A National Care Service for Scotland - Consultation

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Scottish Government
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Ministerial foreword

As Minister for Mental Wellbeing and Social Care - indeed the first Minister to have social care in a ministerial portfolio - I am very proud to launch this consultation which seeks views on our proposals to improve the way we deliver social care in Scotland.

The importance of our social care services has never been clearer. We owe an enormous debt of gratitude to our nation's carers, paid and unpaid, for the commitment and compassion we have seen throughout the pandemic.

I believe social care services, just like health care services, should be provided on a truly universal basis. I want our social care system to consistently deliver high quality services to every single person who needs them, across Scotland.

The Scottish Government commissioned the Independent Review of Adult Social Care, during the pandemic, because it was clear we needed to do things better in future. I acknowledge the many contributions to the Independent Review on Adult Social Care and have heard both the views you have expressed and the insights and experiences that you shared; they were an invaluable part of that review process.

I am committed to implementing the recommendations in the report of the Independent Review of Adult Social Care and staying true to the spirit of that report by building a system with human rights at the heart of it. I am listening and want to ensure that care is delivered in a way that enables people to live a happy and fulfilled life – not simply care that is delivered to suit the system. As one of the contributors to the Review said: "social care should be a springboard not a safety net".

The Independent Review acknowledged that current structures have not fully delivered the improvements intended to be achieved by integration of health and social care and recommended the creation of a National Care Service, with Scottish Ministers being accountable for adult social care support.

I believe however that it is right for this consultation to look beyond simply the creation of a national service for adult social care. The ambition of this government is to go much further, and to create a comprehensive community health and social care service that supports people of all ages. This will support the provision of care that wraps around families and smooth transitions between different categories of care for everyone, taking account of individual circumstances, the communities they live in and their wishes.

If we get social care delivery right, we can help people live the kind of life they want to live; going to college, getting a job, remaining in their own communities for longer. Peoples' lives can be transformed.

Absolutely vital to this is ensuring that our invaluable social care workforce feel happy, respected and fulfilled in their role. By rewarding and valuing our workforce we recruit and retain great staff. It is crucial that unpaid carers are supported to have a life alongside caring, and that they are able to sustain and improve their own health

and wellbeing. They must be involved in the decisions that affect them and those they care for.

Social care should no longer be seen as a service of crisis intervention but one which is there to help and support people at the earliest stage, preventing deterioration and people getting into crisis situations.

Social care is an investment in our communities and our economy, so that everyone can take their part in society.

A National Care Service will provide us with consistency, equity and fairness, and the accountability needed to deliver high quality services across Scotland.

As we undertake the work to create a National Care Service, we will review the systems, remove unwarranted duplication of functions and make best use of the public purse. I want to ensure that the new service is designed around the needs of those who access services and supports the needs of the workforce. My priority is that the interests of those who use and deliver social care are firmly at the heart of decision making in building a stronger system.

We are at the beginning of a journey to improve social care in Scotland. We will only get this right with your support.

Kevin Stewart
Minister for Mental Wellbeing and Social Care

Introduction

The proposed reforms around social care represent one of the most significant pieces of public service reform to be proposed by the Scottish Government, and have the potential to be the biggest public sector reform in Scotland for decades.

The implementation of the recommendations of the Independent Review of Adult Social Care (IRASC), and particularly the establishment of a National Care Service (NCS), is an opportunity to address some of the challenges across social care highlighted before and during the pandemic.

This is an opportunity to change the way we deliver support and services - to place human rights at the centre of our decision making; shift our emphasis to prevention; empower people to engage positively with their own care; embed fair work and ethical commissioning; and strengthen our commitment to integrating social care with community healthcare, which we last legislated for in 2014.

Independent Review of Adult Social Care
The delivery of social care support is currently the statutory responsibility of local government under the 1968 Social Work (Scotland) Act. The Scottish Government sets out the policy and makes legislation on social care and therefore has a role in supporting improvement and ensuring positive outcomes for people across the country by having the right policy and legislation in place.

In February 2021 the Independent Review of Adult Social Care report was published. It concluded that whilst there were strengths of Scotland's social care system it needed revision and redesign to enable a step change in the outcomes for the people in receipt of care. The review provided a number of high level areas of focus:

- Ensuring that care is person-centred, human rights based, and is seen as an investment in society
- Making Scottish Ministers responsible for the delivery of social care support, with the establishment of a National Care Service to deliver and oversee integration, improvement and best practices across health and social care services
- Changing local Integration Joint Boards to be the delivery arm of the National Care Service, funded directly from the Scottish Government
- The nurturing and strengthening of the workforce, and
- Greater recognition and support for unpaid carers.

What we are already doing
The Scottish Government is committed to implementing the recommendations of the IRASC. Before the pandemic began, we had been working with a wide range of partners, including people who use social care support, COSLA (the Convention of Scottish Local Authorities), unpaid carers, the social care sector and the workforce, to address many of the areas highlighted in the review. This work provides a strong context from which to implement the recommendations of the IRASC, including how social care is understood and valued by individuals and our society; how it is funded and paid for into the future; what approaches to care and support we need in

Scotland and how they are delivered; and how we achieve Fair Work for all of our social care workforce.

That work was largely paused due to the pandemic, but we have continued to work on key priorities including working with the trade unions and sector stakeholders through the Fair Work in Social Care group, to make progress on the recommendations in the Fair Work Convention's Fair Work in Social Care Report and in doing so, improve fair work practices across the sector. We have also worked with Social Work Scotland and others to develop the Self-directed Support (SDS) Framework of Standards to drive a more person centred, human rights based approach to care.

This year we provided funding of £64.5m to ensure that adult social care workers in Scotland will be paid at least the Real Living Wage of £9.50 per hour.

To support the development work required to design and establish a National Care Service and related reforms we have set up a steering group including people with lived and living experience of social care to help us devise a social covenant. The aim is to ensure the new service is designed around the needs of people who access social care and supports the needs of unpaid carers and care workers.

As part of a rights-based approach to care, the Scottish Government has committed to strengthen residents' rights in adult residential settings. This will include delivering 'Anne's Law' – ensuring that care home residents have the right to contact with their families and friends to support their overall health and wellbeing at all times.

As part of taking forward the 30 recommendations from the National Taskforce for Human Rights Leadership for a new human rights framework for Scotland, a Human Rights Bill will be introduced in this parliamentary session. This new Bill will complement the work in relation to developing a new National Care Service.

We will not wait for a National Care Service or for new legislation to continue with work to improve social care. We are establishing a Proactive and Preventative Care Programme, as part of the "Remobilise, Recover, Redesign" of Scotland's Health and Care services as we strive to ensure that more consistent and equitable support and services are in place across the country and that they operate in a person centred way. We are keen that this will embed change at a practice level and deliver integrated support for people, so that the foundations are right when the NCS is created - regardless of the structural arrangements. It is crucial that we continue to make improvement as soon as possible and that we do not see stagnation, a lack of innovation or significant disruption during the development of the NCS.

What is the purpose of the consultation?
This consultation is focused on exploring the suggestions for significant cultural and system change that will need to be supported by primary legislation, new laws, to ensure the governance and accountability across the system to deliver successfully for people.

New laws are necessary to implement the scale of change required to refocus the system to one that upholds human rights and promotes the health and wellbeing of people who access and who offer care and support.

Moving forward there needs to be a focus on high quality delivery, continuous improvement and consistent access to services regardless of what part of Scotland you live in.

Transparency is paramount. Transparency of expectations and standards. Transparency of care plans between providers and recipient. Transparency between services to promote preventative and proactive care plans.

Achieving this will facilitate a shift from a system that supports people to survive to one that empowers them to thrive.

Inclusivity and wholescale improvement
It is important to use this opportunity to consider the scope, remit, inclusivity and delivery mechanisms of the National Care Service in its widest sense. The assumption is that as a minimum it will cover adult social care services. However if we want to build a community health and social care system to make sure that all people receive services that cluster round them to deliver the best possible outcomes, then we must consider the merits of extending the scope of a National Care Service to oversee all age groups and a wider range of needs including:

- children and young people;
- community justice;
- alcohol and drug services; and
- social work.

This consultation sets out proposals for an expanded scope for the National Care Service. The priority in these considerations for each and every one us needs to be the people these services support and improving the quality of outcomes for them.

Finance
The proposals set out in this consultation paper will have a cost to the public purse. But, as the IRASC emphasised, social care support should not be seen as a burden. It is an investment in society, it creates jobs and economic growth, and allows people who access care and support and their carers to fulfil their potential and, in many cases, access employment themselves. Done well, a focus on early intervention and prevention avoids the need for more costly action at a later stage. For example, supporting unpaid carers so that they can continue their caring relationship, supporting families to prevent family breakdown, or ensuring appropriate care to prevent deterioration or falls resulting in a need for hospital treatment, all result in benefits for individuals and families, and for our health and care services.

This Government has committed to increase investment in social care by 25%, but public resources are still limited. As we consider the feedback from this consultation, all proposals will be assessed for value for money, to make sure the maximum impact is achieved from that investment. But in doing so we will look at the overall

benefits of improving people's experience of care and the outcomes they achieve, as well as the direct costs or savings of providing that care.

What is social care?
Social care is there for people of any age who need help with day-to-day living because of illness, physical disability, learning disabilities or mental health conditions, or because of older age, frailty or dementia. Social care also supports people with or recovering from alcohol or drug addictions, and those who are or have been homeless or are at risk of becoming homeless. Children's social care services also provide help for children and families who may need additional support, or where children are unable to live with their own families.

Social care may be provided in people's own homes, including through remote care and technology enabled care, in residential accommodation and care homes or in the wider community, including many advice and support services. The population receiving social care and support is diverse, with wide ranging needs and circumstances.

For example, based on 2018/19 figures:

- Around 245,000 (1 in 20) people in Scotland, of all ages, receive social care and support.
- Around 60,000 people are receiving home care at any one point.
- On 31 March 2019 there were around 35,500 people residents in care homes, of which around 90% are aged 60 and over.

Of the total 245,000 people receiving social care, just over 1 in 5 (23%) were under the age of 65. Of those:

- Just over 1 in 3 (34%) have a physical or sensory disability
- Just over a quarter (27%) have a learning disability
- Around 1 in 6 are receiving social care support due to mental health issues.
- People can be receiving support for more than one reason. Other reasons include problematic substance use, neurological conditions, dementia, palliative care, autism or other vulnerabilities

On 31 July 2020 there were almost 14,500 children in Scotland being supported at home, with kinship carers, with foster carers or in residential accommodation.

The system of adult social care is planned, commissioned and delivered by a wide range of partners. This includes organisations in the public, independent and third sectors.

- There were 206,400 people employed in the social service sector in December 2019. Of these around half were employed in adult services and around 45,000 in daycare or residential care for children. There are many more individuals supporting delivery through our multidisciplinary health and social care teams.
- It is also important we recognise the invaluable role of unpaid carers with an estimated 700,000 to 800,000 carers in Scotland, including around 29,000 young carers.

- In 2019 there were 5,957 social workers employed by local authorities. Almost half of these work in children's services.

What happens next and when?
This consultation is intended to start discussion and debate about what changes should be made to achieve better outcomes for people. We are asking you to engage, to challenge and suggest innovative solutions. By working together, the role of a National Care Service and the system that supports it will be stronger.

Our commitment is to seek the views of as many people as possible to shape a better future - including users of social care services, members of the workforce and members of the public, carers, and potential future users of services, which includes everyone. In addition to this consultation paper we will engage with people, both online and in person where possible, to ensure that as many people as possible are able to have their say.

We recognise that there will be many different views as we explore new options, however a shared vision for a future community health and social care system for Scotland that works for people is essential. To do that we must focus on practical suggestions that can be implemented in order to improve outcomes and support.

There will be further opportunities for people to shape and design the detail of how the system will operate once we have identified what it will be.

