodies. Where even single professions such as OTs and Physiotherapists can be both local authority and health board employees. The introduction of Free Personal Care has gone someway to address this challenge, but still leaves artificial boundaries, arbitrary assessments and significant exclusions. We need to design a care system that can deliver this core care at home service as the norm.

3.2 Provision of a homely setting for those with high care needs is another core component of a good care system but in Scotland we rely on a legacy service from the Edwardian era - Care Homes. Residents of care homes have no legal rights - they can be evicted at the whim of the owner. The cost is a lottery, with some residents paying nothing while others pay substantial sums. The quality is variable - with the best, modern homes providing good bedsit type facilities alongside good quality personal and nursing care while most provide adequate physical and social care environments. We should aspire to better.

3.3 Very sheltered or extra care housing should be the norm for those with high care needs unable to stay in their existing home. A secure tenancy, shared equity or ownership of their own flat with care provision tailored to meet specific and changing needs within a supportive social environment that minimises the risk of loneliness is what older people with high care needs should expect. Such provision is thin on the ground not because it does not offer better value for money as well as better care provision than care homes but because capital and revenue funding is required from multiple sources and getting alignment between them to commission provision is a nightmare!

3.4 I Chair Hanover (Scotland) Housing Association and our stated aim is to provide **homes for life** with the care and support necessary to avoid the need for transfers to care homes. We actively want to develop very sheltered care establishments, however we can only commit 20% of our substantial private sector finance to such projects, the remaining 80% is committed to amenity housing which effectively cross-subsidises our very sheltered housing.

3.5 At Varis Court in Forres we have a Very Sheltered development that uniquely across the UK has NHS flats offering Augmented Care, controlled by the local GP team - in effect this provision is a modern Community Hospital set within a residential development with Dementia friendly flats. There are 33 flats - 5 leased to NHS Grampian - along with 24/7 care, lounges and full catering and day care provision. Since opening nearly 3 years ago we have had a succession of visitors from across the UK and beyond, including the First Minister. All have been extremely impressed - but to date no further similar developments have been commissioned in spite of the development being extremely popular with residents and families and providing exceptional value for money. The reason is the complexity of aligning multiple capital and revenue budgets from different agencies - the development in Forres occurred because the level of trust and commitment that had been established over a decade or more and still took around 7 years to achieve in spite

off and not because of the infrastructure we had to work through. (see appendix 1 for more detail.)

3.6 Most older people will continue to live in their current homes, hence the importance of a great care at home service supplemented by speedy delivery of aids and adaptations. Increasingly within this we must utilise the potential of technology which offers a rapidly increasing range of opportunities. We have an infrastructure that can be readily developed to support the growth of technology enabled care - the Community Alarm services that are widely available. In addition to providing the basic Alarm call service they can support a wide range of alerts and monitors, including diagnostic health monitoring, they can facilitate social interactions to offset loneliness and will continue to expand functionality and benefits. It will be necessary to rationalise the plethora of call centres that currently operate and accelerate the move to digitised provision to provide a more coherent and efficient service that joins up effectively with care at home services.

4.0 How can a great Adult Care Service be achieved?

4.1 We must focus on the core elements necessary to deliver our agreed policy goals. Supporting older people to sustain their independence in their own homes requires a great Care at Home service and availability of housing suitable for those with reduced physical and cognitive abilities along with technology enabled care - and critically these must be connected within a fully integrated care system. Integrated from the Top and through to the delivery arrangements. A unified Adult Care group at Scottish Government setting policy and overseeing the distribution of a single Adult Care budget to local integrated commissioning bodies, most obviously strengthened Integrated Joint Boards would provide a streamlined and efficient infrastructure.

4.2 Provision of a unified Adult Care Budget must move us beyond the redundant debate around whether the budget is NHS or Social or Housing Care. This distinction is usually used to distinguish if a service is an NHS “free at the point of delivery” or a potentially Social Care means tested, charged for service. This is an artificial distinction that generates all manner of confusion, for instance around Dementia Care, around the determination of when NHS continuing care should be available and when it is an NHS health visitor/community nurse or a social care home carer who provides support. The introduction of Free Personal Care has been a first step toward unifying some health and social care budgets. Budgets allocated via Local Authorities and Health Boards mean they will always be subject to competing pressures from within those bodies, hence subject to rationing and corrosive arguments regarding the level of provision from each “parent” body. Direct allocation from Scottish Government to the Integrated Joint Boards will eliminate this wasteful exercise.

4.3 The funding arrangements for Adult Care is clearly an overt political decision which covers the level of public funding to commit, how to generate the necessary

funds and the balance between public funding and personal funding contributions - and there are essentially 3 stark options
1/ continue with something similar to current arrangements - a mix a free services and means tested paid for services. This is unsatisfactory but the default option pending the agreement and commitment of an alternative.
2/ A service that is considered to be NHS provision - being free at the point of delivery and organised through the NHS infrastructure (although not all NHS services are free - so there could still be charges.) This is likely to deliver a health focused service that struggles with eligibility criteria with scarce resources. While superficially attractive it will be highly complex to achieve - are all independent and 3rd sector care homes and services to be acquired? Are all services to be free?
3/ A publicly funded service within prescribed limits with funding directed to the newly strengthened Integrated Joint Boards with local authorities providing the support service, in the way they do for Joint Valuation Boards. This is the most attractive as it provides a local focus, enables a "mixed economy of car"e to be sustained and incrementally modified and crucially supports an integrated approach.

4.4 The more significant issue relates to the level of public funding that is committed to the service. The current funding levels are not sufficient to provide the level and quality of service on a consistent basis that is desired. The options are
1/ cut other budgets to enable an increase from within current public sector budgets - not a realistic option.
2/ increase in general taxation
3/ increase in National Insurance contributions
4/ introduction of a new compulsory insurance scheme

These options were all well rehearsed by the Dilnot commission back in 2011 and their recommendations remain the least worse option, with a cap on personal funding contributions. Dilnot recommendations should be re-visited and used as the basis for future funding and charging arrangements.

5.0 Recommendations

5.1 Adult and older people's Care services must be an integrated service combining Health, Housing and Social Care
5.2 The Service must be integrated from Scottish Government through to commissioning and delivery
5.3 The legal, funding and bureaucratic infrastructures must be integrated and designed to support the delivery of agreed Scottish Government Policy goals.
5.4 The core service should be a care at home service incorporating health, social and housing support functions and providing good pay and career structures.
5.5 The development of very sheltered housing with scope for NHS provision should be enabled and encouraged to gradually supersede care homes and provide a modernised form of community hospital.
5.6 The responsibility for planning and commissioning services should be given to strengthened and remodeled Integrated Joint Boards that are given specific statutory powers and duties.

5.7 Funding for the delivery of assessed care needs should primarily be from public sources with personal contributions capped as set out in the recommendations of the Dilnot Commission in 2011.

Appendix 1 - Varis Court, Forres : A model for the future

1.0 Varis Court - a brief description

1.1 Varis Court is a development of 33 two bedroom flats for older people with high care needs located in the heart of Forres. In addition to the flats the development contains a number of communal spaces including lounges, dining area, cinema room, kitchen and office space. Six of the flats are clustered in a safe area with a particular focus on supporting residents with dementia. Five flats have been leased to NHS Grampian for use as Augmented Care Beds under the control of the local GPs. This is the only example of NHS beds located within a Housing Association development anywhere in the UK.
1.2 Care and support for residents comes through Hanover core staff plus Hanover homecare and day care staff alongside the District nurse staff who provide "on site " care for the patients in the NHS beds but also provide support to other residents if/when required.
1.3 The development cost £6.9million making each flat £210k. This is high cost when considered against general amenity or sheltered housing, but good value compared to hospital or nursing home costs.

2.0 The Varis Court vision

2.1 Varis Court is a real working example of how Scotland's Health and Social Care policies can be delivered in practice. It achieves great outcomes for residents and delivers excellent value for money. It enables independence in a good quality home with the tailored care and support necessary to achieve a "home for life" ambition. The inclusion of NHS Augmented Care flats enable those with very high health care needs to remain in a homely setting supported by their family/friends in their community at less cost than staying in a hospital bed. The inter-agency staffing delivers an "economy of integration" with a flexibility and agility that is impossible in more traditional segmented arrangements. In practice these flats support the prevention of admission to acute hospital and facilitate the timely discharge from acute settings.
2.2 Varis Court has been operational for over two years and is a model that should be replicated across Scotland. Many people have come to visit and been impressed, but to date no other similar developments have been commissioned. Why?

3.0 The Challenges

3.1 Varis Court was achieved in spite of, not because of the financial and administrative infrastructure within which Health,Housing and Social Care organisations have to operate. The infrastructure frustrates rather than facilitates the delivery of agreed policy goals.
3.2 In Moray the Council, NHS Grampian and Hanover have a long history of effective joint working which has generated trust and a willingness to take measured risks. In the context of Varis Court this enabled the Integrated Joint Board (IJB), the local GPs, Council and NHS Grampian service planners and commissioners along with Hanover to seize the opportunity and develop a shared vision and a product that could deliver the vision.
3.3 The specific challenges relate to Capital funding and Revenue funding.
3.4 Capital Funding - This came from Hanover with Scottish Government support. The Scottish Government grants are £75k per unit, which for small general needs/amenity housing is sufficient. However for more expensive projects such as Varis Court it is not sufficient. The level of private finance required necessitates a payback period that is not sustainable. Hanover can only afford to put 20% of its development programme to Varis Court type developments - effectively the remaining 80% of the programme has to off-set or cross subsidise the 20% directed to high cost very sheltered developments.
3.5 Revenue Funding - The core revenue funding is achieved through rents and service charges to cover the landlord functions, from Social Care budgets for care costs (including Free Personal Care) and from NHS budgets for rent/service/nursing costs for the Augmented Care Beds. The Scottish Housing Regulator is rightly concerned that rents and service charges should be affordable to residents (ie housing costs should be less than 30% of the resident's income) Social Care services are based on assessed needs and usually procured through a competitive tender process to demonstrate vfm. Similarly the NHS are reluctant to get tied into long term commitments when negotiating the lease of Augmented Care beds. The result of these inter actions is that Hanover holds a disproportionate risk, which is ultimately carried by Hanover tenants.
3.6 The complexity and uncertainty involved in negotiating and co-ordinating both the capital and the revenue funding is also a major deterrent to the commissioning of this model care. It is essential that the Capital and Revenue funding arrangements are modified to better fit this multi-agency model.

4.0 The solutions

4.1 Capital - The Scottish Government Capital Grant should be capable of increasing above £75k for very sheltered developments such as Varis Court. This could be either through a higher payment from the Housing Division or through a contribution from NHS Capital resources or local authority social care capital programmes. However, it is essential the scheme remains as well administered as at present - a single point of contact and a clear, transparent and speedy grant criteria and assessment process. This would suggest the best solution would be to enable an increase in grant from £75k up to £100k - £120k for very sheltered developments administered by the

Housing Division. (Behind the scenes, within the Scottish Government it is open to consider moving funding from other sources to increase the housing budget.)
4.2 Revenue - Where the IJB is commissioning a scheme with health, housing and social care services and facilities this should be a single integrated process. The IJB creates a brief and undertakes a competitive process to identify the preferred provider based on a quality and cost approach. The aim should be to identify a long term "partner" to be the main provider, and subject to quality and value thresholds being maintained there should be no need to regularly re-tender. This approach would require the IJB to pull together the budgets necessary to support the range of services and activities envisaged from the Health and Social Care agencies into a single budget. This approach should also encompass the need for continuous reviews of the range and levels of care and support services provided to meet changing needs of residents along with periodic reviews of care costs/hourly rates to ensure sustainability and vfm. The care provider can be the housing provider (eg Hanover at Varis Court) or a separate care provider thus giving the commissioners the comfort of not being tied to care provider regardless of cost or quality concerns.

