INDEPENDENT REVIEW OF ADULT SOCIAL CARE

SUBMISSION FROM CCPS –
Coalition of Care & Support Providers in Scotland

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

About CCPS

CCPS exists to identify, represent, promote and safeguard the interests of third sector and not-for-profit social care and support providers in Scotland, so that they can maximise the impact they have on meeting social need.

The not-for-profit sector provides just over a third of all registered social care services and employs just under a third of all social services employees. CCPS has over 80 members, including virtually all the most substantial third sector providers in Scotland. Our wider network includes smaller providers, fellow third sector umbrella groups and public sector partners.

Our members support adults with care & support needs; older people; people with convictions; homeless people; and children, young people & families. Some of our members have a specialist focus on one particular area of care & support, others have very broad portfolios. Together, they support more than 200,000 people and their families in Scotland, and manage a combined total income of over £1.2bn, an average of 73% of which, per organisation, relates to public funding.

Our members work in every local authority, NHS board and health & social care partnership area in Scotland. They are all non-profit distributing charities registered with the Office of the Scottish Charity Regulator (OSCR).

The third sector and "adult social care"

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

These people, and these homes, are extremely important and we recognise that what has happened since March has had a profound impact on them. Some of our members operate care

homes; but in general the majority of their work is not in this area, although the review's eventual recommendations are likely to have a very significant impact on them.

Very few third sector organisations talk about themselves as providers of "adult social care". This is what (a selection of) our members say they do:

- Supporting people & communities
- Enabling everyone to live a valued life – the life they choose
- Your way to a brighter future
- Supporting good lives
- Joy in later years
- No barriers – for all of life
- Here for disabled people
- Care you can put your faith in

Only after this, if at all, would organisations in our sector talk about "adult social care" or about "services".

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

In this context, "social care" isn't a *service* (ie. someone stepping in to do something that you can't do for yourself); rather it is a *vehicle* through which people can live their lives in a way that those of us without such challenges take for granted. In this sense, "social care" is not a destination, end point or outcome in itself; it is the provision of support and assistance that allows people to achieve their own destination, end or outcome.

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

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

The third sector has been providing good "social care" for decades, and certainly for much longer than the public sector. Some of our members have their roots in the 19th century with missions & charitable objectives that have been reviewed and modernised, certainly, but that remain fundamentally unchanged.

The emergence of "adult social care"

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

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

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

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

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

But we have, arguably, reached a point where the codification has in effect become the service, now described as "adult social care". People are assessed as "needing" 20 hours of home care a week; "needing" four 15-minute visits a day; or "needing" a permanent care home place.

This is what is meant by social care having become 'service-led': the system responds to need by deciding the quantity or volume of service that it will allocate to each person, from a range of services that it has *a priori* decided to provide.

Meanwhile we have opted to put those services in place through a market mechanism which describes people's care & support arrangements as "packages"; we divide groups of people with support needs into "client groups" and bundle them into "lots", to be tendered on the market.

Similarly, we have arrived at a position whereby "adult social care" is confined to those services commissioned & funded by Health & Social Care Partnerships/Integrated Joint Boards. Crucial support services provided to homeless people, for example, are often not defined as "adult social care" purely because they are commissioned and funded by local authority housing or community services departments. Services that do not fall into Care Inspectorate registration categories, but are critically important to people's wellbeing, are not included in the definition. This can mean that significant parts of the workforce are excluded from important initiatives such as the Living Wage in social care.

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

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

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

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

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

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

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

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

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

There is insufficient critical challenge applied to systems and decisions that (appear to) undermine the rights of individuals, and the principles of SDS, including many procurement decisions. ***We***

would encourage the review to consider how to strengthen our collective ability to challenge poor decision-making without recourse to the courts, particularly where people's rights are concerned.

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

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

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

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

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

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

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

Health & social care partnerships and local authorities rarely support the third sector to implement all the dimensions of Fair Work – particularly pay, terms & conditions – that they implement

themselves, as employers of their own staff. This is unjust, inequitable and in our view, indefensible in the context of a national approach to Fair Work and to professional registration, qualifications, standards and conduct. ***We would encourage the review to seek to dismantle the "two-tier" workforce and ensure parity of status, esteem and reward across all sectors.***

3. Regulation, scrutiny and improvement of social care

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

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

The third sector supports the ongoing shift away from 'tick-box' regulation & inspection towards self-evaluation and improvement. We do not believe that quality can be "inspected in", although we are mindful of the regulator's role in protecting individuals and providing public assurance. ***We would encourage the review to ensure that scrutiny continues to develop its focus on self-evaluation & improvement and improves, in turn, its own ability to measure performance & quality on the basis of experiences and outcomes for people, rather than provider compliance with policy and process.***