At the end of the consultation process all of your feedback will be analysed and the conclusions will be used to shape and develop new legislation (a bill) which will be introduced in the Scottish Parliament in summer 2022. As we reach conclusions on the National Care Service we will continuously consider how it will integrate with the National Health Service and any implications for the NHS.

We will also consider the impact of our proposals on equality groups and others, including businesses and island communities and will carry out a suite of impact assessments before finalising the proposals.

The legislation is likely to be extensive and complex and is likely to take at least a year to be scrutinised by the Parliament. After that we need to set up the organisation and put the legislation into effect. We intend the National Care Service to be fully functioning by the end of the Parliamentary term.

Responding to this consultation

You don't need to read all of this paper, or answer all the questions, unless you want to. We know that different people will be interested in different issues. We have set out individual parts of our proposals in separate sections in this consultation. You can use the menu or contents page to skip to the areas you are interested in, and just answer the questions on those sections.

We are inviting responses to this consultation by 02 November 2021.

Please respond to this consultation using the Scottish Government's consultation hub, Citizen Space (http://consult.gov.scot). Access and respond to this consultation online at https://consult.gov.scot/health-and-social-care/a-national-care-service-for-scotland. You can save and return to your responses while the consultation is still open. Please ensure that consultation responses are submitted before the closing date of 02 November 2021

If you are unable to respond using our consultation hub, please send your response, including the completed Respondent Information Form to NCSconsultation@gov.scot or by post to:

National Care Service Team
Scottish Government
Area GE-15
St Andrew's House
Regent Road
EDINBURGH,
EH1 3DG

Handling your response
If you respond using the consultation hub, you will be directed to the About You page before submitting your response. Please indicate how you wish your response to be handled and, in particular, whether you are content for your response to published. If you ask for your response not to be published, we will regard it as confidential, and we will treat it accordingly.

All respondents should be aware that the Scottish Government is subject to the provisions of the Freedom of Information (Scotland) Act 2002 and would therefore have to consider any request made to it under the Act for information relating to responses made to this consultation exercise.

If you are unable to respond via Citizen Space, please complete and return the Respondent Information Form included in this document.

To find out how we handle your personal data, please see our privacy policy: https://www.gov.scot/privacy/

Next steps in the process
Where respondents have given permission for their response to be made public, and after we have checked that they contain no potentially defamatory material,

responses will be made available to the public at http://consult.gov.scot. If you use the consultation hub to respond, you will receive a copy of your response via email.

Following the closing date, all responses will be analysed and considered along with any other available evidence to help us. Responses will be published where we have been given permission to do so. An analysis report will also be made available.

Comments and complaints
If you have any comments about how this consultation exercise has been conducted, please send them to the contact address above or at NCSconsultation@gov.scot.

Scottish Government consultation process
Consultation is an essential part of the policymaking process. It gives us the opportunity to consider your opinion and expertise on a proposed area of work.

You can find all our consultations online: http://consult.gov.scot. Each consultation details the issues under consideration, as well as a way for you to give us your views, either online, by email or by post.

Responses will be analysed and used as part of the decision making process, along with a range of other available information and evidence. We will publish a report of this analysis for every consultation. Depending on the nature of the consultation exercise the responses received may:

- indicate the need for policy development or review
- inform the development of a particular policy
- help decisions to be made between alternative policy proposals
- be used to finalise legislation before it is implemented

While details of particular circumstances described in a response to a consultation exercise may usefully inform the policy process, consultation exercises cannot address individual concerns and comments, which should be directed to the relevant public body.

A National Care Service for Scotland - Consultation

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

To find out how we handle your personal data, please see our privacy policy: https://www.gov.scot/privacy/

Are you responding as an individual or an organisation?

- ☐ Individual
- ☐ Organisation

Full name or organisation's name

Phone number

Address

Postcode

Email

The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing preference:

- ☐ Publish response with name
- ☐ Publish response only (without name)
- ☐ Do not publish response

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

- ☐ Yes
- ☐ No

Individuals - Your experience of social care and support
If you are responding as an individual, it would be helpful for us to understand what experience you have of social care and support. Everyone's views are important, and it will be important for us to understand whether different groups have different views, but you do not need to answer this question if you don't want to.

Please tick all that apply

- ☐ I receive, or have received, social care or support
- ☐ I am, or have been, an unpaid carer
- ☐ A friend or family member of mine receives, or has received, social care or support
- ☐ I am, or have been, a frontline care worker
- ☐ I am, or have been, a social worker
- ☐ I work, or have worked, in the management of care services
- ☐ I do not have any close experience of social care or support.

Organisations – your role
Please indicate what role your organisation plays in social care

- ☐ Providing care or support services, private sector
- ☐ Providing care or support services, third sector
- ☐ Independent healthcare contractor
- ☐ Representing or supporting people who access care and support and their families
- ☐ Representing or supporting carers
- ☐ Representing or supporting members of the workforce
- ☐ Local authority
- ☐ Health Board
- ☐ Integration authority
- ☐ Other public sector body
- ☐ Other

Improving care for people

The case for change

We need to improve community health and social care support for those who rely on it, and for unpaid carers, and those who work in it. More of us each year are needing or seeking to access community health and social care support, or are helping others who need access. These services are core to supporting the health and wellbeing of the population, to enable everyone in Scotland to thrive. They must be a springboard not a safety net. Developing a system that delivers consistent and fair access to care and support services across the country and improves outcomes for people is a priority. Making Scottish Ministers accountable for social care will help to achieve that consistency and drive forward improvement.

Creating this improved system, one that works for people, will require every one of us to work together, placing the interests of the person at the centre of our decision making.

This chapter covers proposals that look to transform the system, put a human rights based approach at its heart and strengthen the focus on preventative approaches across community health and social care services.

Improvement

How it works now
Despite improvement methodology and implementation science being widely used and embedded in social care practice, we have yet to see the impact of large-scale evidence based improvement work in the integrated world of health and social care.

Nationally there are several organisations that advocate, practice and advise on improvement including CELCIS (Centre for Excellence for Children's Care and Protection), IRISS (Institute for Research and Innovation in Social Services), HIS (Healthcare Improvement Scotland – ihub) and CYPIC (Children and Young People Improvement Collaborative). The Care Inspectorate also supports improvement alongside its primary role of scrutiny and inspection. The Improvement Service provides improvement support to Local Government.

Yet we have not been able to consistently scale up good practice – partly due to lack of investment but also due to the many complexities of different professional governance and regulation structures, multi-agency working and the different cultures that underpin practice across the sectors.

The establishment of the National Care Service (NCS), accountable to Scottish Ministers, is an opportunity to consider how better to align the proven successful elements of improvement methodology and implementation science - to provide a model that practitioners at all levels can implement as a whole rather than a sum of the parts. To do so, there is merit in reviewing the services delivering improvement in Scotland and consider the most efficient method to deliver this for community health and social care.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 27: A National Improvement Programme for social care, along the lines of the NHS Patient Safety Programme, should be introduced by the National Care Service, and should address the three following key areas:

- The experience and implementation of self-directed support must be improved, placing people using services' needs, rights and preferences at the heart of the decision making process.
- The safety and quality of care provided in care homes must be improved to guarantee consistent, appropriate standards of care.
- Commissioning and procurement processes must be improved in order to provide a vehicle for raising the quality of social care support and for enhancing the conditions and experience of the social care workforce.

Recommendation 29: A national approach to improvement and innovation in social care is needed, to maximise learning opportunities and create a culture of developing, testing, discussing and sharing methods that improve outcomes. The future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service must be considered.

What we propose

Improvement must be a key focus of the NCS. The establishment of a single national body, with clear lines of accountability to Ministers at a national level, gives us the opportunity to ensure that consistent, high standards of performance are developed and maintained across Scotland. That national view will also ensure that learning can be shared and implemented across the country. Intelligence gained from inspection and scrutiny of services will be used to identify where improvement is needed, and themes will be fed back into commissioning and procurement.

Questions

Q1. What would be the benefits of the National Care Service taking responsibility for improvement across community health and care services? (Please tick all that apply)

- ☐ Better co-ordination of work across different improvement organisations
- ☐ Effective sharing of learning across Scotland
- ☐ Intelligence from regulatory work fed back into a cycle of continuous improvement
- ☐ More consistent outcomes for people accessing care and support across Scotland
- ☐ Other – please explain below

Q2. Are there any risks from the National Care Service taking responsibility for improvement across community health and care services?

Access to Care and Support

How it works now

Where it is identified that a person may have a social care need, their local authority's social work department has a legal duty to undertake or organise an assessment. This is mandated by the 1968 Social Work Act (section 12A), which obliges local authorities to “decide […] whether the needs of the person being assessed call for the provision of any [community care] services”.

This assessment is a care management process, in which a care professional meets with an individual to explore and observe their support needs. It should also include investigating their existing care arrangements, strengths, and hopes in order to inform decisions about meeting their needs. The assessment should include discussions with the individual and their support network to discuss how the person’s needs can best be met and how they would like their care and support delivered.

A person’s access to care and support is determined by their eligibility, according to National Standard Eligibility Criteria. These criteria are descriptions which categorise the care needs of individuals, which are currently defined as: ‘critical’, ‘substantial’, ‘moderate’, or ‘low’.

People who are not at critical or substantial risk may still have needs for some personal care or other social care support. Local authorities are expected to have in place arrangements for meeting, managing, and reviewing these needs. This may involve providing or referring to preventative or other support services, including providing advice about alternative sources of support or setting a clear timescale for reviewing the person's needs.

Where individuals have critical and substantial needs, and high levels of risk or public protection issues arise, this requires a Social Worker to carry out a risk management assessment and develop a care plan. The care planning will be led by the Social Worker and sets out how the complex care needs will be managed and co-ordinated and risk mitigated. This level of care planning will require input from a range of agencies and professionals and a high level of professional judgement.

In certain circumstances because of the levels of risk to the individual this will also require the Social Worker to use statutory powers to support and protect the individual

The Social Care (Self-directed Support) (Scotland) Act 2013 was introduced as a way of providing support that means people are given choice and control over how their care and support can be delivered. It means that people can choose and arrange some or all of their own support instead of having it chosen and arranged by other people. Implementation across Scotland has been variable and a new Framework of Standards to support Self-directed Support (SDS) was recently published.

Different arrangements apply to support for unpaid carers. All unpaid carers (regardless of their caring role) have rights to an outcomes-focused support plan to

look at their caring situation, identify what is important to them and their needs for support. Eligibility criteria for carer support must be set locally to determine which needs are eligible for support. All carers have rights to information and advice relevant to their caring role and most areas have preventative support open to all carers such as activity groups or peer support.

Since 2011, the Scottish Government has funded a network of independent support organisations to provide, advice and advocacy to help people understand their rights to social care and to support them to access the care that is right for them. The current Support in the Right Direction Programme funds 31 projects covering all but one of the local authority areas. They provide advice and help with pre-assessment to understand the SDS process, help people identify their personal outcomes and develop support plans, and provide coaching, advocacy, and peer support for people accessing care and support. They aim to provide an “end to end” service for people throughout their journey through social care and they can work with families and unpaid carers as well as people accessing support.

The Public Bodies (Joint Working) (Scotland) Act 2014 created Integration Authorities which are accountable for the planning of health and social care services. Health and Social Care Partnerships represent the delivery of these integrated community health and social care by integrated teams. All adult social care is delegated to Integration Authorities, and around a third of Integration Authorities also have delegated responsibility for children and families. Around half have a delegated responsibility for justice social work.

The Independent Living Fund (ILF) was established in 2015, following the closure of a UK Government programme, and is effectively a national scheme of direct payments to support independent living by disabled people. The Independent Review of Adult Social Care (IRASC) called for ILF to be re-opened. We will consider options for the future of the ILF within the context of the development of the National Care Service.

Whilst the IRASC acknowledges there is already much good practice, there is a gap between what is intended by the existing legislation and frameworks and what is actually delivered, with too much variation in outcomes between different parts of the country.