5.0 A further thought …

5.1 Scotland is well endowed with Community Hospitals, however most of these are a legacy from a pre- NHS era and are in aging buildings in random locations. There is a pressing need to modernise and redesign community hospitals to ensure they are fit for the future and also to ensure they are in locations where their contributions can be most beneficial. The potential of GP controlled community hospital beds to contribute to meeting community and intermediate care needs is not being fully exploited.
5.2 Varis Court is in effect the hub of a Community Hospital, alongside the GP practice. It is not suggested that the Varis Court model should be the sole model for redesign of Community Hospitals, but it is an option that might be attractive in locations where a current Community Hospital is no longer fit for purpose and it is not possible or desirable to build a new hospital and GP practice as a replacement. The model might also work well to either supplement a community hospital that serves a wide catchment area or to provide a facility in an area with no community hospital provision.
5.3 Finally - while a new build model for very sheltered and augmented care combined is the most desirable there is no reason why existing sheltered housing developments could not be considered with a number of flats being set aside for use by the NHS/GPs for Augmented Care along with nursing and other agreed staff being located on site.
5.4 Hanover has a strategic priority to promote a hub and spoke approach to neighbourhood care, where appropriate utilising our sheltered developments to provide a "hub" to facilitate the co-ordination of statutory, community and voluntary care services and activities within the neighbourhood. The evidence from our pilot initiatives reinforces our belief that this approach makes the best use of capacity and delivers the best outcomes for communities. The Varis Court model, by drawing in GPs and community nursing reinforces and extends the hub and spoke approach in exciting ways.

6.0 Conclusion and recommendation

6.1 IJBs across Scotland should be encouraged or required to consider the strategic contribution the "Varis Court model" could make to supporting residents with high care needs to optimise their independence and well being alongside reducing the pressure on acute hospital services through prevention of emergency admissions and enabling timely discharge.
6.2 A commissioning guide should be designed that facilitates the design and procurement by IJBs of the Varis Court model and enables capital and revenue funding drawn from various sources to be integrated into a unified commissioning budget.

6.3 Hanover is passionate about continuing to develop and deliver housing and care that supports older people and achieves the ambition of a "home for life". We are keen to work with IJBs/Commissioners of health and social care and housing services to share our experiences and learn from the experiences of others. We believe the Varis Court model is an exciting option that can truly make a significant, qualitative difference to the levels of care and support that will enable more older people to continue to live independent lives at home or in a homely setting. We are anxious that Hanover and other RSLs should be commissioned to take this model forward.

Haylie House

Submission to the 'Independent Review of Adult Social Care'

Haylie House Residential Care Home

Dear Sir/Madam

We, the Trustees of Haylie House Residential Care Home, Largs, North Ayrshire wish to submit the following to be considered as part of the information and evidence gathering for the independent review of adult social care in Scotland.

Whilst we have noted the terms of reference that the review is working to, we are disappointed that the critical area of funding has not been prioritised. However, we expect that many respondents will, as we are doing, raise the subject of finance in their submission. Such is the significance of the long-term impact of funding inequalities on the quality of care for the elderly that any credible review of adult social care must include recommendations for future funding arrangements. We hope that the information provided below illustrates the need for a radical reform of funding for local authority funded residents and that this need will be addressed in the report.

Haylie House Trustees Ltd is a not for profit charity and has been operating as a residential care home since 1955. Any profits are reinvested into the home for the benefit of our residents' health and well-being and to continue to improve their quality of life. As a small care home with twenty-six residents, Haylie House Residential Care Home does not have the economy of scale of larger care homes.

In the middle of an ongoing pandemic, many care homes throughout Scotland are working in financially challenging times with uncertain futures. Haylie House Residential Care Home is in this category. It would be simplistic to say that the pandemic is the reason why so many care homes are questioning their future viability. We acknowledge there is a decrease in income because it is increasingly difficult to fill vacant rooms as prospective residents and their relatives are naturally apprehensive about taking up a place in a care home. The negative press that care homes receive from the media also does not help.

However, Trustees wish to be clear to the review panel that the pandemic is a **contributor** to financial difficulties. The true reason that budgets are stretched has been growing over several years as the funding received for local authority funded residents does not cover the true cost of care. It is common knowledge that in order to balance the books the cost of fees for private residents has been progressively increased over successive years to cover the shortfall.

This practice cannot be allowed to continue as it is masking the significant differential between the true cost of care and what a local authority pays per local authority residents. We know that the solution which would make the greatest difference to funding challenges for care homes is to match more closely the recognised true cost of care for local authority funded residents. For example, at Haylie House, the cost of care for one resident for one week is £875. Privately funded residents pay £912 per week. We receive a total of £637.29 per week for local authority funded residents with on average 31% of this sum being paid by the resident themselves and 69% or £440 paid by the local authority. Therefore, the local authority only funds 50% of the actual cost of care, resulting in a weekly deficit of £238 for each Council funded resident.

We believe that this review must make a specific recommendation that it is now an imperative for the Scottish Government, knowing the many challenges that care homes are dealing with, increases the National Care Home Contract rates for 21/22 so that long term financial viability is secured. What can be more important than ensuring our elderly residents are safe, happy and well in high quality care homes? The Trustees of Haylie House residential care Home assert that an immediate priority must be to urgently address the funding issues in care homes.

Please do not hesitate to get in touch should you wish to discuss the contents of this submission in more detail or via a virtual meeting.

Jane Golightly, Chair of the Board of Trustees, Haylie House Residential Care Home
Millar Boyle, Chair of the Resilience Sub-Committee, Haylie House Residential Care Home

04.11.2020

Health and Social Care Scotland, Chief Officer Group

Response to: Independent Review of Adult Social Care

From: Health and Social Care Scotland, Chair and Vice-Chair of Chief Officer Group

Date: 12.11.2020

Health and Social Care Scotland (HSCScotland) is a national collaboration through which those who lead change within Scotland's 31 health and social care partnerships (HSCPs) can learn from and support each other, and work collectively to deliver better health and wellbeing outcomes for the people of Scotland.

As a network of health and social care leaders, we represent:

- Chief officers
- Integration joint board (IJB) chairs and vice chairs
- Chief finance officers
- Strategic commissioning improvement managers

Health and Social Care Scotland's shared vision is a Scotland where health and social care services are delivered in a sustainable and integrated way and people receive the treatment, care and support they need at the right time and in the right setting, with a focus on community based and preventative approaches.

Health and Social Care Scotland is led by the Chief Officer Executive Group.

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Chief Officers warmly welcomed the Independent Review of Adult Social Care and have engaged with the review team to explore what's currently working well for people and staff, and areas of improvement that would benefit people's experience of health and social care services.

Chief Officers strongly endorse the view that the significant community-based response during COVID-19 pandemic, including partners, staff, volunteers and local people, was possible due to existing local integrated working arrangements, and illustrates the benefits and power of collaborative partnership working in localities.

However, this operational response to an operational emergency and the unique circumstances of COVID-19 pandemic also enabled removal of some of the challenging and cumbersome governance that Chief Officers normally work within, freeing them to mobilise with speed and effectiveness. COVID-19 has impacted service provision for our citizens, leading to service model changes, which may never revert back to pre-COVID times.

Integration is making a significant positive difference to local working relationships and improving peer connections across the breadth of health and social care

providers. Integration is an enabler for collaborative commissioning and a mixed economy approach that enables better choice for citizens, and promotes holistic and whole life journey thinking. While there is aspiration and intent towards outcome based individual planning, there is a need for aligned whole system thinking, monitoring and reporting to ensure people's rights and needs are fully met.

Along with leaders in partner organisations, Chief Officers have a combined appetite to deepen the commitment to collaboration. Entrusting the reform of the sector to its leaders by harnessing their collective insight and capacity to drive change, the better it will be for the vibrancy of the system and the people we support. We should all work together on that.

Chief Officers are keen to focus on collaboration, building on what's been achieved and partnership, that whole scale structural change is time consuming and detracts from operational focus, which they are keen to avoid.

What is working well?

- Empowered locality decision making, utilising a bottom-up engagement approach, where local service delivery is informed and co-designed with involvement of people who use services and staff who provide those services
- Realising the full potential of Christie Commission principles and community planning, appreciation of uniqueness of areas, from urban to island
- Outcome focused approaches to citizens' care and move away from one size fits all approach
- Collaboration commissioning with provider organisations, which enables mixed economy of care and promotes citizen choice

What could be improved and what are the barriers?

- Extending integrated health and social care working and ensuring full and consistent enactment of the Public Bodies (Joint Working) (Scotland) Act 2014, across all areas in Scotland
- Articulation of our shared whole-system, outcomes-based purpose with citizens' rights, preferences and needs to the fore
- Understanding that social care services provide whole-life journey support, and includes not only older adults, care homes etc
- Wider implementation of SDS and the principles of individual choice
- Significant service model change as a result of COVID-19, may have to consider increased staffing, reduction in building based services, etc
- Removing the 'postcode lottery' of funding, while not suggesting a one size fits all approach, there is currently too much variation in the system
- Understanding of significance of budget as an enabler to innovation and transformation in planning and ability to make change happen
- Consistency (not uniformity/standardisation) and quality in approach and sharing of best practice and lived experience to inform continuous improvement and service redesign

- Holistic public (and staff) messaging, including, which services when, self-management, conversation person-centred approach to ACP, POA and realistic health and social care

Barriers include:

  - Lack of full understanding/recognition of the scope of integration
  - Organisational cultures
  - Relationships and behaviours
  - Current IJB financial arrangements
  - Varying local priorities resulting in differing levels of local investment, therefore a level playing field is unachievable
  - Public expectation

Where is radical change needed?

- IJB funding model
- IJB governance arrangements
- Budget setting process
- Parity of esteem and T&Cs for staff
- National conversation with the public

This submission, in response to the Independent Review of Adult Social Care https://www.gov.scot/groups/independent-review-of-adult-social-care/, is issued on behalf of Vicky Irons and Judith Proctor, chair and vice-chair of Health and Social Care Scotland.

Vicky Irons
Chair, Health and Social Care Scotland Chief Officer Group

Judith Proctor
Vice-Chair, Health and Social Care Scotland Chief Officer Group

Health and Social Care Scotland, Chief Officer Group - Supplementary response

HEALTH AND SOCIAL CARE
SCOTLAND

Response to: Independent Review of Adult Social Care

From: Health and Social Care Scotland, Chief Officer Group

Date: 31.12.2020

As invited by Derek Feeley at a recent engagement session with chief officers, this response has been collated from comments submitted by chief officers from across Scotland. Therefore, there are differences in experience of integrated working and differences in services, depending on locality.

Each of the 31 health and social care partnerships has a unique set of integration arrangements, however, all of the partnerships have a common purpose – to deliver better health and wellbeing outcomes for the people of Scotland.

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The current system has key processes/gatekeepers to manage the finite resources available to it. These key processes do not sit comfortably with early intervention, choice, control and personalisation and a focus on strengths and assets.

1. Where should we prioritise investment in the system?

1.1 The workforce

- Equity of remuneration across health and social care staff is needed as currently there are officers employed to undertake the same range of extensive responsibilities but the pay gap between them can be significant (some post holders are employed by the local authority partner and some are employed by the health partner.)
- There is also an impact on recruiting to health posts as a result of higher salaries being offered by neighbouring health boards for posts with the same/similar responsibilities.
- Sufficient funding for health and social care services and the practice of relying on staff turnover and holding vacancies to achieve financial balance should be avoided. The priority for person-centred care must be maintaining optimum staffing levels.
- Terms and conditions of the third and independent sector employees also differ from those offered by the partners. There is a belief they are often poorer with more reliance on short fixed term employment contracts, which is mainly due to the uncertainty about future recurring funding for the sectors.
- Incentivising the uptake of pensions could help to make social care professions more attractive.
- Having sufficient capacity to release staff for professional training and development and the funding to support this.
- In addition to the funding required to harmonise salary differentials, funding would be required to invest in learning and development teams to

maintain core skills and to provide professional enhancement opportunities for social workers and social care staff.

- In respect of the enablers, Health and Social Care Partnerships (HSCPs) have little control on the extent and direction of these key resources.