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

4. Human rights and ethics in social care

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

There are long-standing concerns about the extent to which people's human rights in the context of social care support may be re-interpreted in the light of budgetary considerations. Probably the most stark example of this was played out in the case of R vs. Royal Borough of Kenginston &

Chelsea (there have been similar instances in Scotland although they have not all proceeded to court action). ***We would encourage the review to consider this case, and others like it, and to clarify where it believes a Scottish future social care system should stand, in particular on the question of how far the human rights of individuals should be considered subordinate to the needs of a population to have basic social care needs met, within a limited budget.***

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

Considerations of ethics in care & support commissioning & procurement have been usefully addressed in Unison's "ethical care charter". Whilst we are generally supportive of the charter, it doesn't address head-on the need for commissioning authorities to pay a competent rate for care, particularly if providers are to implement better pay & conditions, and Fair Work. ***We would encourage the review to establish a clear line of sight between high ethical standards and the level of budget required to underpin them.***

5. Commissioning and procurement

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

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

In the context of the dominance of competitive tendering as the primary means of arranging care & support provision, we have adopted two responses: first, to ensure that if competitive tendering is the approach taken, then at the very least it must be conducted in accordance with guidance

(guidance that we instigated, and continue to promote); and second, to explore the potential of alternative, more collaborative approaches. Our 'Big Ideas' project goes into these in more detail. ***We would encourage the review to focus primarily on the second of these, rather than the first: we append a specific paper on commissioning & procurement, and our 'Big Ideas', in this regard.***

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

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

6. Finance

As a provider representative association, CCPS has no fixed organisational view about how any additional investment in care & support should be financed, be it through higher tax rates, altered priorities, the introduction of specific insurance schemes, and so on. We believe that this is a question to be addressed by political leaders in full consultation with the public. ***We would encourage the review to approach this question from the perspective of a renewal or renegotiation of the 'social contract' between the state and citizens.***

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

Accountability, transparency and equity are key financial issues for our sector. As noted, we see significant problems with the current 'two-tier' system in which 'in-house' care & support is routinely funded more generously than commissioned support; and we experience major problems with the

absence of any effective ring-fencing of resources or monitoring of spend. This is very starkly revealed by the huge difficulties that third sector organisations have experienced in accessing the multi-millions allocated to public bodies to support additional social care spend arising from Covid-19. In general, third sector finances are minutely scrutinised whilst comparatively little independent scrutiny is applied to public expenditure on social care. ***We would encourage the review to address these issues as a matter of urgency: every citizen, regardless of who provides their care & support, ought to be confident that the same financial rules and standards apply to the funding of that support.***

7. Potential national aspects of a social care system

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

A further narrative surrounding proposals for a National Care Service relates to the perceived fragmentation of the social care system. In our view and indeed our experience, problems of PPE distribution, the introduction of effective infection prevention & control measures and other challenges arising during the pandemic were the result of an almost total failure to treat third sector providers as part of the existing system, and as equal partners within it. Again, this is not new. Addressing this, we believe, would be a far better way of streamlining the system than the introduction of a top-down, command-and-control model of governance. ***We would encourage the review to interrogate such proposals rigorously and test their ability to solve the problems to which they present themselves as the answer.***

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

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

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

Also as above, in section (1.), we would note again that the rights conferred on people with care & support needs are scattered across various legislative instruments. ***We would encourage the review to consider bringing them together in a single "Bill of Rights" at a national level.***

In the ongoing debate about what is best decided or organised nationally, rather than locally, we would want to raise two further points: one, ***we would encourage the review to examine the history of recent centralising initiatives in Scottish public services, and review the evidence regarding both the upfront investment required, and the financial and service outcomes delivered***; and two, we would question the extent to which local government or health & social care partnership boundaries are themselves an appropriate reflection of what people understand to be 'local'. This has been a subject of debate since health & social care integration policy required the identification of 'localities' for planning purposes, and that debate remains live. ***We would encourage the review not to limit itself by considering 'local' decision making or discretion to be entirely synonymous with local authority decision making, but to consider further dimensions of locality.***

Thank you for reading this submission. We would be pleased to discuss it with the review Chair, panel and secretariat, in whatever way would be most convenient.

Please contact Annie.Gunner_Logan@ccpscotland.org.

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CCPS – Coalition of Care & Support Providers in Scotland
Norton Park, 57 Albion Road
Edinburgh EH7 5QY
0131 475 2676