Issues and problems

The IRASC highlighted a number of issues with the current provision of adult social care. Too often, adults and their families can be excluded from assessment and support processes by complex bureaucracy. The IRASC labels eligibility criteria a ‘barrier to accessing care’, with supported people describing a ‘maze of benefits’. People report that the system is complex and challenging to navigate, and that the support received depends on where they live.

The organisation of services, with different professionals and agencies, often seems overwhelming for those seeking support. Supported people responding to the IRASC called assessments “intrusive, not focused on rights or equality, not focused on assets or potential but on deficits, reduced to identifying care tasks, and always

overly focused on eligibility, which was frequently set at ‘critical needs’, and costs” and stated “there are too many times that adults are expected to repeat those worst moments of their life, including at annual reviews, to ‘justify’ the services provided to them.”

For many the current experience for adults and their unpaid carers can be summarised as follows:

- A complex system that is difficult for people to negotiate.
- Lack of a consistent point of contact to speak to or liaise with.
- Lack of consistency across the country in what people can access (the postcode lottery).
- Lack of “portability” of care packages/plans if people need to move around the country.
- Application of eligibility criteria.
- Lack of a national practice model that will provide a single planning process.
- No single adult’s plan or pathway.
- A system that is not flexible to reflect changing needs.
- A system which focuses on acute and crisis support rather than prevention and early intervention.
- People having to tell their story over and over again.

The IRASC recognised the importance of independent support and brokerage services such as the Support in the Right Direction projects, which make people aware of their choices and possibilities across the SDS options and to support them to ensure the process of arranging and receiving care is co-produced. It says that not enough of these services are available and there is not enough awareness of them.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 1: Human rights, equity and equality must be placed at the very heart of social care and be mainstreamed and embedded. This could be further enabled by the incorporation of human rights conventions.

Recommendation 3: People must be able to access support at the point they feel they need it, including for advice and signposting to local community-based resources and help, and for barriers to this, such as the current eligibility criteria and charging regime, to be fundamentally reformed and removed, to allow a greater emphasis on prevention and early intervention.

Recommendation 4: People should understand better what their rights are to social care and supports, and “duty bearers”, primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.

Recommendation 6: Informal, community based services and supports must be encouraged, and funded to respond appropriately to the needs of local citizens, including for preventative and low level support.

Recommendation 7: A co-production and supportive process involving good conversations with people needing support should replace assessment

processes that make decisions over people's heads and must enable a full exploration of all self-directed support options that does not start from the basis of available funding. Giving people as much choice and control over their support and care is critical.

Recommendation 8: More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.

Recommendation 10: Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.

Recommendation 31: Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives.

Recommendation 39: A decisive and progressive move away from time and task and defined services must be made at pace to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes, to have a good life and reach their potential, including taking part in civic life as they themselves determine.

Recommendation 51: Re-open the Independent Living Fund, with the threshold sum for entry to the new scheme reviewed and adjusted.

What we propose

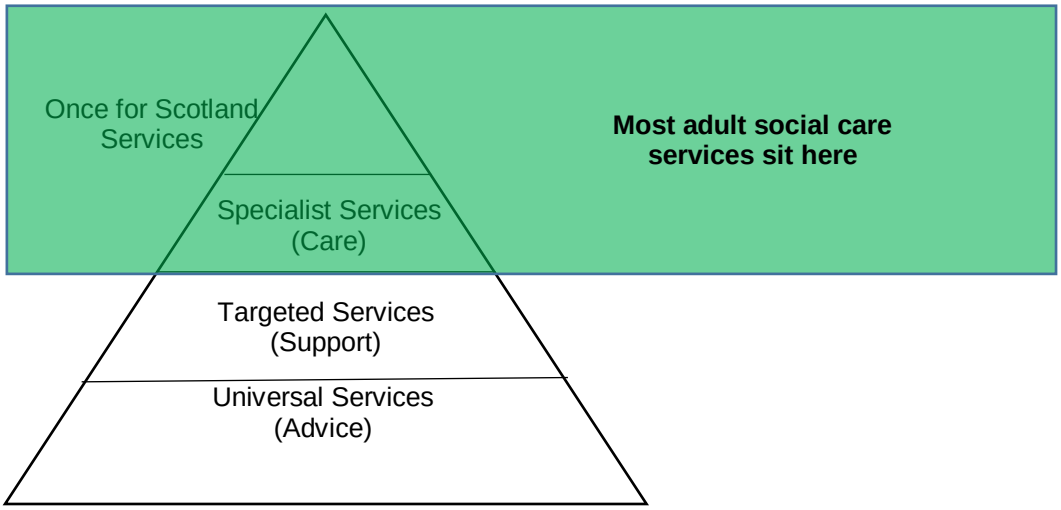
The creation of a National Care Service, accountable to Scottish Ministers, provides an opportunity to deliver transformational change to the way care and support is delivered to adults in Scotland. We will remove eligibility criteria in their current form by moving away from a focus on risk and instead focusing on enabling people to access the care and support that they need to lead a full life. This will mean significantly changing the way care and support services are designed, so that prevention and early intervention is prioritised and people can move easily between different types of care and support as their needs change.

Public services are often thought of as a pyramid. Universal services, which are engaged with by the majority of people, are at the base of the pyramid, while specialist services which are only required by a minority of people are at the top.

In health, for example, GPs and community healthcare teams provide a combination of universal and targeted services, while hospitals provide more specialist services.

In adult social care, the majority of services currently provided are at the top end of the pyramid of services. That means that people who need targeted and universal services often either are not able to access support or have to use specialist services

instead, meaning that they do not get the early support they need and putting more pressure on specialist services.



The approach to care and support being proposed as part of the National Care Service will involve designing and implementing consistent care and support services at all levels of the pyramid. This will allow support planning to focus on which type of support people need, rather than a decision between getting support or getting no support.

We will increase the number of care and support services which focus on prevention and early intervention, including community based services which can be accessed without a referral or full assessment. These will be at the heart of a Getting it Right for Everyone approach to care and support, and will work seamlessly with services for people with more complex care needs. We will set this new approach to care and support out in legislation, to ensure that there is not a postcode lottery and to support the portability of care.

The National Care Service will have a clear focus on positive outcomes for people and Getting it Right for Everyone. It will involve the people of Scotland in the design, development, and delivery of support and services from the outset and on a continual basis. It will define the strategic direction, quality standards, and the framework for person-centred operational delivery of community health and social care in Scotland, working in concert with the NHS, local authorities, and the third and independent sectors to plan, commission, and deliver the support and services that the people of Scotland require.

Care and Support Services

We propose that there will be a single approach to care and support services covering all types of care and support from early intervention to specialist intervention. This will be applicable to all settings, including prisons and places of detention, and will include:

- More support and services addressing early intervention and prevention, for example open access and community based provision.

- Join up between advice, support, and care services, to enable people to easily move between different types of care and support.
- A single model which eliminates variations in practice, but with flexibility of delivery approach depending on geography and need.

Getting it Right for Everyone
Drawing on the success of the "Getting It Right For Every Child (GIRFEC)" multi-agency approach, we want to develop a GIRFE National Practice Model: Getting It Right for Everyone. This is a pathway through support and services from young adulthood to end of life care. GIRFE will help define the adult's journey through individualised support and services, and will respect the role that everyone involved has in providing support planning and support. Too often, adults and their families are excluded from assessment and support processes by complex bureaucracy. GIRFE is about providing an easier way to access help and support when it is needed - recognising the crucial value of working alongside and with adults and their families, in seeking to achieve the best outcomes for them.

The practice model will define how people, communities, and services, identified as necessary to deliver support to the adult, get involved as early as possible and where appropriate throughout the delivery process, to ensure that support is provided quickly and without unnecessary bureaucracy – with the adult's wishes at the centre of the process. The key aim of this approach is to ensure that support and services cluster round individuals and families to ensure their needs are met, rather than working in silos, mirroring the GIRFEC approach.

GIRFE will provide a model that uses the same language to describe and assess an adult's strengths and needs, and with common practice tools across professional groups. It will include everyone who requires support including younger adults transitioning from Children's Services, adults vulnerable to exploitation or abuse, adults within the justice system in the community and following discharge from prison, and older adults who are experiencing or at risk of physical or mental frailty.

Support Planning
A critical aspect of the new approach is a single adult's plan and a single planning process. This will cover all aspects of care planning from the point that it's identified that care and support may be needed, through to agreement of the care and support to be provided and beyond. This should:

- Be rights based, based on the relationships that are important to the adult, and relentlessly focused on putting the adult at the centre of decision making and improving outcomes with them and for them.
- Feature a strengths-based support planning process, which enables the person to manage their own care as far as possible.
- Include options for both light touch and more detailed support planning, depending on the level of complexity and need, as part of a single planning process and model of care. Linked to the development of an integrated social care and health record, to ensure that, with their consent, people's information moves through the system with them.

- Provide a No Wrong Door approach to access to care and support, so that people only have to enter services once, and are supported within a coordinated system of support.

Questions

These questions ask about accessing care and support and the support planning process. We want to know your opinions on how things should work in the future, under a National Care Service, rather than about how they work now. When you are thinking about these questions, you could reply for yourself or thinking about someone you know, for example a friend, a family member, or someone who you provide unpaid care for.

Accessing care and support

Social care support is accessed by a wide range of people with diverse needs at different points in their lives, including older people; children, young people, and families; people living with disabilities; people with learning disabilities, short or long term mental health concerns, dementia, sensory impairment, complex disabilities, acquired brain or spinal injury, epilepsy, or people experiencing difficulties in relation to alcohol and other drug use; people who are homeless, or at risk of homelessness; and survivors of domestic abuse or gender based violence. It can include lots of different types of support and services, from advice, to someone coming into your home to provide care, or residential care.

Q3. If you or someone you know needed to access care and support, how likely would you be to use the following routes if they were available?

Speaking to my GP or another health professional.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Speaking to someone at a voluntary sector organisation, for example my local carer centre, befriending service or another organisation.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Speaking to someone at another public sector organisation, e.g. Social Security Scotland

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Going along to a drop in service in a building in my local community, for example a community centre or cafe, either with or without an appointment.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Through a contact centre run by my local authority, either in person or over the phone.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Contacting my local authority by email or through their website.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Using a website or online form that can be used by anyone in Scotland.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Through a national helpline that I can contact 7 days a week.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely

Other – Please explain what option you would add

Q4. How can we better co-ordinate care and support (indicate order of preference)?

- ☐ Have a lead professional to coordinate care and support for each individual. The lead professional would co-ordinate all the professionals involved in the adult's care and support.
- ☐ Have a professional as a clear single point of contact for adults accessing care and support services. The single point of contact would be responsible for communicating with the adult receiving care and support on behalf of all the professionals involved in their care, but would not have as significant a role in coordinating their care and support.
- ☐ Have community or voluntary sector organisations, based locally, which act as a single point of contact. These organisations would advocate on behalf of the adult accessing care and support and communicate with the professionals involved in their care on their behalf when needed.

Support planning

The following questions are about the support planning process, which is sometimes referred to as an assessment. This is the process of collecting information about you and your life, and having a conversation with you about your strengths, your support needs, and the type of care and/or support you would like to get. It is used to agree what care and support services you should be able to access.

We are interested in your views on how support planning should work in a National Care Service. You could answer this thinking about care and support services that you use now or may want to use in the future, or for a friend, family member, or someone you provide unpaid care for.

Q5. How should support planning take place in the National Care Service? For each of the elements below, please select to what extent you agree or disagree with each option:

a. How you tell people about your support needs

Support planning should include the opportunity for me and/or my family and unpaid carers to contribute.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

If I want to, I should be able to get support from a voluntary sector organisation or an organisation in my community, to help me set out what I want as part of my support planning.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

b. What a support plan should focus on:

Decisions about the support I get should be based on the judgement of the professional working with me, taking into account my views.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

Decisions about the support I get should be focused on the tasks I need to carry out each day to be able to take care of myself and live a full life.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

Decisions about the support I get should be focused on the outcomes I want to achieve to live a full life.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

c. Whether the support planning process should be different, depending on the level of support you need:

I should get a light-touch conversation if I need a little bit of support; or a more detailed conversation with a qualified social worker if my support needs are more complex.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

If I need a little bit of support, a light-touch conversation could be done by someone in the community such as a support worker or someone from a voluntary sector organisation.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

However much support I need, the conversation should be the same.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

Light touch and/or more detailed support planning should take place in another way – please say how below

Q6. The Getting It Right For Everyone National Practice model would use the same language across all services and professionals to describe and assess your strengths and needs. Do you agree or disagree with this approach?