1.2 **Seven day services**

- The whole system approach to service delivery should inform where there are gaps in service provision that would benefit from extended working hours for effective whole system working.
- Out-of-hours services are under particular strain, which is leading to challenges recruiting staff to work in the Out-of-hours service. When the minimum staffing complement cannot be achieved, the out-of-hours service cannot operate.

1.3 **Recurring sufficient investment in prevention and early intervention activities and services**

- There is currently insufficient funding to invest in prevention and early intervention. (The current demand for resources is to meet current service priorities.)
- The outcome of expenditure on prevention and early intervention will not be evidenced for decades – this needs to be recognised.
- Investment strategies also need to be at scale. The majority of funding on prevention and early intervention is short-term, non-recurring and fragmented. This inhibits the development and retention of an appropriately skilled workforce and service sustainability that is essential to make a difference.

1.4 **Recurring and sufficient investment to pro-actively transform services** to progress the aspirational developments across HSCPs. Recurring funding is also required to sustain and extend existing pilots, many of which are funded from non-recurring funding.

1.5 **EU-exit**

There will need to be a financial cushion to protect against the potential adverse financial implications of EU-exit.

1.6 **Prescribing cost pressures are increasing**

This area of expenditure is difficult to control and there is a high risk that availability and the cost of certain medicines may be adversely affected in the post-EU-exit period.

1.7 **Investment is required in support services** to enhance the effectiveness of front-line service delivery. Skilled and experienced finance, HR, administration and IT support services with sufficient capacity are essential to meet the strategic and operational demands of senior leadership teams and front-line services.

- There are a range of complexities and challenges across health and social care services that require to be fully understood if the correct advice is to be given and if decision-making is to be effective.
- In order to achieve savings over previous years, cuts have been applied to support services and this has led to a loss of experienced staff. This has also significantly impacted on the capacity of support services to keep pace with the extensive range of strategic and operational demands that are needed to progress transformational change rapidly and effectively.
- Quality assurance and contract monitoring is a key area of prioritisation. Often undertaken within partner organisations, it may not be given sufficient priority by the partner due to other competing challenges and demands. Additionally there may be conflicts of interest, particularly when efficiency savings are being applied to support services in order to achieve financial balance. The impact of reducing quality assurance and contract monitoring support services may not be fully assessed.

1.8 **Investment for additional management to support national workforce initiatives**
Recent investment funding made available has been invested in increasing the workforce delivering front-line services, for example mental health Action 15 funding, where the assumption is that the existing management infrastructure will cope with the workforce expansion. This assumption fails to recognise the increase in management responsibilities within a complex and challenging environment. Additional funding is required to invest in additional management and supervisory capacity to ensure the span of management control is reasonable, balanced and continues to be effective.

1.9 **Appropriate funding for demographic growth** which recognises both the increase in the number of people requiring services and also the increasing cost of care packages for adults with complex care needs. Existing recurring cost pressures need to be recognised and addressed.

1.10 There may still be a requirement for **transitional funding to facilitate the move to self-directed support (SDS)**, recognising that there are double running costs until the disinvestment decisions can be taken and funding from existing traditional models of service delivery released to fund SDS packages of care and direct payments.
Local authorities are likely still to be at different stages in respect of this transition.

1.11 **Enhanced use of assistive technology** will support all services in particular care at home services. Equipping front line staff with the latest technology will lead to improved communication and ultimately more effective outcomes for individuals.

1.12 **Investment in IT functionality** to ensure it supports front-line service delivery and also informs the strategic direction through the provision of real time, complete and accurate management information.

1.13 **The Covid-19 pandemic** and lessons learned is likely to result in the requirement for ongoing significant service model changes. There will be recurring financial implications associated with this including increased staffing and a recognition of reduced capacity in building based services.

1.14 The multiple employers across the social care landscape is complex. There is a requirement to invest in the quality assurance and contract monitoring support services and processes across commissioned services.

1.15 **Community led support initiatives** and utilising strengths that already exist in communities to support health and social care packages.

1.16 **Investment in community social care support** including new models of care in the community, which allow adults to remain independent in the community. Currently inhibited in local areas due to lack of access to capital resource for new developments, additionally interim solutions are expensive and difficult to disinvest from.

1.17 **Investment required to properly recognise the growth in demand** for social care services, i.e. more older people, more individuals with co-morbidity and the life expectancy of adults with complex needs, investment in supports and care models but also in the workforce to deliver care.

1.18 **Investment in early intervention and prevention supports**, including supports for individuals with low and moderate needs from eligibility criteria. Longer term benefits across all services is evidenced but immediacy of financial challenges and savings targets means that there is limited investment in new early intervention and prevention services and where the budget is significantly challenged these are the services which undoubtedly can fall to cuts or reductions as they are the lower risk needs that do not immediately need to be addressed.

1.19 **Adult social care needs significantly more than a regulatory and inspection approach**. It needs a focus on improvement, supporting providers of care and support to ensure improvement in the whole social care system.

1.20 **Whole system of adult social care from early intervention to full time care**, where needed – model the basic offer, with costings.

2. What are chief officers inhibited from doing / investing in by the current availability of resources?

2.1. **Local decision-making and empowerment is critical to the achievement of successful outcomes**

- Decision-making is slow and can be impeded by other people's / partner's priorities, which can also impact on both the availability and flow of funding.
- Integration Joint Boards (IJBs) now need to further evolve.
- IJB voting members are not in an independent role and have dual roles as either elected members or NHS non-executive roles. Consideration should be given to how IJB members can increase their independence and minimise / avoid conflicts of interest with the health board and the local authority.
- In addition to insufficient recurring funding, political resistance to change at a local level can be a barrier to transformational change. Disinvesting from out-dated models of care in order to release existing funding resources for reinvestment in key service priorities is challenging.
- Duplication of governance structures remains an issue.

2.2. **The current governance arrangements are complex, confusing and slowing down decision-making**

- The current management reporting lines are illogical:
    - On behalf of the IJB, the Chief Officer is required to direct the Chief Executive of a Local Authority and the Chief Accountable Officer of the Health Board.
    - The Chief Officer is then required to accept the instructions of the Chief Executive acting on behalf of the Local Authority and the Chief Accountable Officer acting on behalf of the Health Board.
    - The IJB Chief Officer then reports to both the Chief Executive and the Chief Accountable Officer in terms of performance appraisal.
- It would be informative to ascertain if there are any other organisational structures which are based on a similar complex interchangeable reporting line between the IJB Chief Officer and the Local Authority Chief Executive and Health Board Chief Accountable Officer.
- The high turnover rate among the IJB Chief Officers operating within this challenging accountability structure continues to be highlighted. (It would be informative to ascertain the turnover rate among Local Authority Chief Executive and Health Board Chief Accountable Officers.)
- A logical management reporting arrangement needs to be established for IJB Chief Officers. An option which could be explored is the IJB Chief Officer reporting directly to the IJB only and not held to account by each of the partners. This would increase the independence of the IJB and the IJB Chief Officer.
  N.B. Maintaining effective working relationships between the partners would also continue to be important.

2.3. **Strategic and operational financial responsibilities** are by necessity interlinked. The split of strategic and operational financial responsibilities does not work in practice.

- Access to financial information can be limited, particularly the financial implications of operational activities and in-year underspends. Opportunities to redirect underspends may not always be highlighted early in the financial year which could inhibit the ability to redirect the funding to other priorities.

2.4. **The statutory responsibilities of the officers employed by each of the partners did not change** when the IJBs came into existence, and officers employed by each partner are therefore still required to fulfil their own statutory responsibilities for the partner. Confusion can occur about what takes precedence – the IJB directions or the statutory responsibilities of the partners. Every effort has to be made to ensure they are compatible.

2.5. IJB Chief Officers' strategic decisions are inhibited by the reality that the **budgets will never lose their identity** while each partner has control of the partner contribution to the IJB and each partner also has budget pressures to manage across the wider local authority and health board services.

- As an example, Partner A has advised that if "their" funding is used to fund Partner B's cost pressures now, then in the future Partner A cannot be expected to provide additional funding for Partner A's own services and cost pressures if, in total since the inception of the IJB, they had already given sufficient funding overall but it was the IJB's decision to transfer part of Partner A's funding to Partner B. This discussion was in the context of officers employed by Partner A believing they had a responsibility to protect Partner A's position.
- This approach limits the IJB's ability to allocate the funding between the partners.
- In order to maintain effective and positive working relationships across the HSCP and with both partners, care is required when proposing change, the sensitivities of which are further heightened when there are financial implications.
- The reality is that the majority of change that is going to make a tangible difference will be underpinned by financial change, to some extent.

2.6. **The HSCP does not have its own support services and relies on the support services provided by each partner**.

- The partner will support their own service areas within the HSCP but will be unlikely to support the other partner's service areas within the HSCP.
- Employees are accountable to the partner who employs them. This accountability is likely therefore to take precedence over the HSCP's requirements.

2.7. **Support services are the enablers.**
There needs to be investment in the support for the IJB Chief Officer and the senior leadership teams. Support services also require to be HSCP focussed at a local and national level.

- Over many years, efficiency savings have been applied to support services – financial, HR, administration, IT and legal support services.
- The health and social care environment is complex and can be complicated to work within. The Chief Officer and the senior leadership

teams rely on sound advice and effective support from support services. Support for the implementation of tests of change and pilots and the full and comprehensive evaluation of the outcomes, including prevention of hospital admission, is critical if a proper business case is to be prepared to secure support for change from all key stakeholders. Affordability will be one of the key considerations of any proposed change.

- Financial, HR, admin and IT teams are all stretched and struggling to fully support and drive pro-active change. The reduced availability of support services staff is impacting on their ability to keep pace with the rate of transformational change. Inevitably, the change cannot progress while the funding to support the change is being sought.
- Reliance also needs to be placed on management information if available resources are to be deployed to best effect. There requires to be investment in IT systems to ensure real time, accurate information is collated and translated into meaningful management information reports timeously. Currently, the collation of the relevant management information can often be time consuming which contributes to the delays in respect of decision-making.
- Despite the recommendations set out in the Ministerial Strategic Group (MSG) for Health and Community Care Review of Progress with Integration of Health and Social Care in February 2019, appropriate support has not yet been provided to the IJB S95 Officer or the IJB Chief Officer. The main challenge is the existing statutory financial responsibilities of the S95 Officer within the local authority and the Chief Accountable Officer/Director of Finance within the health board which must continue to be complied with under the current legislative arrangements. To provide appropriate support for the IJB S95 Officer, additional expenditure would be incurred. The alternative of realigning the existing finance teams to report directly to the IJB S95 Officer would require a fundamental restructure. There requires to be careful consideration of the statutory responsibilities of all officers and how these would continue to be exercised if a different model of finance support was established.
- MSG Recommendation 2(v) stated that the existing statutory guidance should be amended by removing the last line in paragraph 4.3 recommendation 2, leaving the requirement for such support as follows:

  It is recommended that the Health Board and Local Authority Directors of Finance and the Integration Joint Board financial officer establish a process of regular in-year reporting and forecasting to provide the Chief Officer with management accounts for both arms of the operational budget and for the Integration Joint Board as a whole. It is also recommended that each partnership area moves to a model where both the strategic and operational finance functions are undertaken by the IJB S95 officer: and that these functions are sufficiently resourced to provide effective financial support to the Chief Officer and the IJB.
- The role of all support services should be to provide high quality support to the IJB; there should be no conflicts of interest. Sufficient support services are required in order to achieve this.

2.8. There is a **mixed market economy** between in-house and external care services. Reliance is being placed on social care services which are delivered by the private sector.

- Current commissioning arrangements provide an element of choice and the mixed market economy is key to offering choice. Commissioning also provides an opportunity to innovate and adopt new service models.
- Efficiency savings proposals often consider the cost effectiveness of in-house and external care services. Historically, costs have been reduced by externalising care services previously delivered in-house.
- Where an external care provider is predominantly funded by local authority funding then it may be a reasonable conclusion to reach that their profitability is dependent on public funding.
- External care providers are unlikely to have a business model which operates to a break-even target with surplus funding being re-invested in care services in particular the development of the workforce, the physical environment and additionality. External companies will be driven by profitability targets, particularly the larger companies who have shareholders. The care home sector has experienced significant challenges over recent years:
    - Southern Cross collapsed in 2011
    - Four Seasons was taken over by its creditors in 2017
    - HC-One reported that local authority funding cuts were causing a financial crisis within the care home sector, however they paid out around £48m in dividends over a two year period.