☐ Agree

☐ Disagree

Please say why.

Q7. The Getting It Right for Everyone National Practice model would be a single planning process involving everyone who is involved with your care and support, with a single plan that involves me in agreeing the support I require. This would be supported by an integrated social care and health record, so that my information moves through care and support services with me. Do you agree or disagree with this approach?

☐ Agree

☐ Disagree

Please say why.

Q8. Do you agree or disagree that a National Practice Model for adults would improve outcomes?

☐ Agree

☐ Disagree

Please say why.

Right to breaks from caring

How it works now

Breaks from caring are a vital element of carer support. We use the term ‘carer’ to mean someone providing unpaid care for another person so it does not include members of the paid social care workforce. The full legal definition of carer is in section 1 of the Carers (Scotland) Act 2016 (“Carers Act”).

The term ‘respite’ (as used in the Independent Review of Adult Social Care (IRASC)) is not defined or used in legislation but usually refers to support which enables a carer to have a break. The duration can vary from a few hours to a week or more. It can involve support at home, the cared-for person visiting a day service or residential setting, or a holiday break for both parties. It often includes support for the cared for person to replace what the carer usually provides. It can also incorporate support for the carer to achieve what matters to them like participating in a sport or hobby, or seeing friends.

While the term ‘respite’ is widely understood, it is contested as implying a burden or negative representation of the relationship in which care takes place. This document therefore refers to ‘breaks from caring’ or ‘short breaks’.

The Carers Act gives carers the right to support to meet their eligible needs. The Carers Act does not use the term respite and does not create an automatic right to breaks. Instead it requires the need for a ‘break from caring’ to be considered as part of carers’ wider rights to support. Under the Carers Act:

- All carers have the right to an adult carer support plan or young carer statement to identify their personal outcomes and needs for support.
- If any (or all) of these ‘identified needs’ meet the local eligibility criteria, the carer has the right to support to meet such ‘eligible needs’. This can either be support for the carer or the cared for person.
- The authority can also decide to provide support where the identified needs do not meet local eligibility criteria.
- Carers have the right to choose how any such support is provided, in line with the options for self-directed support.
- Whenever an authority is providing support to meet a carer’s identified needs, it must consider whether that support should include a break from caring.

Alongside statutory support under the Carers Act, the Scottish Government also funds the £3 million per year voluntary sector Short Breaks Fund. The Time to Live element of this fund allows local carer centres to offer small grants for unpaid carers to spend on something that gives them a break. These grants provide preventative level support, mainly to carers who do not receive more extensive statutory short break support, to help them recharge - improving their resilience and helping prevent caring relationships breaking down. They have the advantage of reaching carers who may not yet want or need to be in contact with the wider social care system or to prepare a full adult carer support plan or young carer statement. The grants are personalised through discussion with local carer centres about what the carer needs.

Issues and problems

Despite the above rights, relatively few unpaid carers (around 3%) receive statutory support for breaks from caring. This support is often expensive and local authority and Health and Social Care Partnership (HSCP) local eligibility criteria are generally set at high levels of need, to help manage budget pressures.

There were 700,000 – 800,000 unpaid carers before the pandemic, and potentially over 1 million during the pandemic. Caring roles vary in nature and intensity so, while all carers need to be able to take a break, they may not all need the same support to achieve that. It is important that a right to breaks from caring recognises this.

Before the pandemic, there were problems with lack of availability of short break facilities for people with complex or high level support needs.

During the pandemic, there have been problems with availability of many services which enable breaks, particularly day centres and short breaks in care homes.

Relevant Independent Review of Adult Social Care Recommendation

Recommendation 11: Carers need better, more consistent support to carry out their caring role well and to take a break from caring with regular access to quality respite provision. Carers should be given a right to respite with an amendment to the Carers Act as required, and a range of options for respite and short breaks should be developed.

What we propose

The proposed right to breaks from caring will function as a part of the wider social care support system. We want it to be one element of plans to create a single, outcomes-focused approach to care and support which stretches from prevention and early intervention through to acute and specialist provision.

To achieve this, there are several important factors to consider in designing a right to breaks from caring, such as fairness, personalisation, transparency and the value of preventative support. We have considered options which strike different balances between these factors.

Preventative support versus acute need

A right to breaks from caring needs to balance the need for preventative support for a wide group of carers and more intensive support to meet the needs of a smaller group of carers who need it. Both aspects are important for carer wellbeing. It is equally important that short break support achieves positive outcomes for those with care needs (the cared-for person). Preventative support will help to stop many carers and cared-for people reaching crisis point – improving their resilience. But it will never wholly eradicate the need for more intensive support at some stage in many caring journeys. Our preference is a right to breaks from caring which is capable of meeting needs for preventative support as well as needs for more intensive support.

Standard support packages versus personalised support
A right to breaks from caring could be expressed as a right to a standard support package or as a right to personalised support to meet need. Each of these can be viewed as fair or unfair, depending on how fairness is determined.

An entitlement to a standard support package would ensure all qualifying carers were entitled to the same thing. The entitlement could be expressed in terms of days or weeks of short break support or in financial terms. A standard entitlement expressed in financial terms could disadvantage carers of people with more complex health and care needs because replacement care would be more expensive. However, every caring situation is different and a standard package of support may not enable a carer to achieve what matters to them. A lower standard level of support would fail to meet the needs of carers in more intensive and complex caring roles. A very high standard level of support (set at the most acute level of need) would be disproportionate for most carers and unlikely to be affordable. No flat rate entitlement could be fully consistent with the aim of personalising support to deliver personal outcomes.

A tailored entitlement to personalised short break support to meet need would result in different carers receiving different support. But it would be fairer in terms of wellbeing and would better support the needs of both those requiring lower level preventative support and those in intensive and complex roles.

The starting assumption in the Independent Review of Adult Social Care (IRASC) is that any new right to breaks from caring would be integrated into carers' rights under the Carers Act. The Act already creates a structure for discussing each carer's personal outcomes and broader support needs and rights. It would be possible to ensure personalisation by following the IRASC recommendation to integrate a new right to breaks from caring into the Carers Act.

A right for all carers versus thresholds for accessing support
A right to breaks from caring could apply to all carers or only to those who meet a threshold in terms of hours or intensity of caring. The options here look different in terms of outcomes and affordability, depending whether the right is to a standard package or to personalised support.

A right for every carer to a standard package of support may be initially appealing. Given the numbers of people involved (around 1 million), affordability constraints would be likely to mean this is a more modest entitlement, which could not meet the needs of carers in more intensive roles.

Alternatively, a threshold could be set to enable a smaller number of carers to access a larger standard package of support. This would not deliver the preventative support element. It would also exclude carers in less intensive caring roles who may nonetheless be unable to take a break. These issues could be mitigated by setting a series of thresholds to access a series of set packages of support. This would refine the system but would not deliver fully personalised support.

A right for every carer to personalised support to meet need would enable different levels of need to be supported without excluding any set of carers and without

setting thresholds. This would also be in line with the existing approach in the Carers Act, which deliberately moved away from the old threshold of “regular and substantial” caring before a carer could access support, and would be in line with our proposed future approach to accessing support generally.

Transparency and Certainty versus Responsiveness and Flexibility
A right for every carer to a standard package of short break support would be very transparent, providing certainty for carers and authorities about what carers are entitled to. But it would be neither flexible nor responsive to individual need and would not deliver personalised support or fairness in terms of outcomes.

A right to personalised support would be more flexible and responsive and would involve the carer in identifying outcomes and scoping the support needed. But this process implies less transparency and certainty on the face of legislation about exactly what support each individual carer will receive. It would therefore be important for the personalisation process to deliver certainty for individual carers about the short break support they are entitled to and for this to be consistently applied across the country.

Verification and support planning
Every option will require some kind of verification and support planning process in order to access support under a right to breaks from caring. All options require some engagement with the carer about their caring situation. Options which involve a threshold of caring hours to qualify for the right require a way of establishing whether the carer meets the threshold. Options which involve personalised support require discussion with the carer to identify what support is needed. The key issue is ensuring that these processes are person-centred, proportionate and carer friendly.

Under the Carers Act, these processes are intended to work on an informal and person-centred basis through engagement with carer centres and through discussion when preparing an adult carer support plan or young carer statement. The existing Time to Live grant model also offers a light touch means for accessing and personalising non-statutory support for breaks. However, this might end up looking very like a Carers Act process if it were converted into a statutory entitlement.

Options

Group A options – Rights to standard short break packages
a. A universal flat rate entitlement could entitle all carers to a flat rate entitlement to a standard short break package (expressed in number of hours/weeks or in financial terms).

b. A flat rate entitlement restricted to carers who cannot otherwise get a regular break from caring due to the intensity of the caring role. This might be based on hours of caring (e.g. 20+ hours per week; 35+ hours per week; 50+ hours per week) or more sophisticated nationally set criteria covering people in less predictable caring situations. Restricting to a smaller group may enable a more generous flat rate entitlement than an entitlement for all carers.

c. Both of the above approaches could be refined by having a graded level of break entitlement increasing (possibly in steps) according to intensity of the caring role. Again, the level of intensity might be measured on the basis of hours caring (e.g. a basic entitlement for those caring under 20 hours per week; a medium entitlement for those caring 20-35 hours; etc.) or some more sophisticated nationally set graded criteria.

d. A standard entitlement for all carers who have a break from caring identified among their support needs as part of their adult carer support plan or young carer statement. The level of the standard entitlement could vary according to the intensity of caring as in (c). In this model, the adult carer support plan or young carer statement would identify an entitlement to a break but the support provided could still be standardised in some way.

A standard entitlement would be transparent but has limitations for the following reasons. A universal flat rate as in (a) would either underprovide for those in greatest need or overprovide for those with less intense caring roles. A flat rate with a threshold for who the right applies to as in (b) would be inconsistent with the aims of the Carers Act to recognise that the impact of caring is not solely linked to hours of caring and to deliver personalised support, based on what matters to each carer. This option would also exclude carers with less intense caring roles, whether or not those roles have a significant impact on wellbeing or prevent them taking breaks. A graded series of entitlements as in (c) would go some way to matching the level of support to need but would still lack personalisation. The approach in (d) would go through the person-centred processes in the Carers Act to identify personal outcomes and personal needs but would then ignore those to deliver a standard package rather than personalising support.

Group B options – Rights to personalised support

e. A right to personalised support wherever the need for a break from caring is identified as part of the carer's adult carer support plan or young carer statement. This would be a personalised entitlement to meet the carer's specific needs as identified in their individual plan under the Carers Act. Subject to wider decisions on the approach discussed at the Access to Care and Support section of this consultation, this right could apply without additional criteria for who it applies to.

f. Option (e) could be strengthened by the following provisions:

- A statement of principle that every carer is entitled to have sufficient rest and regular breaks from caring. Consideration could be given to whether this should refer to a certain number of days or weeks break from caring.
- A new duty to consider whether this entitlement is being achieved when identifying the personal outcomes for every carer as part of an adult carer support plan or young carer statement.
- If a carer is not achieving this entitlement then their identified personal needs must include a need for support to achieve sufficient rest and regular breaks from caring.

This would then connect to the existing Carers Act duty to provide support to meet these needs. Option (f) would have the advantage of establishing universal statutory

recognition that all carers need a break while retaining scope to personalise the support required to meet the need in each case.

It would create a statutory expectation that all carers should have a level of time off. It could be used to set a standard expectation about how many days or weeks break people need.