2.9. There is a view that whole scale structural change is time consuming and detracts from operational focus however governance and accountability needs to be simplified.

- Implementing the correct structure for the IJB to enable the workforce to operate effectively to deliver the changes required is critical.
- A compromise arrangement will continue to limit the HSCP's ability to deliver the best outcomes for all.
- Strong and effective working relationships between the IJB and the local authority and acute services will continue to be essential however the role and independence of the IJB requires to be asserted if transformational change is to be fully achieved.
- It should be remembered that the structure prior to the establishment of the IJBs did not achieve the required transformational change.
- The current structure has shown some shift and improvement but ongoing control by both partners is impacting the pace of change and is limiting further progress.
- Since 2016, the IJBs have demonstrated progress despite having to navigate complex governance arrangements and bureaucracy. The Scottish Government now requires to address this and commit to full and complete integration. This message of trust in and support for IJBs is critical.

2.10. **Difficulties in disinvesting resources for investment in new models**. Need a shift to creating community services that feel as tangible as buildings

and instil safety and confidence. There is community attachment to traditional models, for example, day care, which inhibits shifting resources for alternatives.

2.11. **Approach to living wage for commissioned support** is a barrier and introduces a baseline or minimum cost and drives 'time and task' oriented approach to commissioning of services, rather than encouraging fair work practices and having social care as an attractive career prospect and meeting individuals needs in a creative and person centred way.

2.12. **IJBs are inhibited from meeting the assessed needs of the whole population assessed as requiring care** due to resource limitations. All areas will operate and manage waiting lists for services and there will be a significant amount of unmet need.

2.13. Adding change funding and transformational funding *without* addressing what the true costs of providing the type of social care system consistent with the principles of early intervention, choice, control and personalisation and a focus on strengths and assets, will lead to no meaningful sustained change, no transformation and failure of aspirations.

3. How should the money flow? Ensuring a package of support to help a person live a meaningful life? What does a perfect design look like?

3.1. **The funding model must be improved**.

- Transformational change across health and social care services relies on financial sustainability and recurring funding.
- Financial planning is constrained by the uncertainty associated with one year financial settlements.
- Financial settlements need to be long term with a minimum of 3-year settlements to support longer term financial planning.
- There also requires to be improved financial sustainability for the third and independent sector if partnership outcomes are to be secured and the third and independent sector services are to be relied on with certainty.
- Allocating the funding directly to the IJB/discrete identified funding allocation from the Scottish Government would ensure the funding lost its original identity and would enable the IJB to direct the funding to progress its strategic commissioning intentions. This is the only way that the health and social care budget can be truly integrated and the pound loses its identity, this would also support improved partnership working between local authority and health boards.
- There should be parity of funding within this for health and social care services as investment in social care is eroded year on year by the challenges local government face and also the scale of demand pressures across social care services.
- There should be a re-balancing of resources across Scotland for social care (similar to the shift to NRAC parity in territorial Health Boards) to ensure areas can move to provide equity of provision across Scotland, all areas at differing starting points and have made differing degrees of progress with integration agenda due to legacy funding and investment since the inception of IJBs.
- The Health Board should be able to hold reserves. This would allow funding to be matched to expenditure profiles, which extend over more than one financial year.
- Charging policies to access social care services should not be locally determined. A national approach requires to be implemented for a fair and equitable charging regime.
- The cross-charging between health boards should be revisited and clarification sought about the value added by this process. It introduces uncertainty in the budget setting and financial planning processes and, on the basis that it is all public funding moving between health boards, it is not clear what additional benefit is gained from this cross-charging process.
- The Ordinary Residence Guidance requires to be more robust.
- Hosted services have brought additional complexities and challenges which involve complex cross boundary working with other IJBs and HSCP areas.
- Increasing demographic challenges, particularly in island/rural communities, where HSCPs are responsible for equity of provision in terms of need. Meaningful lives should ideally be fully supported, but are

necessarily subjective, a fact which is often at odds with the statutory duties and finite resources.

- SDS options including Direct Payments should remain as they are, however to achieve fairness there requires to be an equitable level of support applied nationally to meet individuals assessed needs and their support should be tailored creatively to that – i.e. we have a resource allocation system for SDS DPs which aligns the assessed support to individual needs based on the hands on delivery of traditional care packages, however this is still time and task orientated. Individuals could manage expectations and design creative solutions to meet their own needs if a financial envelope was agreed nationally for different types of support and level of need.

3.2. **The notional set-aside budget concept needs to be removed.**

- Although investment in social care is expected to reduce costs to other parts of the system such as acute services, it will not be sufficient to release budgets to transfer to the HSCP to fund community health and social care services.
- Acute services do not have sufficient resources to release funding to invest in the HSCP services that need to be established.
- The funding allocated to the IJB should be sufficient to support the HSCP service developments without relying on funding being transferred from acute services.

3.3. **There will always be a requirement to ensure best value is secured**. The unique nature of health and social care services however needs to be recognised through the further development of the procurement regulations, in particular tendering processes. Longer term commissioning opportunities should be explored to support the person-centred approach, to ensure more personalised outcomes are achieved for individuals and to allow some degree of flexibility whilst still maintaining stability. Procurement processes require to support the principles of individual choice and the implementation of SDS and direct payments.

4. Investing in the short term v long term, including articulation of proposed use of change funds / transformation funds and being able to have an alignment between population level planning, service planning and financial planning.

4.1. The **requirement to invest in demographic growth, prevention and early intervention** is highlighted in section 1.
The **challenges of transferring resources from acute services to HSCPs** has also been highlighted at section 3.2.
The **role of support services** to the alignment of population level planning, service planning and financial planning is critical to informing this relationship within complex service areas.

4.2. **Social care services is a whole-life journey.** Children and Justice Services are not mandatory services delegated to the IJB. The seamless transition between Children's Services and Adult Services is important. The impact of addictions on adults and the role of Justice Services is also relevant. Prevention and early intervention strategies need to be effectively targeted if a difference is to be achieved. Co-ordinated planning and commissioning strategies are key to achieving this.

4.3. The person, their family, their carers and professional social work advisors need to be able to put in place the appropriate support that the person requires without being adversely influenced by other considerations such as available funding. The requirement to secure best value and equitable access to quality services will however continue to be guiding principles.

4.4. Links to section 1 above. There is no/little point in having short term transformation funding when acute services are at de minimis level for safe delivery. Transformation funding, in this case, needs to be long term.

4.5. Short term:
- Investment in technology solutions for individuals with lower level need, creative solutions could be driven nationally.
- Funding for 'double running' of services for a period of time to facilitate resource release.
- Funding for 'tests of change' for individual areas to pilot new models to inform wider roll out.

4.6. Long term:
- Workforce
- Capital funding for new models of community support (sitting alongside plans to disinvest from old)
- Buildings fit for delivering services in the future (for example the care home estate).

5. Suggested national conversation with the wider public, including those not accessing health and social care services, including realistic health and care, human rights based approaches such as powers of attorney and anticipatory care planning.

5.1. **Re-launch of principles of integration**, including our ambitions to shift the balance of care and move services into communities, nationally the case for change needs to be well understood, complexity of integration structures has distracted from the clear messaging.

5.2. **Asset based approach to providing care in communities**, potentially a timely conversation to have during COVID-19 recovery when communities value health and social care services so highly.

5.3. **Communities are well placed to help shape how social care is reformed** in terms of lived experience. The role of the third sector is also fundamental in considering how social care is reviewed as the sector can bring unique and specialist service provision beyond that which local authorities provide.

- Currently, there are insufficient resources to allow the HSCPs to meet all demand therefore the contract with the public and their expectations need to be reset through the dissemination of public information.
- There requires to be a pro-active national and local public messaging campaign to set out a more realistic understanding of what public services should provide.
- There should not be 32 variations of the approach to accessing social care services which may lead to a postcode lottery.
- There should be consistency in respect of governance, eligibility and economies of scale.
- Eligibility criteria for social work services are not clear. Health provides universal services while social work services are targeted.
- The definition of 'Carer' within the Carers Act requires to be more specific.
- Public messaging to promote self-management, person-centred approach to anticipatory care planning and the uptake of powers of attorney.

5.4. Whilst the democratic mandate is a key dimension to all public services, the election cycles will influence the timing of change and may be a barrier to progressing transformation depending on the perceived public response to proposals.

- Where there is real or perceived resistance to change from the local community and the general public, there is a risk that the proposed change becomes an election issue. This can be detrimental to securing the best outcome for the service users cost effectively.
- Consideration of who is best placed to shape the future of health and social care services should be explored. This should include an awareness of stakeholder professional qualifications, the lived experience of people receiving the services, the efforts of the workforce delivering the services, affordability and the achievement of best value.

5.5. There requires to be realistic and responsible media reporting of health and social care matters.

Health and Social Care Scotland, IJB Chairs and Vice Chairs Executive (IJB Executive) and IJB Chairs and Vice Chairs Network

HEALTH AND SOCIAL CARE
SCOTLAND

18 September 2020

Dear Mr Feeley

The IJB Chairs and Vice Chairs Executive (IJB Executive) represent a network of Integration Authorities in Scotland. The IJB Executive welcome the review of Adult Social Care and prior to our meeting on 22 September, offer this written submission as an initial contribution to the review. The experience of our network members will be invaluable in contributing to the review and as such we would welcome further direct involvement as the review progresses. In particular, our experience of strategic planning and commissioning of HSC staff integration, home care initiatives, connections to the community and community representatives built up over the last 4 or 5 years are all excellent foundations to build on.

In spite of the excellent contribution of IJBs much has been written about the challenges preventing us from realising the maximum potential of integration of health and social care services. The attached report provides an overview of how we can realise that drawing particularly on the experiences during the COVID-19 pandemic.

The information from which the report was collated included a questionnaire responded to by national organisations who have first-hand experience of working with IJBs. Information was also drawn from three separate engagement meetings held over Teams with current Chairs & Vice Chairs convened during July and August.

A distillation of the responses provided suggest some key themes.

Key Themes:

- Funding
- Clear patient pathways to ensure best route to care and avoid A&E
- Support for all care at home / homely setting intentions
- Guidelines for practices eased during Covid should continue (where appropriate)
- Human rights / person centred approach to strategy and service re-design
- Inequalities should be at the forefront
- Partnership working including communication, representation, engagement and involvement in strategic planning
- Data improvement for practice and planning, and improving sharing of data
- Less red-tape and bureaucracy
- Enhanced use of assistive technology to support care at home

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SCOTLAND

It also provides detail on the most significant challenges to delivery of the expectations set out in the Public Bodies (Joint Working) (Scotland) Act 2014 all of which have remained stubbornly similar for a considerable period. These are:

- Commitment to collaborative leadership and building relationships
- Integrating finance and achieving realistic medium term financial plans, especially in context of Covid settlements'
- Effective strategic planning for improvement
- Agreed governance and accountability arrangements
- Ability and willingness to share information
- Meaningful and sustained engagement.

To varying degrees these issues have impacted upon the successful delivery of adult social care within the existing constraints. It is understood that the Review will cover social care in all settings, and will be developed from identifying the needs and preferences of the people who need services. Any on-going involvement of the Chairs & Vice Chairs would be aided by some more clarification on the scope of the review in the following areas:

(i) Policy and Strategy

Clarity on the span of social care services to be under review. For example what is the future modelling of non-home based provision? How much care and how will it be delivered - nursing home (public, private, voluntary sector), sheltered housing, very sheltered, core and cluster, hub and spoke, palliative.

(ii) Commissioning and Regulation

If we assume residential care - what standards prevail across the sectors, including health and social care standards prior to and during the COVID-19 pandemic?
What has been the adequacy of compliance control arrangements of commissioned services?