It would ensure that all carers who do not currently have sufficient time off can have their needs for breaks identified through the existing adult carer support plan or young carer statement process in the Carers Act. It would do this by ensuring breaks are considered at an earlier stage and are always a key personal outcome and need for every carer. These outcomes and needs for breaks would then be captured in every carer's adult carer support plan or young carer statement and would flow through to the duty on authorities to provide support under the Act.

It would also provide a way to target investment to maximise benefits for carers by ensuring that support is personalised to meet what each carer needs to achieve their breaks outcomes. The support needed may vary, with some carers needing significant replacement care, while others may need lower levels of preventative support for their own break.

Group C options – Hybrid approaches
We are considering whether it is possible to establish a hybrid approach, combining:

- a smaller, guaranteed minimum flat-rate entitlement (as options (a) or (b)) which is easier to access for those in less intensive caring roles; and
- a more personalised entitlement, based on identified needs (as options (e) and (f)) for those in more intensive caring roles.

This has potential to target investment to maximise the benefits in terms of improving outcomes and protecting wellbeing for carers by combining preventative support alongside support for those with higher levels of need.

Such an approach would still require criteria for which carers could access the two elements and consideration would need to be given to whether it was workable, affordable, or proportionate to legislate for two different approaches to entitlement.

An alternative would be to consider non-statutory ways of increasing access to preventative breaks support for carers who may not yet want or need to be in contact with the wider social care system or to prepare a full adult carer support plan or young carer statement. Options for doing this might include expanding the existing non-statutory Short Breaks Fund.

Questions

Q9. For each of the below, please choose which factor you consider is more important in establishing a right to breaks from caring. (Please select one option from each line. Where you see both factors as equally important, please select 'no preference'.)

Standardised support packages versus personalised support

☐ Personalised support to meet need ☐ Standardised levels of support ☐No preference

A right for all carers versus thresholds for accessing support

☐ Universal right for all carers ☐ Right only for those who meet qualifying thresholds ☐ No preference

Transparency and certainty versus responsiveness and flexibility

☐ Certainty about entitlement ☐ Flexibility and responsiveness ☐ No preference

Preventative support versus acute need

☐ Provides preventative support ☐ Meeting acute need ☐ No preference

Q10. Of the three groups, which would be your preferred approach? (Please select one option.)

☐ Group A – Standard entitlements

☐ Group B – Personalised entitlements

☐ Group C – Hybrid approaches

Please say why.

Using data to support care

Current issues and problems

At present, there is a wealth of data available about individuals in receipt of care and support, but it is not always easily available – including to service users and their carers – or used for maximum benefit.

Data about an individual is often held in multiple different places, making it difficult for people providing support across health and social care to access the most relevant, up-to-date information. This makes effective delivery of care, and continuity of care across different service providers and over time as care needs change, more challenging than it needs to be. It also hampers planning and development of services, research, and continuous improvement.

The pandemic has further emphasised that despite the volume of data, there remain significant information gaps and concerns around data quality and reliability. This includes, but is not limited to, information on care at home services, levels of unmet need, experiences of service users, and, crucially, the outcomes achieved for people. Most importantly, it makes it difficult to fully recognise and reflect a complete picture of an individual's personal needs and aspirations in an integrated approach that supports their wellbeing across health and social care.

In addition, there is a lack of a common approach to how data is recorded, what data is stored, and how service users are identified. This makes it challenging to provide services and understand things like equity of provision, and places additional burdens on individuals and provider organisations who may need to provide multiple different types of data to different commissioners for different purposes.

The gaps in existing data and intelligence are made worse by a vast array of formal and informal digital (and paper) systems for recording data across service providers. Data is overwhelmingly held in separate silos at the local level, so it is difficult to form a national picture. The increase in use of technology by individuals to manage their own care also generates a wealth of additional data (which is either captured in proprietary formats or probably held in silos).

This makes accessing and sharing of information to help improve and tailor the services being delivered to people far more challenging. And this extends to how information is shared from social care into and with health (and vice versa).

Early identification and prevention of issues as they arise is critical in delivering improved outcomes for people. For example, an individual who suffers from repeat falls at home will often only come into contact with the health service in relation to their fall when they injure themselves (e.g. break a hip), but repeated falls may suggest an underlying health issue. This data is often collected in social care systems if the person uses a telecare service, but not shared with GPs or the wider community healthcare team who cannot then proactively intervene to address possible causes and reduce the risk of further problems.

We know that social care users continue to be frustrated at having to repeat their care and support needs to different areas of the health and care system. In part, this frustration arises from the reasonable assumption that the sharing of care information is already happening. Information strategies have been developed and systems built to support the sharing of good quality data but we recognise there is a gap between expectation and reality when it comes to data sharing in the social care system.

The Independent Review of Adult Social Care (IRASC) Review set out an ambition for national provision for social care data and information. Whether a social care user, a health or care professional, or those involved in local and national decision making, health and social care provision needs to be enabled by consistent, effective, and efficient information. With the promise and opportunity of a National Care Service, we have the chance to meet this ambition and provide person-centred care and health information to help people plan and support their own care.

Relevant Independent Review of Adult Social Care Recommendations

The key IRASC recommendation relating to using data to support care is:

Recommendation 25: The National Care Service should address gaps in national provision for social care and social work in relation to workforce planning and development, data and research, IT and, as appropriate, national and regional service planning.

However, many of the recommendations (around 20) set out in IRASC are premised on the need for good quality data and digital infrastructure. Improved data and digital infrastructure are critical to helping people live fulfilling, independent lives; enabling professionals to support those people; facilitate ethical and collaborative commissioning; underpin regulation and improvement programmes; support workforce planning; and facilitate research and intelligence. Specific recommendations requiring improved data and digital infrastructure include but are not limited to:

- Recommendation 5: Where not all needs can be met that have been identified as part of a co-production process of developing a support plan, these must be recorded as unmet needs and fed into the strategic commissioning process
- Recommendation 10: Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.
- Recommendation 12: A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights based approach to the support of carers.
- Recommendation 17: The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers.

- Recommendation 18: The National Care Service should lead on the aspects of social care improvement and support that are best managed once for Scotland, such as workforce development and improvement programmes to raise standards of care and support.
- Recommendation 38: A condition of funding for social care services and supports must be that commissioning and procurement decisions are driven by national minimum quality outcome standards for all publicly funded adult social care support.
- Recommendation 50: Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.

What we propose

A National Care Service (NCS) is an opportunity to meet expectations around how information is used to provide and support care, across all care settings and social care decision making at all levels.

Data for an integrated social care and health record

People expect their social care and health information, where appropriate and at the right time, to be available to the people that need to see it. We already have many means to record this information, so do not expect to replace medical records or other well-functioning systems where they already exist. However we do need a platform that can draw this, currently fragmented, information together to focus on people and their outcomes, rather than service provision.

The IRASC recommends a NCS address gaps in national provision for social care data.

Through the NCS, a nationally-consistent, integrated and accessible electronic social care and health record would be put in place that can be used and seen by all those who provide health and care support. Appropriate permissions and consent will be put in place to control who can see what information. This is not about imposing a single, new system but seeing the potential the NCS could provide to act as the additional national framework that allows for person-centred data and information to be shared safely and securely.

We would consider systems and functionality already in place as well as realising the opportunities that a NCS could provide to create new digital and data infrastructure. We would also learn from current specialised records, for example, the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT), which creates personalised recommendations for a person's clinical care and treatment in a future emergency in which they are unable to make or express choices.

Consistent, good quality and portable information would help people achieve their own goals and desired outcomes by ensuring those providing services have a better

understanding of people's care and support needs. Your care plan would assist your care and support, be responsive to your changing needs and be accessible across different care settings. It will support the Getting it Right for Everyone national practice model, enabling all providers to ensure they are meeting your needs as set out in your care plan. It would allow you to control how different care services see and use your data, and give you confidence that the latest information is accessible across the care system and the healthcare system as appropriate.

In line with our strategic approach to digital health and care, this would be co-designed with users and their support networks. We will take particular care to respond to concerns over the security and governance of information. We need to ensure the appropriate and respectful use of personal data, with controls in place that maintain data confidentiality, to maintain people's trust. This includes support to those that may lack capacity to provide consent to share their data.

We would be transparent on the purpose of the information, transparent on who can access it, and transparent on how it can be shared. We would listen to the range of perspectives on these issues. It will be our responsibility to make sure everyone understands how their data is used. We will need to reassure those that are hesitant about data sharing and build-in an opt out option if required. Throughout, we will fully meet our privacy and security obligations.

Data to assist care and support across all settings

To provide the best possible care and support, and outcomes on a day-to-day basis, health and social care professionals need good quality, relevant, timely, and accessible data and intelligence that is consistently recorded in an agreed format using nationally-agreed definitions. In the context of a resident in a care home, for example, that means access to a care plan and care records by those outside of the care home providing support along with access for the care home to relevant data held by the NHS. A NCS would allow the safe and efficient sharing of data across all care settings and be clear on the agreed purposes to share data.

To achieve this we will look to introduce legislation to require all primary and community health care and social care services to provide data to the NCS. This would enable improved data for and from the vast array of health and social care providers (including both third sector and private providers). There would also be the opportunity to reduce the administrative burden of managing data and streamline data collection.

The NCS would make sure people's data and information moves with them from prevention and early intervention through to acute and specialist provision. Achieving this is an imperative, to make sure wherever care and support is accessed the right data is available to those that support and provide care.

Data to inform local and national decision making

Beyond the day-to-day care management, the NCS should be able to require data that can be used locally and nationally for strategic plans, commissioning, delivery monitoring, and performance reporting.

Aligning with the Digital First Service Standard, we will look to introduce legislation that requires data for local and national decision making to address the social care information gaps along with a requirement to meet common data standards and definitions.

We do not propose to set out the requirements themselves in primary legislation, as it cannot be changed fast enough to adapt to the rapid changes in technology and new ways of using data. We will set out a requirement that will be specified in guidance to meet common data standards and definitions for how that data is collected, received and stored.

A consistent approach to data and effective information infrastructure should also support service delivery, inform planning, facilitate better regulation (which in turn helps drive improving standards), and provide the data required for research and analysis. The NCS could be the driving force for true collaboration with a minimal viable social care dataset as a starting point to develop social care policy at the local and national level.

We also recognise that this would require additional investment in data and digital systems, locally as well as nationally. And investment in people to make sure they have the right skills to use and analyse these data. We need to help the workforce improve their understanding of how to provide and use quality data and why it matters, and we need to have data specialists to drive improvement and accountability.

Data Protection and Freedom of Information
Individuals have a legal right of access to information about themselves under Data Protection legislation, which will apply in addition to the systems that will be created to make sure people are able to use their own integrated social care and health record.

It is also important that people can get information more generally about health and care services. The National Care Service and Community Health and Social Care Boards will be subject to the requirements of the Freedom of Information (Scotland) Act 2002 (FOISA), as IJBs are at present. The Scottish Government consulted in 2019 on the future use of Scottish Ministers powers under section 5 of FOISA to extend Freedom of Information requirements to bodies that either exercise functions of a public nature or have a contract with a Scottish public authority to provide a service which is a function of that authority. This could potentially include private and third sector organisations that deliver health and social care functions. The analysis of that consultation was published in March 2020, and a paper setting out the Scottish Government's next steps will be published later in 2021. Any proposals will be subject to further detailed consultation as required by section 5 of FOISA.

Questions

Q11. To what extent do you agree or disagree with the following statements?

- There should be a nationally-consistent, integrated and accessible electronic social care and health record.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

- Information about your health and care needs should be shared across the services that support you.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree

Q12. Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection?

☐ Yes

☐ No

Please say why.

Q13. Are there alternative approaches that would address current gaps in social care data and information, and ensure a consistent approach for the flow of data and information across the National Care Service?

Complaints and putting things right

How it works now

As part of the package of improving people's experience of social care services, it is important that, where things do not go well, people know how they can complain and there are effective systems to make sure things are put right. We also need to have good information about people's experience of care, to help understand where improvements could be made.

Currently, complaints can be made against individual registered services via the Care Inspectorate and for individual staff via the Scottish Social Services Council (SSSC). Feedback or complaints can also go via the local Health and Social Care Partnership (HSCP), this includes feedback/complaints on assessment, eligibility/payment and wait for care and support as well as about quality/safety of services.

If people are not happy with the decision relating to their complaint, from any of these bodies, they can approach the Public Sector Ombudsman for Scotland.

There is currently some limited information on experiences of social care and caring available from the Health and Care Experience Survey (HACE). HACE is carried out every two years by Health and Social Care Analysis. It provides insights into people's experiences of receiving care including how they felt about the decision making process, the support that they received, and their overall satisfaction. Although the current survey provides an insight into experience of care it does not have detailed information on the type of care received which limits our understanding of the context of the experience. Around 13,000 – 14,000 responses are received for care and support. The limited questions mean it is not possible to examine fully all the domains of quality and safe care.

Issues and problems

The current system could be viewed as complex with separate channels for feedback and complaints about those providing services and about individual staff. There is also no dedicated website or information for those who wish to give feedback or make a complaint as there is with the National Health Service.

The Competition and Market Authority report into care homes in 2017 recommended that for the market to work better for those using services there must be more support for those making decisions on care, but also critically that they must be protected when things do not work out.

Although detailed data is available on complaints via the Care Inspectorate and SSSC this could be viewed as difficult to find and may not be easily accessible for those who currently use services or those planning on using services.

HSCPs have different processes for handling complaints and feedback and one criticism of the current system is that it may not be uniform across areas.

Duty of candour legislation places a legal requirement on all health and care services (including independent and third sector organisations) that when things go wrong then people have a right to know what happened.

It is also recognised that people are not aware of advocacy services that are available to them or they are unable to access appropriate services. This can leave people without a voice and unable to articulate the issues they face.

A robust, credible system that people (or their advocates) can access easily to provide feedback and complaints is necessary for a well-functioning system. It is also critical that lessons are learned from feedback and complaints and a continuous response loop operates. Feedback and complaints should also be both monitored nationally to provide an overview of issues and used proactively by local bodies and the Care Inspectorate when reviewing the quality and safety of services. It is also critical to examine any previous feedback or complaints in light of adverse events.

It is also important that we are able to measure experience more broadly across social care than is currently the case. Experience is a key measure in any quality/safety framework and is directly related to outcomes. To date as the review states, “previous attempts to establish a single set of outcome measures across adult health and social care have been hampered by complexity and duplication. These obstacles need to be overcome to ensure clarity of purpose and transparency of the evidence base for progress”.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 8: More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.

Recommendation 9: When things do not work well for people and their rights have not been upheld, they must have rapid recourse to an effective complaints system and to redress.

Recommendation 12: A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights based approach to the support of carers.

Recommendation 21: The National Care Service in close co-operation with the National Health Service should establish a simplified set of outcome measures to measure progress in health and social care support, through which to oversee delivery of social care in local systems via reformed Integration Joint Boards and national care bodies.

What we propose

We propose that there should be a national single point of access for information on making a complaint or giving feedback about social care, providing links where necessary to relevant organisations. This would also include information on what people can do if they are not content with the process, and an overview of advocacy

rights and services. The same single point of access would provide relevant links to data/information on feedback and complaints.

Local systems for initial complaints and feedback should be strengthened so there are similar processes across local bodies who commission and deliver services. It is important that people feel that they can still approach local community health and social care bodies and that where possible feedback or complaints are dealt with at that level.

We will consider developing a charter for rights and responsibilities, as there are for health, for carers, and for Social Security Scotland. A charter would provide clarity as to what rights and responsible individuals, their families, and their carers can expect and outline clearly the process for feedback and complaints.

Local bodies will be required to demonstrate that they have informed clients, their families, and carers about advocacy services and their right to a voice.

We will consider whether it is appropriate to appoint a commissioner for social care. A commissioner would champion the rights of those who receive care and support, their families, and carers and ensure they are protected by the law. The commissioner and the office would act on behalf of those who receive care and support. We would need to consider carefully the role of such a commissioner, as it could overlap with the responsibilities of other existing commissioners, such as the Children and Young People's Commissioner, and others which have been proposed including the Patient Safety Commissioner.

Feedback and complaints should be used proactively with other data and intelligence to understand the quality and safety of services nationally and locally. Relevant national information should be fed back to local bodies who commission and work with services on a day to day basis. Specifically, any trends in feedback or complaints relevant to certain parts of the sector or across one provider should be proactively addressed.

Care providers will be required to demonstrate they have taken feedback and complaints on board when they are inspected. This will be used as a key outcome measure. Experience of care has been found to be a powerful indicator of people's outcomes. An outcome is the result or the effect of care and support, it will be directly impacted by the care or support received but also by the process around that care and support such as communication and timeliness of care and support.

We will carry out a review of capturing experience in adult social care. This may include a survey but also potentially other methods. A key theme to capture will be how people feel about communication as this is consistently raised in complaints. Other themes may include timeliness of care and support, how supported individuals were in decision making, and safety.

Questions

Q14. What elements would be most important in a new system for complaints about social care services? (Please select 3 options)

- ☐ Charter of rights and responsibilities, so people know what they can expect
- ☐ Single point of access for feedback and complaints about all parts of the system
- ☐ Clear information about advocacy services and the right to a voice
- ☐ Consistent model for handling complaints for all bodies
- ☐ Addressing complaints initially with the body the complaint is about
- ☐ Clear information about next steps if a complainant is not happy with the initial response
- ☐ Other – please explain

Q15. Should a model of complaints handling be underpinned by a commissioner for community health and care?

- ☐ Yes
- ☐ No

Please say why.

Q16. Should a National Care Service use a measure of experience of those receiving care and support, their families and carers as a key outcome measure?

- ☐ Yes
- ☐ No

Please say why.

Residential Care Charges

How it works now

Current regulations and guidance provide the framework for local authorities to charge for the residential care that they provide or arrange. The local authority will carry out a financial assessment on any individual requiring or choosing to have residential care to determine how much someone is expected to contribute towards their care home costs.

The financial assessment looks at a person's resources compared to a number of set levels called 'capital limits'. Currently, anyone with capital (including property) of more than £28,750, must meet their care costs (over and above any assessed entitlement to free personal and nursing care) in full. These individuals are commonly referred to as 'self-funders'.

Where capital falls between £18,000 and £28,750 a resident will be expected to contribute a proportion of their assets towards the cost of care. If someone has capital of £18,000 or less, they will not ordinarily be asked to contribute towards the cost of their care and be placed within a care home on the National Care Home Contract (NCHC). The NCHC is negotiated annually between local authorities and care providers and provides a framework for national charging for residential care.

The Scottish Government are aware of instances where families are asked to contribute to care over and above the NCHC rate by care home operators.

These capital limits are ordinarily uprated each year in line with inflation

By comparison, England and Northern Ireland have a lower capital limit of £14,250 and an upper capital limit of £23,250. In Wales there is a single capital limit of £50,000.

Residents are expected to contribute to care home fees from income such as their pensions, but are entitled to keep an amount for personal expenses (the Personal Expenses Allowance). This is currently set at £29.30 per week.

Adults who have been assessed as requiring Personal Care do not pay for this service, regardless of their condition or means. Nursing Care is also free at the point of delivery. The local authority pay for these elements of the residential care for all those assessed as needing them. The current rates are £193.50 per week for Personal Care and £87.10 per week for Nursing Care. For self-funders, this payment is made directly to the provider on behalf of the resident.

These rates for Personal and Nursing Care are generally uprated each year by inflation. However, the cost of providing these services has increased above inflation in recent years, meaning the rates of payment have not kept pace. To help address this, for 2020/21 we increased the rates by 7.5%. However, some stakeholders expressed concern that care providers would increase their fees by an equivalent amount and self-funders will not see any benefit.

Issues and problems

The Independent Review of Adult Social Care (IRASC) makes an associated recommendation to remove charging for non-residential social care. If this were to be implemented it should mean that the only cost for people in receipt of social care should be the means tested accommodation costs for care home residents.

However, in recent years the cost of providing Free Personal and Nursing Care has increased significantly and the payment made to providers by local authorities for self-funding residents has not kept pace with this. This is not an issue for local authority funded placements covered by the NCHC, which IRASC felt contains reasonable provision for the cost of Free Personal and Nursing Care.

IRASC estimated that the cost of increasing these payments on behalf of self-funders to the rate paid by local authority-funded placements to be in the region of £116 million per year.

IRASC did not consider in detail whether adjustments should be made to the means testing arrangements of the residential charging regime, though it suggested that this may be something the NCS may wish to consider in future.

Over a number of years the current level of capital limits have been criticised as they capture many middle and lower income households.

Relevant Independent Review of Adult Social Care Recommendation

Recommendation 51. Additional investment in order to increase the sums paid for Free Personal and Nursing Care for self-funders using care homes to the levels included in the NCHC.

What we propose

In line with the IRASC recommendation, increase the sums paid for Free Personal and Nursing Care for self-funded care home residents to the levels included in the NCHC or consider alternatives, such as revising means testing, to assist in ensuring self-funding residents are treated fairly in their financial assessment.

Questions

Q17. Most people have to pay for the costs of where they live such as mortgage payments or rent, property maintenance, food and utility bills. To ensure fairness between those who live in residential care and those who do not, should self-funding care home residents have to contribute towards accommodation-based costs such as (please tick all that apply):

- ☐ Rent
- ☐ Maintenance
- ☐ Furnishings
- ☐ Utilities
- ☐ Food costs
- ☐ Food preparation
- ☐ Equipment
- ☐ Leisure and entertainment
- ☐ Transport
- ☐ Laundry
- ☐ Cleaning
- ☐ Other – what would that be

Q18. Free personal and nursing care payment for self-funders are paid directly to the care provider on their behalf. What would be the impact of increasing personal and nursing care payments to National Care Home Contract rates on:

- Self-funders

- Care home operators

- Local authorities

- Other

Q19. Should we consider revising the current means testing arrangements?

☐ Yes

☐ No

If yes, what potential alternatives or changes should be considered?

National Care Service

The case for change

The priority is to ensure national minimum standards, improve consistency, and raise the quality of services across the country. Variation in quality and access to community health and social care has been raised as a concern by those in receipt of support and care and their families. The pandemic shone a spotlight on these issues and regardless of the systems in place people made clear that they saw the Scottish Government as accountable for failings and variations.

The establishment of a National Care Service (NCS), accountable to Scottish Ministers, will ensure that we can:

- achieve consistency across the country, and drive national improvements,
- ensure strategic level integration with the NHS that promotes preventative care and reduces the need for hospital stays,
- sets clear national standards and terms and conditions for the commissioning and delivery of services; and
- vitally bring national oversight and accountability to ensure that all individuals universally have access to the services needed.

In this chapter the proposed core scope, role, and remit for a new NCS are set out. These are considered the minimum national levers needed to deliver the pace and scale of improvement needed to improve and maintain outcomes for people across Scotland in a consistent way.

How it works now

At present, local authorities have statutory responsibility for providing social care support, and Scottish Ministers, through local Health Boards, have responsibility for health care. Under the Public Bodies (Joint Working) (Scotland) Act 2014 (PBJWSA), and secondary legislation made using powers granted by that Act, local authorities and Health Boards are required to delegate certain functions (and budgets) to a local integration authority, and may delegate others. In most areas the integration authority is an Integration Joint Board (IJB) which includes members from both the local authority and local Health Board; Highland uses a Lead Authority approach, in which the Health Board takes responsibility for all adult health and social care services, and Highland Council takes responsibility for all children's services.

The integration authority then plans what care is needed in its area and directs (and provides funding to) the Health Board and the local authority to deliver it. The local authority is responsible for commissioning and directing procurement of social care support services.