(iii) Finance

- Identification of the 'national purse' and its shortfall over time of the whole - community and residential sectors.
- How do we address the variation of the terms and conditions across the sector?
- How will the infrastructure costs be addressed?
- Do we envisage a continuation or otherwise of the current mixed economy?
- The value of Free Personal Care and SDS to the public, to the public purse, and to addressing poverty.
- Debate around the multiplicity and overlap of governance arrangements across Local Authority, NHS Health Board, JB and third and independent sectors.

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SCOTLAND

(iv) Review Outcome

If the stated political will is 'mindful' of a national Social Care service:

- What would it look like?
- Can a national care service fulfil the principles of individual choice at the heart of integration?
- Is it affordable?
- How would it be governed and regulated?
- How would it align with NHS Scotland?
- How would it align at local levels?

With all of the above there is clearly much to be done. The future contribution of IJBs will be key to any change in the provision of adult social care. The IJB Executive are well placed to assist in a number of ways to the review. In particular, as the conduit to the wider IJB C&VC Network and as an excellent reference group for the review.
We look forward to meeting with you on 22 September and picking up on the points above.

Yours sincerely

Peter Murray
Chair of IJB Executive
Vice Chair of East Lothian IJB

Vice Chair of IJB Executive
Chair of Argyll & Bute IJB

HEALTH AND SOCIAL CARE SCOTLAND

REPORT FOR THE INDEPENDENT REVEW OF ADULT SOCIAL CARE

IJB CHAIRS AND VICE CHAIRS NETWORK
SEPTEMBER 2020

SUMMARY

The IJB Chairs and Vice Chairs Network (IJB Network) welcome the Independent Review of Adult Social Care. The experience of IJB's will be invaluable in contributing to the Review. IJB connections to the community and community representatives that have built up over the last 4 or 5 years have provided an excellent foundation for integration and can be built upon. However, questions remain on whether the IJB governance arrangements are the most effective way to allow these foundations to be further developed.

This report sets out how the existing governance, structural and community facing aspects of IJB's have been effective but also shows some areas where there is opportunity to improve. This report doesn't specifically speak to the issues covered in the Review Terms of Reference but takes account of all of the current IJB responsibilities.

It seems reasonable to assume that there will be an increased demand for care in the community. Previously, this would have been assumed on demographics, however COVID-19 has introduced an added pressure of delays in access to hospital treatment which is likely to bring increased care in the community. The priorities of IJBs will need to address this additional demand and consider what ways of working are required to ensure there is high quality care available for service users that can be delivered effectively, efficiently and sustainably.

This report contains some background information, an overview of IJB progress to date, key strategic priorities that have been identified by the IJB Network, and finally, there are a range of identified actions and opportunities for IJBs to progress (as appropriate and determined on a local basis) as well as suggestions which require external support.

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INTRODUCTION

Integration Authorities are responsible for the planning and delivery services that provide quality sustainable care for people in the community or in a homely setting. This supports the Scottish Government priority areas of early intervention and prevention towards reducing unnecessary hospital admissions. There are two models available under current legislation – (i) lead agency where the health board and local authority can delegate functions between each other or (ii) body corporate where the health board and local authority can delegate to a third body called the Integration Joint Board (IJB). At present, Highland is the only area which has opted for the lead agency model – further detail on this is provided in a case study below. There are a further 30 Integration Joint Boards across Scotland based upon local authority localities (Stirling and Clackmannanshire have one board).

The IJB Network (which includes a representative from Highland) submit this report as a collective contribution to the Independent Review on Adult Social Care. It represents the views of the majority of IJBs and considers the inputs from national organisations (see Appendix 2) who are aligned to our strategic planning responsibilities. The IJB Network is grateful to all contributors for their considered and measured suggestions.

This submission supports the central tenets underpinning the Public Bodies (Joint Working) (Scotland) Act 2014 and those developed since the Act came into force:

- **Social wellbeing is our guiding vision**
- **Individual responsibility is central to our plans**
- **All health and social care services should be seamless to the recipient at the point of delivery**
- **Services should be the product of shared strategic planning with key partners, communities and service users.**

To maximise wellbeing, planning must be grounded and focussed upon inequality in all its forms. As IJBs work with Health Boards, Local Authorities and the Third and Independent sectors, we hold to the ambition that our valued workforce should operate on a multi-agency, multi professional basis. Such is one key feature of integration.

This paper presents the principles, values, leadership and culture statements from which the IJB Network strategic contribution is offered. It contains:

i. **an analysis of how far IJBs have come and how far they still have to go.**
ii. **the main strategic areas IJBs wish to commit to and prioritise**
iii. **some of the main challenges and opportunities for IJBs.**

BACKGROUND

The IJB Executive invited a range of national organisations to share their views on how IJBs could revise or replace existing strategic plans for the recovery from COVID-19 and beyond (see Appendix 2). The key themes from the partner organisation submissions include:

- Funding
- Clear patient pathways to ensure best route to care and avoid A&E
- Support for all care at home / homely setting intentions
- Guidelines for practices eased during COVID-19 should continue (where appropriate)

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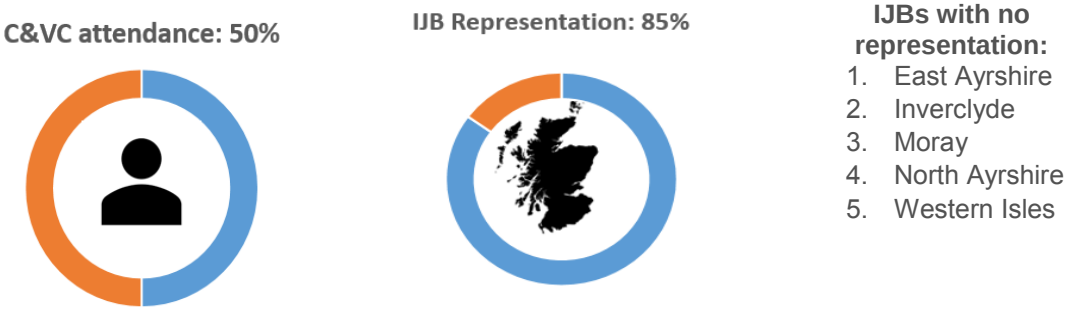
- Human rights / person centred approach to strategy and service re-design
- Inequalities should be at the forefront
- Partnership working including communication, representation, engagement and involvement in strategic planning
- Data improvement for practice and planning, and improving sharing of data
- Less red-tape and bureaucracy
- Enhanced use of assistive technology to support care at home

The responses were shared with the IJB Network to inform discussion in a series of virtual meetings. The aim of these sessions was to reach a collective view on:

1. **How IJBs should influence health and social care policy, delivery and support for the response to the COVID-19 pandemic.**
2. **Longer term sustainable changes which will impact upon adult social care.**



ANALYSIS OF HOW FAR IJBS HAVE COME

While power is legally vested in IJBs, in practical terms this has not always been recognised across all IJB localities. IJBs have been criticised for not operating at the expected levels of effectiveness and for the pace of integration being slower than desired.[1] However this should not undermine the contribution IJBs have made to integration thus far, nor should it detract from the potential IJBs have to further support health and social care integration across Scotland. Although some IJBs may be lacking maturity, generally IJBs are well-placed to invite greater involvement from communities in decision-making and reduce some of the impact of the wider democratic deficiencies being experienced by some communities. IJBs have a broad open membership and can make independent decisions removed from politics and personal views.

The challenging circumstances that IJBs operate within have been well-documented[2], however they have also had many effective outcomes – both before and during the pandemic. Some examples are described in more detail in case studies below:

- Highland lead agency model
- Effective partnership working through the North East Steering Group

[1] MSG Review of Progress of Integration of Health & Social Care
[2] Audit Scotland Paper on Integration and MSG Review of Progress of Integration of Health & Social Care

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IJB NETWORK STRATEGIC PRIORITIES

During the IJB virtual meetings a range of common strategic priorities emerged. These are not ranked in any order of priority, nor will they be of equal importance in each locality and there will be additional priority areas particular to some regions. However, this list can be used as a general consensus of key priorities for the majority of IJBs. These priorities had been identified prior to the pandemic, but may now be considered as more urgent due to COVID-19.

1. WHOLE SYSTEM APPROACH

Health and social care is widely recognised as being most effective when centered on a 'whole system' approach. A whole system approach includes working with communities and stakeholders to understand problems and identify solutions. Some believe it goes beyond the usual scope associated with health and social care and extends to poverty, housing, employment and other contributors to health and social inequalities. Clarity and definition of 'whole system' would be helpful as IJBs review their strategic plans and priorities.

The experience in the response of IJB's during COVID-19 have ensured IJB Members across Scotland are well placed to provide some observations on the interconnectedness and common purpose which has seen remarkable improvements in some areas. Examples of this includes the strong relationships established by staff from different organisations, the lowering of risk tolerance, data sharing to support decision-making for service users, and new digital methods being utilised to continue patient care. Lessons learned from systematic changes should be used to inform the identification of new patient pathways. However, these pathways should also consider the needs of each individual beyond their immediate health needs. IJBs will reflect on this as they review their strategic plans.

2. SOCIAL ISOLATION & LONELINESS

The impact of social isolation and loneliness upon individuals and communities is well documented as a having a huge impact upon peoples' health and wellbeing. The experience of lockdown between March and July has emphasised this and shown it exists on a wide scale. The community response and community resilience demonstrated during lockdown has been recognised by the IJB Network as a vital contribution to the pandemic response. IJBs, the Third and Independent Sector, and local communities should work in partnership to sustain and develop community support systems to support those experiencing social isolation and loneliness.

3. MENTAL HEALTH AND WELLBEING

The full impact of the pandemic upon mental health and wellbeing is unknown but is expected to be great and long-lasting. The IJB Network recognise the importance of planning services to support service users and their families, unpaid carers and health and social care staff with their mental health. Burnout and PTSD among staff are areas to be considered as well as a range of short and long term and flexible support options.

Prevention and early intervention are particularly relevant to mental health service provision as well as identifying pathways to appropriate care settings and not using A&E as a default first point of access. In their response to the questionnaire, Scottish Ambulance Service state they are keen to see greater joint working to support better patient care and to support patients with their choices about care options.

NHS24 also say that data from their Mental Health Hub could be shared to inform IJB decisions around mental health and wellbeing.

4. INCLUSIVE PLANNING AND DECISION MAKING PROCESSES

One of the strengths of IJBs is their links to the local community and the bespoke arrangements in place to serve their local area. Local people have a better understanding of the specific needs of their community. Where communities are involved in decision-making, their support of projects and decisions means they are more likely to have successful outcomes. Greater community engagement and participation with IJBs should be encouraged with a longer-term aspiration to achieving co-production in strategic planning and decision-making. Co-production is an aim in many areas in Scotland and beyond, and IJBs need to invest in this approach, learn from successful initiatives in areas such as community planning, and look for best practice on a global scale if there are to be significant steps made towards achieving co-production.

During the IJB virtual meetings various approaches to strategic planning were discussed including a human rights based approach and a needs based approach. Person-centred decisions rather than process-driven decisions is one topic to be considered for Board Member development to ensure there is a better understanding of these models and how to apply them in the health and social care setting.

IJBs should ensure they are open and accessible, decision making processes are transparent and scrutinised, and information is available in a range of formats and languages. This aligns with the indicators in the National Performance Framework on decision making. IJBs should invest in opportunities for the community to fulfil their obligations in the Community Empowerment (Scotland) Act 2015 by ensuring greater involvement from communities – both geographical communities and communities of interest – communities experiencing socio-economic disadvantage, and, health and social care inequalities.

5. PARTNERSHIP WORKING

The submissions received to the questionnaire on adult social care from national organisations have presented opportunities to explore working with national partners in a more meaningful way in the future. For example, Scottish Ambulance Service state they are often omitted from engagement and consultation activity and are keen to work jointly and look at better ways to share data. Greater working with national partners will not diminish local relationships, local partnerships, local planning or local services but will allow IJBs to identify common strategic areas with partners which will inform local decisions and implementation. Initial steps are being taken to explore options with some national partners as a result of the social care questionnaire. There will be opportunities for the IJBs to work with partners on a collective basis either nationally or within a health board locality, or more specifically where disaggregated information and data can be used to support local decision-making.