The majority of adult social care is required to be delegated to the integration authority, as well as community-based healthcare, such as GPs' contracts, community nursing (general practice nursing, district nurses, community mental health and learning disability nurses, school nurses, health visitors, clinical nurse specialists, and prison health nurses), mental health services, and services provided

by allied health professionals such as occupational therapists, podiatrists, and dieticians. Where there is local agreement, social care services for children and justice social work can also be delegated. While the Independent Review of Adult Social Care (IRASC) was concerned only with adult social care, it found that integration arrangements worked especially well where the widest range of functions were delegated.

The following local authority and NHS functions are required to be delegated to Integration Joint Boards (IJBs):

- The strategic planning for Accident and Emergency services provided in a hospital
- The strategic planning for inpatient hospital services relating to the following branches of medicine:
  - general medicine;
  - geriatric medicine;
  - rehabilitation medicine;
  - respiratory medicine.
- Palliative care services
- District nursing services
- Services provided by allied health professionals such as dieticians and occupational therapists
- Dental services
- Primary medical services (including out of hours)
- Some housing functions (adaptations and housing support)
- Assisted garden maintenance
- Ophthalmic services
- Pharmaceutical services
- Sexual Health Services
- Mental Health Services
- Alcohol and Drug Services
- Health improvement
- School Nursing and Health Visiting Services
- Social Care Services for adults and older people
- Carers support services

The following additional functions may be delegated by local agreement:

- Social Care Services provided to Children and Families, including:
  - Fostering and Adoption Services
  - Child Protection
- Homelessness Services
- Criminal Justice Services

What are the problems?

The IRASC identified that a key problem is a lack of national accountability and leadership for social care support. This has resulted in inequitable access to

community health and social care provision for people, and lack of consistency of experience of support and services across the country, with people who use supports and services often referring to a “postcode lottery”. While there is good practice in many places, there is no mechanism for making sure this spreads across the country.

The aim of integration was to improve people’s experience of social care, and to focus on early intervention and preventative approaches, rather than only intervening when people reach a crisis. This has not worked as well as it should have done, particularly due to a lack of collaborative leadership in some areas. Financial planning is not always integrated, long-term, or focused on providing the best outcomes for people who need support. This limits the ability of integration authorities to improve the health and social care system. There is also a lack of strategic capacity and a high turnover of integration authority staff to support planning, commissioning, and delivery. Current commissioning and procurement processes are characterised by mistrust, conflict, and market forces. Procurement methodology and practices in community health and social care have increasingly driven and sometimes undermined commissioning decisions.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 15: Accountability for social care support should move from local government to Scottish Ministers, and a Minister should be appointed with specific responsibility for Social Care.

Recommendation 16: A National Care Service for Scotland should be established in statute along with, on an equal footing, NHS Scotland, with both bodies reporting to Scottish Ministers.

Recommendation 17: The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers.

Recommendation 18: The National Care Service should lead on the aspects of social care improvement and support that are best managed once for Scotland, such as workforce development and improvement programmes to raise standards of care and support.

Recommendation 19: The National Care Service should oversee social care provision at national level for people whose needs are very complex or highly specialist and for services such as prison social care that could be better managed on a once-for-Scotland basis.

Recommendation 20: The National Care Service’s driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce.

Recommendation 22: A Chief Executive should be appointed to the National Care Service, equivalent to the Chief Executive of the National Health Service and accountable to Ministers.

Recommendation 25: The National Care Service should address gaps in national provision for social care and social work in relation to workforce planning and development, data and research, IT and, as appropriate, national and regional service planning.

Recommendation 26: The National Care Service should manage provision of care for people whose care needs are particularly complex and specialist, and should be responsible for planning and delivery of care in custodial settings, including prisons.

The report also suggests that a similar body should be established for NHS Scotland, and there should be a National Integration Joint Board, bringing together the NCS and NHS to agree national strategy and priorities.

What we propose

We will make Scottish Ministers accountable for social care as they are for health care within Scotland.

We will establish a National Care Service, accountable to Scottish Ministers, which will have a clear focus on positive outcomes for people and "Getting it Right for Everyone". The NCS will work in parallel and in partnership with Scotland's NHS, but independent of the NHS.

The NCS will involve the people of Scotland in the design, development and delivery of support and services from the outset and on a continual basis.

We propose that the NCS will define the strategic direction, quality standards and the framework for person-centred operational delivery of community health and social care in Scotland. It will ensure the delivery of consistent, high standards of care for everyone across Scotland.

IJBs will be reformed and will become Community Health and Social Care Boards (CHSCBs) and will be the local delivery body for the National Care Service. The National Care Service and CHSCBs will work in concert with the NHS, local authorities, and the third and independent sectors to plan, commission and deliver the support and services that the people of Scotland require.

The NCS itself will lead on aspects of community health and social care improvement and support that are best managed on a once for Scotland basis. It will also deliver community health and social care provision at a national level for people whose needs are very complex or highly specialist, and the planning and delivery of care in custodial settings, including prisons.

The NCS will be responsible for national workforce planning and development, data to support planning, commissioning and procurement, research to support improvement, digital enablement, and national and regional service planning.

The creation of a NCS does not mean that the Scottish Government would run all care homes or other services directly. There is no evidence that providing services through the public sector increases quality, in fact in community based services, quality is generally highest among third sector providers. The IRASC also identified that it would also be enormously expensive to take social care into public ownership, expenditure that could be better used working to improve care. While some services may be provided directly, we expect that the NCS and CHSCBs will continue to commission and procure services from a range of providers, as IJBs do at present.

When the outcomes of this consultation are clear, we will consider the implications and any necessary changes in structure, integration and alignment for and with the NHS, to ensure a coherent approach to national and local strategy and delivery.

Questions

Q20. Do you agree that Scottish Ministers should be accountable for the delivery of social care, through a National Care Service?

- ☐ Yes
- ☐ No, current arrangements should stay in place
- ☐ No, another approach should be taken (please give details)

Q21. Are there any other services or functions the National Care Service should be responsible for, in addition to those set out in the chapter?

Q22. Are there any services or functions listed in the chapter that the National Care Service should not be responsible for?

Scope of the National Care Service

Children's services

How it works now

The provision of children's social work and social care services is inextricably related to the provision of services to adults. By children's services we mean any service provided to or for the benefit of children by either a local authority, Health Board, Third Sector, or commissioned provider, including those who are leaving or have left care, children with complex health conditions, young people involved in offending behaviour, or those with additional support needs.

A number of Integration Joint Boards (IJBs) already have children's services delegated to them with the remainder remaining within local authorities. For example of the 31 IJBs:

- 19 currently have Children's Health delegated,
- 10 have Children and Families Social Work
- 15 are responsible for Justice Social Work

Where children's services are not delegated to an IJB they have remained within the local authority, often within the Education Department.

Alongside this is a complex statutory framework for social work and care, contained in a number of pieces of legislation cutting across both adult and children's services, in addition to children-specific legislation.

The complexity is such that there are significant implications for children's social work and care services – given it can be particularly difficult to separate out social care support for adults with the social care needs of the children who live with them.

Issues and problems

Not including children's social work and social care within the National Care Service (NCS) risks fragmenting the current system of care and assessment and further adding to complexity for services users – a key issue highlighted by Independent Review of Adult Social Care (IRASC). Any changes to the adult social care system must also take account of the need for parents of children within or at risk of being involved in the care system being able to access treatment early to keep children in loving homes. Whilst for disabled children, continuity of care and support as they transition to adulthood is essential.

Separating the delivery arm of the process by creating a National Care Service focused solely on adult social care would also have consequences for the ambition that improved planning and commissioning functions will deliver through having both social work and social care within the NCS, whilst ensuring continuity of risk management and the protection of human rights.

Whilst the IRASC specifically focused on adult social care, it should be seen in the context of the Promise, the United Nation's Convention on the Rights of the Child (UNCRC), Getting It Right for Every Child (GIRFEC), and other children's policy areas such as increasing the Age of Criminal Responsibility.

The Promise concluded that "for Scotland to truly to be the best place in the world for children to grow up, a fundamental shift is required in how decisions are made about children and families". For this fundamental shift to happen services have to be designed in a truly collaborative way – IRASC therefore provides an opportunity to look holistically at the system of support for children, young people and their families.

Relevant Independent Review of Adult Social Care Recommendations

The IRASC was clear that its focus was on adult social care - it therefore did not consider issues relating to children and family services (by which we mean the provision of social work and social care services to children and families).

It did note though that "Social workers were also concerned about the impact possible fragmentation would have on children, families and adults needing support and who do not lead their lives according to administrative boundaries or arrangements. Careful consideration should be given to these concerns as changes are taken forward and close joint working forged between the implementation of The Promise and the recommendations in this report*".*

What we propose

Our proposal therefore is that children's social work and social care services should be located within the NCS to ensure a more cohesive integration of health, social work, and social care. By doing so, it affords the opportunity to address the unanticipated consequence of integration where children's social work is currently fragmented across different public bodies in different integration arrangements.

Having children's social work and social care within the NCS will provide the opportunity for services to become more cohesive – built around the child, family, or person who needs support – reducing complexity and ensuring improved transitions and support for those that need to access a range of services, including improved links with health. Location within the NCS would also permit us to have a system where access, assessment, funding, and accountability is in one body. In doing so we need to retain and strengthen the existing links with Education and Early Learning and Childcare.

The overarching purpose will be to ensure consistent delivery of services to the most vulnerable children and families, which is inextricably related to the provision of services to adults. In doing so we need to ensure that access to services and reduced complexity for service users is a fundamental principle – this being one of the key messages from the IRASC.

Questions

Q23. Should the National Care Service include both adults and children's social work and social care services?

☐ Yes

☐ No

Please say why.

Q24. Do you think that locating children's social work and social care services within the National Care Service will reduce complexity for children and their families in accessing services?

- For children with disabilities,

☐ Yes

☐ No

Please say why.

- For transitions to adulthood

☐ Yes

☐ No

Please say why.

- For children with family members needing support

☐ Yes

☐ No

Please say why.

Q25. Do you think that locating children's social work services within the National Care Service will improve alignment with community child health services including primary care, and paediatric health services?

☐ Yes

☐ No

Please say why.

Q26. Do you think there are any risks in including children's services in the National Care Service?

☐ Yes

☐ No

If yes, please give examples

Healthcare

How it works now

Primary care is generally people's first point of contact with the NHS. This includes contact with community based services provided by general practitioners (GPs) and others including dentists, optometrists, pharmacists and physiotherapists.

Community based healthcare services in Scotland provided by the NHS and third and independent sectors play a key role in our health and care system and cover a wide range of services provided by registered nurses, midwives, and allied health professionals. This includes, for example, community nurses (district nursing, general practice nurses, prison health nurses, care home nurses, community mental health and learning disability nurses, clinical nurse specialists, health visitors, family nurses, school nurses, and community children's nurses) and allied health professionals such as physiotherapists, occupational therapists, podiatrists, dieticians, and speech and language therapists.

These services play a key role in keeping people well, providing holistic, rights-based, and person-centred care. This includes assessing and anticipating care needs, supporting self-management, treating and managing acute illness, long-term conditions, supporting palliative and end of life care at home or in a community setting, and supporting people to live independently in their own homes.

Community health care teams work closely with Primary Care General Practice teams and alongside social work and social care teams to meet people's health and social care needs. The level of joined up working across community health and social care can vary across Scotland, often as a result of silo working or complex referral systems which impact on seamless care and continuity.

The Primary Medical Services (Scotland) Act 2004 amended the National Health Service (Scotland) Act 1978 by placing a duty on Health Boards to provide or secure "primary medical services" for their populations. Health Boards can contract with general practitioners to deliver services and/or run their own. The majority of GP practices in Scotland are run by GPs as independent contractors. They contract with the Health Board to deliver medical services and in turn they receive funding to provide those services based on the size of their patient list and other factors. The remaining practices are run by the Health Boards directly. The GP contract is nationally negotiated.