Greater inclusion of the Third Sector in IJB planning and decision-making is discussed in more detail below.

6. HEALTH AND SOCIAL CARE STAFF

During the IJB virtual discussions, Chairs and Vice Chairs praised the commitment from health and social care staff during the pandemic response and acknowledged the sacrifices made by staff and their families. Issues around pay and terms and conditions of health and social care staff were recognised pre-pandemic but the pandemic response has brought this issue to the attention of the public – particularly for social care staff - in a way that hasn't happened before. The IJB Network recognise that staff are key to the successful delivery of quality care. There must be improvements in various areas including working conditions for staff, skills investment, and a social care being viewed as a valued

career. To date, attraction and retention of social care staff has been a problem. It is important social care staff can enjoy a long-term career with stability, clear pathways and progression. IJBs want to present social care careers as well structured, suitably supported and remunerated appropriately.

7. INEQUALITIES

Much has been written about the disproportionate outcomes of COVID-19 upon some groups of people including women, disabled people, BAME people and those living in more deprived areas. Consideration of health and social care inequalities should be built in to the decision making processes used by IJBs. Although Equality Impact Assessments and other tools are currently used, inequalities should be build into each stage of decision-making to ensure there is a more robust process.

IDENTIFIED CHALLENGES & OPPORTUNITIES

GOVERNANCE

Many people involved in health and social care have recognised a reduction in bureaucracy and red tape as one benefit of working in the circumstances brought about by the pandemic response. In their submission to the questionnaire, the Care Inspectorate noted that a "more permissible mindset by leaders and Scottish Government"[3] was a contributing factor to better joint working. It is important to note that bureaucracy and governance are not the same thing and scrutiny of decisions is essential even at times of crisis. There are a range of governance structures across IJBs and a local, bespoke approach underpins the fundamental purpose of IJBs and the flexibility required to address local need.

The Ministerial Strategic Group Review of Integration[4] recommended strategic partners review their decision-making arrangements to avoid duplication. From Chief Officer commentary[5], responses to the adult social care questionnaire[6], and IJB virtual discussions, duplication of governance structures remains an issue.

IJBs determined their own solution to governance arrangements in response to COVID-19. These changes tended to fall into two categories:

(i) continue with scheduled IJB meetings using virtual options
(ii) delegate duty to Chief Officers with regular meetings with a smaller number of Board Members – typically the Chief Officer, Chair and Vice Chair on a weekly basis, combined with regular briefings and updates to Board members.

Some members of the IJB Network reported this second solution (and variations of this model) with regular briefings and greater access to information and data led to better informed board members. Although this information was operational rather than strategic, it afforded a greater understanding of the circumstances, challenges and successes within the HSCP due to having access to high quality information shared in real time. However, there remains concerns about the IJB role during the 'command and control' stage of the response to the pandemic, risk tolerances applied and the levels of scrutiny that were possible.

[3] See Appendix 2
[4] MSG Review of Progress of Integration of Health & Social Care
[5] Lessons Learned from Reducing Delayed Discharges and Hospital Admissions
[6] See Appendix 2

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In their response to the questionnaire, Scottish Care say "there should be further exploration on the role of IJBs in a crisis"[7]. The role of IJBs during this period of crisis-management has varied nationally. Inclusion of IJBs in the development of Re-Mobilisation Plans was inconsistent, however the invitation to participate on the Mobilisation Recovery Group[8] was welcomed. IJBs are key stakeholders in the redesign of health and social care and a national commitment to include IJBs in this process should be agreed.

IJB actions	IJBs to consider local arrangements to ensure IJBs have an agile governance structure that can react quickly and effectively to local conditions and needs. Where appropriate, this includes inviting statutory partners to formally review their governance arrangements to ensure there is no duplication of decision-making arrangements for delegated functions. IJBs to focus on strategic decision-making and impact, not operational decisions.
Additional support	Scottish Government to consider guidance on appropriate governance arrangements for IJBs should a situation arise similar to the first phase lockdown of the COVID-19 pandemic response. This would allow a consistent approach which protects the governance status of IJBs for delegated areas of responsibility and also provides sufficient flexibility to respond to the needs of the pandemic. Formal review of the current integration model to ensure it remains fit for purpose to fully deliver integration in a sustained way. Ensure IJBs are included and consulted as key stakeholders in strategic decision-making at local and national level.

TECHNOLOGY, DATA & INFORMATION

IJBs recognise the many benefits from the innovative and increased use of digital options during lockdown. In their response to the questionnaire, Scottish Ambulance Service support digitally focussed assessment methods as they can efficiently and effectively reduce pressures on services[9]. However, broadening the use of technology requires assurance there is adequate access to devices and education available for service users. New technologies should be embraced but alternative pathways must be available to ensure technology is not a barrier to access care.

IT may present a barrier to integration due to different digital infrastructure and incompatible systems between key partners who operate as separate organisations. The lack of consistency and compatibility is a source of frustration among staff from different organisations who are unable to fulfil their integration potential due to IT frustrations. Delays in the roll out of national contracts for delivery of broadband in rural and remote communities limits integration potential in some localities.

There is national inconsistency in the frequency, quality and availability of information and data for IJBs. To allow IJBs to make fully informed strategic decisions, these must be based on high quality and complete information being made available in useful and timeous formats. There is often a focus on providing data on outputs rather than data which measures outcomes and impact. Public Health Scotland, are in a position to support IJBs with local planning requirements through providing a range of analytical supports, and access to data.

[7] See Appendix 2
[8] Mobilisation Recovery Group
[9] See Appendix 2

The flow of information between IJBs and partners is a recognised area for improvement. For example Scottish Ambulance Service have disaggregated data at locality level which could aid IJB decision-making. Finally, Professor Bruce Guthrie[10] and others have noted that having a greater understanding of residents of care homes and their needs and pattern of service use would allow for better consideration of commissioning services to address local need.

IJB action	A data working group is being established to review the quality and consistency of local data made available to IJBs. Key partners are being approached to identify opportunities to share data and information relevant to local decision-making e.g. Scottish Ambulance Service. Explore opportunities with Pubic Health Scotland both locally and nationally through the IJB Network.
Additional support	Consider national standards to ensure appropriate IJB access to consistent and accurate local and national data. Share any findings from engagement to assess impact of new technologies on service users and staff.

WHOLE SYSTEM APPROACH

Discussed above as one of the strategic priorities for IJBs.

IJB actions	IJBs should continue to identify and share best practice where a whole system approach has been used. IJBs should capture information where non-medical pathways and alternatives to acute care which emerged during COVID-19 response. These should be examined for sustainability, duplication and appropriateness. Consider what learning could be applied from other 'whole system' approaches e.g. Community Planning. IJBs should use a Human Rights and person centred approach to decision-making and strategic planning.
Additional support	A clear definition of what a 'whole system approach' is for health and social care integration. IJBs should be considered as a key stakeholder in the development of remobilisation plans to ensure there is a focus on integration.

CULTURE, LEADERSHIP & BOARD MEMBERS

Throughout the IJB Network discussions, the improved relationships between staff from different areas has been cited as a key benefit resulting from new ways of working during COVID-19 and one that should be retained. Relationships have been identified as one of the foundations of success in the North East of Scotland case study below. It takes time and investment to build trust and develop relationships however, the shared common purpose and the rapid response to COVID-19 has advanced relationships at an unexpected and unusual pace. There may be temptation to revert to old behaviours and previous

[10] See Appendix 2

patterns and IJBs should support staff to maintain these new relationships and retain effective new ways of working.

Collaborative and compassionate leadership models are recognised as a preferred leadership style therefore IJB members need to be educated further and supported to commit to this style of leadership.

The high turnover of Board Members and Board Member development have previously been considered as areas of improvement and they remain priority areas for the IJB Executive Group through peer support and board members training opportunities. IJB Members may struggle with the challenging task of separating their independent role as IJB members from their Elected Member or NHS Non-Executive role. IJB members need support and development to ensure appropriate challenge and evidence based decisions by IJBs.

The IJB Network has played an important role in enabling Chairs and Vice Chairs to share challenges and successes and become more informed about good practice. The potential of the network in developing the leadership role of Chairs and Vice Chairs has been significantly strengthened by the funding of a part time strategic officer. The virtual network sessions were well received and more frequent opportunities for IJB Chairs and Vice Chairs to interact are being identified, particularly with people in different geographical areas who are less likely to be in regular contact with their IJB peers. A programme of themed virtual sessions is being developed to look at topics such as locality planning, governance and National Health and Wellbeing Outcomes Framework[11].

The ALLIANCE have challenged how open, accessible and inclusive IJBs are and whether IJB Board Membership is diverse enough. This could be addressed through local publicity to encourage participation or more broadly through a national campaign to raise public awareness of IJBs, the role of IJBs and how communities can be more involved in the work of IJBs. Scottish Care challenge whether integration can be achieved without inclusion of the third sector and they, along with Inclusion Scotland recommend Third Sector representatives should be included as voting members in IJBs.

IJB actions	Work with NES colleagues to create a development programme to enhance Board Member skills and learning e.g. compassionate leadership. IJB Board Members will be signposted to existing training materials e.g. those available from the Standards Commission and on TURAS. Explore coaching and mentoring schemes for members of the IJB Chair & Vice Chair Network. Work with NES and the Improvement Service to develop induction materials for new IJB Members. Schedule a programme of themed IJB Network virtual meetings to allow for more frequent, inclusive interaction among IJB colleagues. This will evolve into a blended model when face to face engagement resumes. Continue to identify best practise case studies and share through the IJB Network e.g. in the IJB Newsletter and in the online library.
Additional support	Identify leadership and development opportunities for Board members to fully understand their role and contribution expectations. Consider a process to assess performance of IJBs. Consider a national campaign to raise public awareness of IJBs and how communities are represented to encourage more diverse appointments to IJBs and greater interest and involvement in service design and decision making.

[11] National Health & Wellbeing Outcomes Framework

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	Consider reviewing voting membership of Boards to include Third Sector representation.

INTEGRATION AND THE PACE OF CHANGE

Integration is universally seen as the 'right' thing to do, but a clash of cultures and struggles related to power and control often hinders progress. The pace of integration has been accelerated as a result of different ways of working necessitated by the COVID-19 response. Although this positive change is to be welcomed, it is important to note that some of these changes had been planned by IJBs as part of the transformation agenda and were re-prioritised or accelerated due to the pandemic. Changes brought about as a result of the pandemic may not be sustainable due to funding, staffing levels and the resuming of paused services. New processes, systems and ways of working should not automatically be considered as the 'new normal', but should be examined to ensure they are not a replacement or duplication of a previous process, and whether there are long-term implications which have not yet been considered due to decisions being made under pressure. Good practice should be identified, embedded and shared with other localities.

IJB actions	IJBs need to work with Local Authority and NHS colleagues to consider prioritised change programmes in a sustainable manner. IJB Network to continue to share best practice examples e.g. through the IJB Newsletter.
Additional support	Clarity from Scottish Government on the expectation of the next phase of integration and implementation of the Framework[12]. IJBs to be considered as key stakeholders in the Independent Review of Adult Social Care and should be included in the next steps to implement recommendations where appropriate.

COMMUNITIES, ENGAGEMENT & LOCALITY PLANNING

The tremendous effort and contribution from our communities during lockdown must be recognised to ensure there is a proper role for communities at all times, not just in times of crisis. The views of local communities are represented at strategic level through the role of non-voting members of IJBs. However more could be done to ensure there is meaningful participation in decision-making as outlined above. Strategic plans are shared and offered for feedback through officially recognised channels but there is little evidence that the feedback received is used in any meaningful way. Robust processes should be introduced to ensure IJBs are open and accessible and information is made available in a range of formats and languages. IJBs should encourage greater participation from under-represented groups which includes people with disabilities, people with long term conditions and unpaid carers.

Locality planning was one of the foundations of the guidance issued in 2015[13]. There are variations across IJBs as to what is in place to meet the aspirations of the Christie Commission Report[14] - specifically that planning should be from the bottom up and not the top down. Locality Planning is one of the priority areas for the IJB Network to address.

IJB actions	Build robust and inclusive engagement and participation methods into strategic planning processes, working with Third sector partners as appropriate.

[12] National Health & Wellbeing Outcomes Framework
[13] Public Bodies (Joint Working) (Scotland) Act 2014: statutory guidance
[14] Commission on the Future Delivery of Public Services

	Greater IJB engagement with partner organisations in the Third Sector as well as greater engagement with communities would result in targeted locality plans focusing on where need is greatest to tackle inequalities
Additional support	Investment and funding for the Third Sector to offer training and support to communities to facilitate an increase in community participation and contribution to IJB planning and decision-making.

CARE PROVISION AND REMODELLING OF CARE

Much has been written and discussed about care homes and care at home during the pandemic. This was a key theme in the submissions from national organisations and in the IJB virtual discussions where there was a view that care homes were 'done to, not done with' during the pandemic. Local relationships played a key role in supporting care homes and a bespoke approach to support the COVID-19 response based on the needs of each care home was essential. To preserve the success of this local approach, the IJB Network supports the development of national standards for funding, data sharing, regulation and staff, which should be implemented and monitored locally.

IJBs could focus on early interventions and prevention provision - including models to provide care at home and rehabilitation at home services for people leaving hospital - to support people to remain at home rather than move to a care home setting. Identification of alternative pathways to reduce unnecessary admissions should be developed at local level to ensure efficiency and effectiveness of care provision for service users and their families.

As stated above, the importance of relationships cannot be underestimated and relationships with care homes at a local level have been vital as part of the COVID-19 response. Also stated above, effective use of data is important and sharing intelligence at a local level will allow for greater oversight to inform strategic decisions and commissioning related to care homes.

IJB actions	Build upon existing relationships with local care homes and take a bespoke approach to support the specific needs of each one and identify commonalities at local level. Consider flow of data between IJB and local care homes to get a better understanding of the needs of residents. Also, to use local data to develop more appropriate pathways for people by working with other partners e.g. Scottish Ambulance Service.
Additional support	Consider national standards and models of funding, regulation and delivery to be implemented locally.

IJB RELATIONSHIP WITH ACUTE

IJB's have a significant number of acute based services delegated to it. It is very clear that this has been the most difficult area to execute with any great impact. The lack of true accountability in the unscheduled care treatment time guarantee is an often cited example where despite the delegation of unscheduled care to IJB's, the responsibility to achieve the 4 hour guarantee lies with the Chief Executive of the NHS Board. It could be argued that it is a lack of invention or boldness which has led to little significant use of Directions from IJB's which alter the way in services currently provided in acute hospitals. What is clear is that a strong relationship to any remodeling of adult social care will require to reach into and partner with acute hospital services. Much has rightly been made of the whole system approach. The review will need to explore any ineffectiveness of the current integration arrangements

to avoid breakings bonds which have been formed between the community services and acute, particularly during the COVID-19 period.

IJB Actions	IJBs will continue to build upon relationships and progress with change programmes and local priorities. IJB representatives will continue to input to the Mobilisation Recovery Group and feed in as appropriate.
Additional Support	Consideration of structures and governance arrangements for delegated acute services.

FUNDING & COMMISSIONING

Finances have been a key issue in the response to the pandemic. Clarity from Scottish Government over budgets should be provided as soon as possible to allow proper planning for COVID-19 recovery and beyond. In the MSG Review of Integration[15], it was stated that "resources held by IJBs lose their original identity and become a single budget". While IJBs are accountable for their spending, tensions remain around budgets and the percentage each of the statutory partners contribute to the IJB pot.

Community and service user participation in financial decision-making should be increased and potential areas identified for pilot schemes to promote co-production and more participatory budgeting initiatives in areas such as community health. Communities should be supported to have a stronger role in influencing finance decisions and commissioning of services which was widely supported in the responses to the adult social care questionnaire including the Alliance. The Alliance also suggest a model that favours more long-term commissioning as much time is wasted on tendering processes. Flexibility of funding is also a key theme and Social Work Scotland suggested more personalised commissioning processes would support the person-centered approach through empowering individuals to make their own choices.

In their submission to the consultation, Social Work Scotland suggested that IJBs should consider greater inclusion of the Third Sector, including local micro providers, in their commissioning framework. CCPS suggest that that more long-term commissioning would remove the burden of constant tendering exercises and allow a degree of stability.

IJB actions	Develop robust methods to allow for greater community influence and engagement for financial decisions. Consider commissioning with a greater focus on needs of people, rather than focusing on economics.
Additional support	Scottish Government to provide funding and budget information as soon as possible. Review of funding processes in place.

REGULATORS

There have been reported inconsistencies from regulators during the response to the pandemic. For example, an inconsistent approach to rules around respite care during lockdown proved problematic for particular IJBs. The decisions of the regulator were attributed to the IJB which lead to service users and their families questioning the commitment of IJBs and whether they were prioritising people's welfare.

[15] MSG Review of Health & Social Care Integration

Regulators should be invited to engage with IJBs to support integration of social care staff to work together whether they be from the private, public or third sector. SSSC say there is potential to link data and workforce data to support a range of activities including strategic planning and quality improvement[16]. IJBs often appreciate that regulators are well placed to identify problems or areas for improvement that IJBs can address, and IJBs would welcome advice or suggestions of appropriate solutions.

In their response to the questionnaire, the Care Inspectorate note that they, along with SSSC, were able to adapt to the circumstances necessitated by COVID-19 and relax some processes to allow greater flexibility for staff and services. This is perhaps a contributing factor of the reduction in red tape and bureaucracy alluded to above.

IJB actions	Improve use of data and information from regulators to inform workforce planning e.g. the workforce planning guidance co-produced by SSSC, Scottish Government, the Care Inspectorate and COSLA.
Additional support	Evaluation of changes to regulation requirements during the pandemic response.

CONCLUSION

If integration is a movement it is also a journey, one that will remain in constant and incremental process of development. The pandemic has paradoxically afforded a unique opportunity - to accelerate progress towards a truly integrated, high quality health and social care service. IJBs remain integral to this process including as the key route for the community to participate. IJBs are committed to the community having a role in decision-making and strategic planning, with a view to achieving co-production and providing a means to address democratic deficiencies experienced by communities.

Integrating services is more than fulfilling the requirements of the 2014 Act or the set of responsibilities enshrined within it to plan, commission, direct, finance and monitor. The Act is the pivotal driver for the work of the IJBs and IJBs intend to meet its requirements in full, and with constant focus on the Nine Outcomes, which will continue to have centrality of focus. The recommendations from the Christie Commission report are still very relevant and align with the strategic priorities the IJB Network has identified to ensure that outcomes for service users remains at the heart of decision-making and planning.

There are a great many opportunities for IJBs to act upon in this report and though they are ambitious, they are realistic and achievable though cultural change, building on relationships, working with partners, retaining a local focus and with support from Scottish Government, COSLA and other stakeholders.

[16] See Appendix 2.

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APPENDIX 1: CASE STUDIES

Some case studies have been included to share some detail on particular aspects of IJBs but there are many more examples of best practice and local arrangements which can be made available to the Review Panel.

Highland HSCP – lead agency model

The foundation of integration of health and social care services delivered by NHS Highland and the Highland Council was first laid in 2010, when both organisations agreed shared principles and values that have influenced joint working over many years. That commitment was to achieve the best possible outcomes through person centred, anticipatory and evidence- based care. From a number of options, the Council and NHS Highland agreed to explore and later adopted the Lead Agency model of integration. Both agencies would be jointly accountable for determining outcomes and the resources to be committed, with NHS Highland having delegated responsibility for all aspects of the delivery of adult health and social care services and the Council similarly for many aspects of childrens' health services. The arrangements were reviewed and updated in line with the requirements of the Public Bodies (Scotland) Act 2014 and the partnership remains the only example of the Lead Agency model in Scotland. There is Highland representation in both the IJB Network and IJB Executive Group to ensure any alternative view from the lead agency perspective is included.

The Highland Health and Social Care Partnership has not been immune to the challenges faced by IJBs, as described in this document. Some might argue that the Highland Partnership has experienced additional challenges of supporting the professional leadership and identity of social care and sustaining elected members' awareness and understanding of their responsibilities for adult social care. However, the COVID-19 pandemic has most definitely highlighted the considerable benefits of 'whole system' working within a single organisation which is a hallmark of the Lead Agency model.

In early March, NHS Highland established a rapid response team to support care homes. The well-established relationships that already existed in a single organisation between the Director of Adult Social Care, Director of Nursing, Medical Director, Director of Public Health and indeed between social care commissioning teams and care home providers meant that a multi-disciplinary response to testing, infection control, bank supply of nursing and social care staff could be quickly mobilised. Joint working with the Council's Chief Social Worker was also essential going forward in ensuring any adult support and protection concerns were properly addressed.

Similarly, NHS Highland was very well positioned to support the social care sector in all its forms with PPE throughout the pandemic, being able to call on established procurement routes and distribution arrangements across its very wide geographic patch. Very quickly a 'dashboard' alert system was established across all health and social care services with contact being made daily at the height of the pandemic with all social care providers to identify any shortfalls in PPE, staffing and access to testing.

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North East Partnership Steering Group

The North East of Scotland has been highlighted as having a collaborative and inclusive approach between three IJBs and NHS Grampian. There is a system in place which preserves the links to localities and local communities, but also identifies commonalities across the region and areas where there are shared or mutual interest. While many IJBs across Scotland have regular contact with other IJBs in their NHS Board area or geographical proximity, there are no recognised formal arrangements in place and the acute sector may not be included in these informal arrangements.

Purpose: The group is an advisory and discursive body to ensure there is a collaborative partnership approach across Grampian for areas of mutual interest. It is not a decision-making body - that remains the preserve of each of the IJBs.

Membership:

- Aberdeen City, Aberdeenshire and Moray IJB Chairs & Vice Chairs
- Aberdeen City, Aberdeenshire and Moray HSCP Chief Officers and Chief Financial Officers
- NHS Grampian's Acute Sector's Leadership Triumvirate

Key contributing factors:

- Flexible and responsive Terms of Reference regularly reviewed to ensure they remain fit for purpose.
- The framework and governance structure in place acts as a point of reference so the group has confidence in the system and resulting actions.
- Review of individual governance structures to reduce duplication of committees.
- IJB Chairs and Vice Chairs set aside their role as NHS/Local Authority representative and approach this independently and openly. All parties are equal in the steering group.
- There is consideration of 'the bigger picture' and a whole systems approach and how other NHS and council services can be enhanced by decisions made at IJB level.
- Some NHS Board members have previous experience on more than one IJB so have a good understanding of other IJB localities. However, the robust systems in place mean there is a sustainable approach which is not adversely affected by turnover of members and the governance structure has resulted in strong organisational memory.
- Members offer valuable peer support and can operate as a sounding board.
- There is no blame culture, only a willingness to learn and to examine contributing reasons for success and failure of outcomes and impact rather than focussing on outputs.

This example from the North East, demonstrates how a heath board area with multiple IJBs can flourish with a collaborative approach to common strategic areas yet retain flexibility to best deliver responses local need. Arguably it can be less complex in the health board areas with a single IJB, however the key principles identified above are applicable to any configuration. While there are many contributing factors, not least of all the willingness of those participants to set aside individual control, this structure could benefit many other IJBs and is shared as a best practice example of effective integrated approaches.

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APPENDIX 2: IJB QUESTIONNAIRE ON ADULT SOCIAL CARE

In July 2020, a questionnaire was developed by the IJB Executive and shared with a range of organisations and individuals to gain their insight and perspective on adult social care in a post- COVID-19 setting. The responses were shared with IJB Chairs and Vice Chairs to inform discussion and debate in a series of virtual meetings. The outcomes of these meetings have been used as the basis of this this report and two key questions were discussed:

1. **How IJBs should influence health and social care policy, delivery and support for the response to the COVID-19 pandemic.**
2. **Longer term sustainable changes which will impact upon adult social care.**

These are the organisations that submitted a response (or partial response):

- Social Work Scotland
- Scottish Care
- Scottish Ambulance Service
- The ALLIANCE
- Professor Bruce Guthrie
- Inclusion Scotland
- NHS24
- Public Heath Scotland
- Care Inspectorate
- Coalition of Care and Support Providers in Scotland
- COSLA

The collated responses can be made available upon request.

Homelessness Prevention and Strategy Group (HPSG)

Submission to the Adult Social Care Review from the Homelessness Prevention and Strategy Group (HPSG)

Introduction

1. The members of the Homelessness Prevention and Strategy Group (HPSG) welcome the opportunity to directly contribute to the review from the perspective of the critical role that specialist adult social care provision can play, in maintaining the wellbeing and health of the significant proportion of the Scottish population who are at risk of, or do experience, homelessness each year.

HPSG – remit and membership

2. The Homelessness Prevention and Strategy Group, co-chaired by the Minister for Local Government, Housing and Planning and COSLA's Community Wellbeing spokesperson, involves a range of cross sectoral homelessness stakeholders and is a key strategic group in the development and implementation of homelessness policy in Scotland. More about the remit and membership of HPSG can be found here**: https://www.gov.scot/groups/homelessness-prevention-and-strategy-group/**

3. The work of HPSG and its sub groups, the Change Team, which involves people of lived experience of homelessness and one on Rapid Rehousing Transition Plans, oversees the implementation of the joint Scottish Government /COSLA **Ending Homelessness Together action plan**, which was updated in October 2020 following recommendations from the Homelessness and Rough Sleeping Action Group and building on the Plan first published in November 2018.

4. The Actions resulting from these recommendations take into account the landscape created in the wake of the COVID-19 pandemic including an action to continue to support local authorities and health and social care partners with their efforts to provide appropriate move on support and stable accommodation for all those currently in emergency accommodation. Work was already underway to address the Action to **'**improve the join up between local health, social care, housing and homelessness planning.'

5. We believe that the flexibility, improved joint working and shifting of resource adopted by a range of partners in the delivery of homelessness services during the pandemic offers many lessons to how we can better deliver services to those facing homelessness in Scotland in the future.

Health and Homelessness in Scotland

6. There is a strong legislative framework for addressing homelessness in Scotland. There is a legal duty on local authorities to provide accommodation for all those assessed as being homeless and a housing support duty exists for those that local authorities consider in need of extra support. With the publication of the Ending Homelessness Together Action Plan in recent years, the focus has been on local authorities and their partners to develop a rapid rehousing approach.

7. This aims to reduce time spent in temporary accommodation and to ensure people are housed in settled accommodation quicker and it also promotes the Housing First model, as defined as permanent, settled accommodation with intensive support, as the default approach for those with more complex needs who may otherwise be at risk of not sustaining tenancies.

8. Additionally, work is being undertaken to consider the options for a Prevention of Homelessness legal duty in Scotland, with a final report on this due in early 2021. More detail on this and the potential implications for the links between adult social care and homelessness can be found in this paper at **Annex A**.

9. Against this background, there is a recognition that homelessness is about much more than housing, and homelessness prevention will be most effective when it is recognised as a priority for a range of public services. We know that there is a strong relationship between homelessness and health in Scotland, and clear evidence of a relationship between repeat homelessness, drugs, alcohol and mental health.

10. As highlighted in the Ending Homelessness Together Action Plan, the **Hard Edges Scotland** report, which highlights the complexity of the lives of people facing severe and multiple disadvantage in Scotland, was published in 2019. It also evidences the need for more multi-agency working across social care structures, if we are to reduce the levels of complex and multiple need and vulnerabilities we see across Scotland.

11. Building on this work and on the learning during the pandemic, it will be essential that responses to people experiencing homelessness take into account the compounded impact of substance use, experience of the justice system, poor physical and mental health, trauma, violence, domestic abuse and poverty. Underpinning this is a person centred and trauma informed approach, responding to an individual's potential range of needs, rather than focusing just on their homelessness, their mental health, etc.

The relationship between adult social care and homelessness responses

12. Homelessness responses in Scotland have traditionally been located strategically and operationally within a housing context, separate to adult social care structures, despite the significant health and social care needs of the people supported. While there has been an integration of health and social care, the vast majority of Local Authorities have chosen not to delegate housing and homelessness to the Integrated Joint Board (IJB) covering their area. However, this does not exclude services designed to respond to local homelessness from being subject to the Regulation of Care (Scotland) Act 2001 or the regulation of the social care workforce (The Registration of Social Workers and Social Services Workers in Care Services (Scotland) Regulations 2013).

13. This level of separation has implications for the people seeking help and who find themselves accessing what is a social care response via a homelessness presentation to their Local Authority. Whilst seeking help for a risk or experiencing homelessness does trigger a statutory response, under homelessness legislation, that does not necessarily connect someone with a community care assessment or statutory intervention via the appropriate legislation, nor does it automatically recognise any carer implications or give direct access for Self Directed Support, regardless of the level of complexity and vulnerability experienced. This can result in what is in affect a two tier approach to responding to the care and support needs of people in Scotland.

14. This has meant that these services may be subject to national policy changes affecting all adult social care, but be largely excluded from consideration within resultant resource allocations distributed via Integrated Joint Boards, putting the people supported at significant disadvantage from those supported via a service commissioned by the Health and Social Care Partnership (HSCP) /IJB structure. Subsequently, it may not always result in equity across commissioning and procurement arrangements between homelessness and other care groups.

15. Adult social care provision should therefore be targeted to responding to the vulnerabilities and supporting the potential of anyone, regardless of the door through which they enter to access a response.

The implications for Adult Social Care

16. As indicated above, Programme for Government ambitions are enshrined in the national Ending Homelessness Together Action Plan, which highlights a number of areas from the prevention and early intervention through to the scaling up of Housing First, where wrap around multi-agency support and care is critical to successfully offering settled homes to those with the most extreme needs, and, in assisting people to sustain the home that they have through a stronger prevention agenda.

17. The routes into homelessness and in particular the most extreme forms of homelessness such as rough sleeping, involve severe and multiple disadvantage, ill health and trauma that can most often be traced back to early life. Any early intervention to prevent the need for a homelessness response goes well beyond the role of housing alone. However the responsibility for delivering the key social care responses for people who are transitioning from a risk of or experience of homelessness lies predominantly out with the health and social care structures they are most likely to require, creating unnecessary barriers to access. It can also increase the level of system based challenges faced when working to ensure appropriate and sustainable packages of care and support are readily available. This may be driven by where budgets are held and department led commissioning approaches.

18. Whilst access to the right housing to build or sustain a home life remains the primary driver of homelessness responses, the key to successful delivery of early and recovery based interventions is equity of access and effective multi-agency working across all adult care responses.

How the Review can support better outcomes

19. In fulfilling the objectives of the review we ask that:

- Adult social care policy and provision actively takes full account of the care and support needs of people facing homelessness. The Hard Edges Scotland research has shown that people facing multiple disadvantage can face barriers in a system which may lack appropriate, joint responses by housing and other partners including lack of access to planned health and social care services; too often having to rely on emergency services to access assistance during a crisis.

- Health and social care services for those facing homelessness should be normalised rather than being labelled homelessness services whilst at the same time take into account the particular challenges that those facing homelessness face (there is evidence that the longer people are using 'homeless' services – whether housing or social care – the longer it will take for them to move on in their lives).

- Self-directed support options should be made widely available to people facing homelessness. Of paramount importance is the speed at which a person's desired outcomes are identified and options presented and put in place. This will help to promote resilience and recovery at a time when a person is particularly vulnerable due to being in insecure housing or without housing at all.

- We specifically recognise that too often one impact of people who fall foul of the immigration asylum system is homelessness and with that comes high prevalence of increased health and social care needs. Much collaborative work is being pursued on how the housing and homelessness system to plan improved responses to prevent and intervene for those at risk. The Everyone Home collective, brings together close to 30 key stakeholders across social care provision and academic institutions. to support change and improved understanding on what works across a number of published route maps, including a collective response for people experiencing the risk of having no recourse to public funds (NRPF). This NRPF route map is being developed by third sector partners in collaboration with COSLA and the Scottish Government.

- That we work to achieve absolute equity of opportunity, access and eligibility for people with social care needs, no matter which doorway they use to ask for help and intervention, particularly when that might sit out with HSCP structures and act as a system barrier.

- To examine fully the ambitions of the Ending Homelessness Together Action Plan and the role of adult social care in supporting its successful delivery, focusing on evidencing the systemic and cultural barriers that exist and recommending ways to eradicate them. Considering the implications of a current system that may result in a two tier system of social care for those either within or out with HSCP structures.

Conclusion

20. Closer working between homelessness and health and social care partners is essential to meeting our common ambition to prevent and ultimately end homelessness in Scotland. The Ending Homelessness Together Action Plan recognises this in its ambitions, and includes this as an overall Action to 'join up planning and resources to tackle homelessness'.

21. The Action Plan also includes reference to Public Health Scotland 'joining forces with health and social care partnerships to explore what further contribution can be made to tackling and preventing homelessness, including through the equivalent of housing contribution statements where appropriate.'

22. Other steps have been taken, such as the current drive to establish a national network of HSCPs across Scotland, working on homelessness and linking into local authorities work to implement local Rapid Rehousing Transition Plans.

23. The review of Adult Social Care provides another important opportunity to strengthen and build on these links and we hope this contribution is helpful in that process.

Homelessness Prevention and Strategy Group

11 December 2020

ANNEX A

THE PREVENTION REVIEW GROUP

1. The Prevention Review Group was established to develop proposals for a legal duty to prevent homelessness in Scotland and is expected to report in early 2021.

2. The Group is still to finalise its proposals, but wishes to share some of the key points from its discussions to help inform the Adult Social Care Review in considering the role of homelessness.

3. The Group's discussions to date have identified the following potential proposals;

- Health and Social Care Partnerships and community planning partnerships should contribute statements to local housing strategies on how they will support homelessness prevention and assistance. Local authorities should make a strategic assessment of the housing support needs of people in their area who are homeless or are at risk of homelessness to inform planning.
- Where it is identified that an individual may have health and social care needs as part of an assessment of homelessness or threat of homelessness, or an assessment of housing support needs, a statutory duty is placed on the health and social care partnership to co-operate with the local authority in planning to meet those needs.
- Where a social worker or social care worker identifies a risk of homelessness, they should make a referral to the relevant part of the local authority. If they consider that there are unmet social care needs, a social care needs assessment should be carried out.
- For people with complex needs requiring input from two or more public services to support their health or wellbeing, or to facilitate community safety, a case co-ordination approach is put in place.
- 16 and 17 year olds (currently usually treated as adults in homelessness services) should be treated as children when they are homeless or at risk, and primarily be supported by children's social work services.

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

Dr Bruce Currey - The isolation paradox: proposed localised care training during the covid-19 pandemic in Scotland

Dr Louisa Harding-Edgar, Prof Allyson Pollock, Prof Luke Clements - Covid-19: why we need a national health and social care service

Dr Louisa Harding-Edgar, Prof Allyson Pollock, Prof Luke Clements - Coronavirus crisis: underfunding, restructuring, privatisation and fragmentation at the heart of the crisis in Holyrood and Westminster

ELCAP - Submission to the Independent Review of Adult Social Care

Equality and Human Rights Commission - Briefing for care homes: Equality in residential care in Scotland during coronavirus (COVID-19)

Equality and Human Rights Commission - Briefing for Scottish Government and public authorities: Equality in residential care in Scotland during coronavirus (COVID-19)

Equality and Human Rights Commission - EHRC Scotland input to the Independent Review of Adult Social Care: Using the equality framework to deliver adult social care reform

EVOC and the voluntary and community sector in Edinburgh - Submission to the Independent Review of Adult Social Care

Health and Social Care Alliance Scotland (The ALLIANCE) - Briefing for Scottish Parliament debate on Independent Review of Adult Social Care

Hospice UK and Partners – Joint response to the Scottish Parliament's Health and Sport Committee's social care inquiry