Other services such as dentistry, pharmacy, and optometry may also be provided by independent contractors in a similar way.

The Public Bodies (Joint Working) (Scotland) Act 2014 was introduced to ensure that health and social care services are well integrated, so that people receive the care they need at the right time and in the right setting, with a focus on shifting the balance of care from hospital to community settings with a focus on prevention, anticipatory care, and early intervention.

The Act requires local authorities and Health Boards to delegate powers and funding to an integration authority, usually an Integration Joint Board (IJB). The integration authority is then responsible for planning what care is needed in its area and for directing (and providing funding to) the Health Board and the local authority to deliver it.

Integration authorities are responsible for planning and commissioning almost all primary care and community-based health care. They also carry out strategic planning for Accident and Emergency services and inpatient hospital services for certain types of medicine. This is intended to help integrate services to avoid the need for hospital care where it is preventable, for example where better social care could help a person to manage their health condition at home.

All healthcare commissioned by the Integration authorities is provided or contracted by the Health Board. NHS provided community based services fall under NHS legislation and are free at the point of access. Unlike social care there is no eligibility criteria for accessing community health care.

The fact that all healthcare continues to be provided through the Health Board, although commissioned by the integration authority, allows the Health Board to maintain responsibility for clinical and professional governance arrangements for services provided and professionals employed by the NHS. This is the process by which accountability for the quality of health care is monitored and assured, supporting staff in continuously improving the quality and safety of care.

Issues and problems

The Independent Review of Adult Social Care (IRASC) identified that integration of health and social care has not worked as well as it should have done, particularly due to a lack of collaborative leadership in some areas. Where there is tension between Health Boards, local authorities, and IJBs it can stifle progress and innovation. It can also lead to community health services not aligning adequately with social care and hospital-based health care to provide a whole system approach to health and social care.

As the GP contract is a nationally negotiated contract there are limits to the ability of the IJB to influence GP service delivery.

There can be challenges of communication and cultural differences between workers in different areas of health care, social work and social care. These can cause difficulties in providing integrated, person-centred care for an individual and on the approaches to governance and quality improvement. Effective professional and clinical and care governance structures are critical to supporting professionals to work together better across these traditional boundaries.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 17: Integration Joint Boards should manage GPs' contractual arrangements, whether independent contractors or directly employed, to ensure integration of community care and support provision, to respect and support

professional interdependencies, and to remove the current confusion about where responsibility for primary care sits.

The IRASC suggests that a National Care Service should ensure effective working with NHS Scotland, establishing a joint approach where beneficial to people accessing care. This priority could be enabled by the creation of a similar board of governance for NHS Scotland and the creation of a National Integration Joint Board where the senior leadership of the National Care Service and NHS meet regularly to agree strategy and priorities.

It also proposes that The National Care Service should develop and maintain the distribution formula for direct allocation of budgets by the Scottish Government to Integration Joint Boards and national care bodies.

What we propose

IRASC was only concerned with adult social care, and therefore did not make further recommendations in relation to health. However, the ambition for the National Care Service is to go further and deliver consistent, person-centred, community health and social care services for all ages. It would also be possible to consider the National Care Service, and in turn, Community Health and Social Care Boards, taking responsibility for the commissioning and procurement of a range of health services, similar to (and potentially wider than) the range of services currently delegated to Integration Joint Boards. This commissioning is already done to an extent by IJBs. We are seeking your views on what services might be included in this responsibility.

In line with the recommendations of IRASC, we also propose that Community Health and Social Care Boards (CHSCBs) should manage GPs' contractual arrangements.

In doing so, and in any consideration of distribution formula for direct allocation of budgets by the National Care Service, it should take into account the recommendations of the Remote and Rural General Practice Working Group, in their report "Shaping the Future Together", including the recommendation to "review the method of funding allocations to territorial Boards with significant remote and rural areas, including Island Boards, in the light of changing demographics, care needs and evolving models of care provision".

We recognise that any such reforms will need to make appropriate arrangements for clinical and professional governance, and to consider the opportunities available for staff. How any reforms align with the role of Healthcare Improvement Scotland will also need careful consideration. We do not envisage a wholesale change in employment status for people in the NHS, rather that robust commissioning and procurement arrangements are in place. Regardless of which organisation plans, commissions and delivers services, health and social care professionals will require to continue to work in an integrated way to support the person-centred approach to care that we seek to deliver.

Questions

Q27. Do you agree that the National Care Service and at a local level, Community Health and Social Care Boards should commission, procure and manage community health care services which are currently delegated to Integration Joint Boards and provided through Health Boards?

☐ Yes

☐ No

Please say why.

Q28. If the National Care Service and Community Health and Social Care Boards take responsibility for planning, commissioning and procurement of community health services, how could they support better integration with hospital-based care services?

Q29. What would be the benefits of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

☐ Better integration of health and social care

☐ Better outcomes for people using health and care services

☐ Clearer leadership and accountability arrangements

☐ Improved multidisciplinary team working

☐ Improved professional and clinical care governance arrangements

☐ Other (please explain below)

Q30. What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

- ☐ Fragmentation of health services
- ☐ Poorer outcomes for people using health and care services
- ☐ Unclear leadership and accountability arrangements
- ☐ Poorer professional and clinical care governance arrangements
- ☐ Other (please explain below)

Q31. Are there any other ways of managing community health services that would provide better integration with social care?

Social Work and Social Care

How it works now

Social work is a profession with responsibility for discharging statutory powers and duties and is deep rooted in human rights across all age ranges and care groups – it is also key to the assessment of need and the planning, commissioning, and delivery of social work and social care services.

Social work has a key role in the co-ordination and delivery of social care support for adults, children, and often whole families, supporting individuals and families to manage the transition from children and family services into adult care services. Social workers provide direct support, help, and signposting to people in assessing their need for social care. The assessed need is then delivered through social care services. Subsequently, social workers have a responsibility for monitoring and reviewing care to ensure the individual's needs continue to be met. They also ensure safeguarding through their statutory responsibilities including Adult Support and Protection, Child Protection, Mental Health Care and Treatment, Adults with Incapacity, and Public Protection.

Social work has a complex statutory framework cutting across adults' and children's services and criminal justice services. The Public Bodies (Joint Working) (Scotland) Act (2014) resulted in social work across these areas being delivered across a variety of structures within Integrated Joint Boards and Councils

Issues and problems

Careful consideration is needed about how to best use the professional qualified skills of social workers, recognising their direct relationship with social care across all age groups.

Not including all social work and children's social care within the National Care Service (NCS) risks fragmenting the current system of care and assessment and further adding to complexity for services users – a key issue highlighted by Independent Review of Adult Social Care (IRASC). It can be particularly difficult to separate out social work support for adults with the social work and social care needs of the child who live with them.

Creating a NCS to deliver only adult social care, whilst retaining social work duties and responsibilities within local authorities would have consequences for the NCS's ambition to improve planning and commissioning functions, and for ensuring continuity of risk management and the protection of human rights.

Relevant Independent Review of Adult Social Care Recommendations

Whilst IRASC focused on adult social care, its findings have led to further consideration about how adult, children and justice social work and social care are intrinsically linked, how we improve social work and health and social care outcomes for individuals and their families and how changes will empower people to engage with their care either in the short or longer term, depending on their needs.

IRASC noted that, “Social workers were also concerned about the impact possible fragmentation would have on children, families and adults needing support and who do not lead their lives according to administrative boundaries or arrangements. Careful consideration should be given to these concerns as changes are taken forward and close joint working forged between the implementation of The Promise and the recommendations in this report*”.*

What we propose

Our proposal therefore is that duties and responsibilities for social work and adult and children and families’ social care services should be located within the NCS to ensure a more equitable and cohesive integration of health, social work and social care. By doing so, it affords the opportunity to address the unanticipated consequence of integration where social work and social care is currently fragmented across different public bodies in different integration arrangements.

It will provide the opportunity for services to become more cohesive – built around the child, family, or person who needs support – reducing complexity and ensuring improved transitions and support for those that need to access a range of services. Location within the NCS would also permit us to have a system where access, assessment, funding and accountability is in one body.

Including social work within the NCS would mean social work’s legal powers and expertise would remain inextricably linked with the delivery of care, and with the work of a National Social Work Agency (see page 88) to enable the consistent scaling up of good practice.

Questions

Q32. What do you see as the main benefits in having social work planning, assessment, commissioning and accountability located within the National Care Service? (Please tick all that apply)

- ☐ Better outcomes for service users and their families
- ☐ More consistent delivery of services
- ☐ Stronger leadership
- ☐ More effective use of resources to carry out statutory duties
- ☐ More effective use of resources to carry out therapeutic interventions and preventative services
- ☐ Access to learning and development and career progression
- ☐ Other benefits or opportunities, please explain below

Q33. Do you see any risks in having social work planning, assessment, commissioning and accountability located within the National Care Service?

Nursing

How it works now

In Scotland registered nurses are the largest group of clinicians within the NHS responsible for the delivery of safe, person centred, and effective care and treatment. Social care services, mainly the independent care home sector, also employ registered nurses. Registered nurses within health and social care services play a pivotal role in prevention, anticipatory care planning, early intervention, assessment, treatment, recognition of deterioration, and palliative and end of life care. They play a key role as part of the wider integrated multi-disciplinary team working within the Health and Social Care Partnership (HSCP) as well as supporting the wider social care team.

Professional and clinical governance - for nursing, midwives, allied health professionals such as podiatrists, physiotherapists, speech and language therapists, dietitians, and clinical health care support workers working within the HSCP - is retained within the structures of the local Health Board which delegates the service to the integration authority. These groups are professionally accountable to the NHS Board Executive Director of Nursing.

NHS Board Executive Directors of Nursing, Midwifery and Allied Health Professionals (AHPs) are appointed by the Scottish Ministers and are responsible for professional and clinical care governance and providing the Health Board with assurance on the standards of care to ensure services are safe, person centred and effective. They do this through a delegated framework to other professional clinical leaders within the organisation.

Other clinical staff may be employed by services delegated or commissioned by the integration authority, such as independent care homes or GP contracted services. Under current legislation the NHS Board Executive Director of Nursing, Midwifery and AHPs does not have professional accountability or responsibility for these services. Professional and clinical governance for this group of staff is provided through their employer.

There is limited data on the nursing workforce within social care but' we know that there is a vast variation in the provision of and access to nursing support throughout Scotland. Whilst some independent services do employ specialist nurses, not all do. We estimate only around half of adult and older peoples care homes in Scotland have registered nurses. For care homes that do not employ registered nurses, nursing care is provided by NHS community nursing services, which may include district nursing, care home liaison nurses, community mental health and learning disability nurses, and Advanced Practice Models may be used.

All statutory regulated health care professionals such as registered nurses, allied health professionals, and doctors must comply with their regulatory bodies' standards of conduct and practice. Registered Nurses at all levels including Executive Directors of Nursing are regulated by the Nursing and Midwifery Council and must comply with the Nursing and Midwifery Code and revalidation requirements.

Issues and problems

Throughout the COVID-19 pandemic, measures have been taken to provide additional oversight and support to the social care sector and to the care home sector in particular. The challenge of providing safe environments for often our most vulnerable of citizens during the COVID-19 pandemic is significant. The Cabinet Secretary for Health and Sport wrote to Health Boards on 17th May 2020 setting out new local oversight arrangements including Executive Directors of Nursing Midwifery and AHPs to provide support to the social care sector through their delegated nursing leadership frameworks within the HSCPs and acute hospitals. This largely focused on infection prevention and control and care assurance in care homes. NHS Board Executive Directors of Nursing, Midwifery and AHPs provided additional support from infection prevention and control nurses and community and speciality nursing teams, who have provided infection prevention and control advice, support and expertise and oversight throughout the COVID-19 pandemic..

On 23 March 2021 the then Cabinet Secretary for Health and Sport asked that enhanced multidisciplinary arrangements to support care homes and the wider social care sector, including care at home settings, be kept in place until at least March 2022. It was noted that through the direct involvement of Executive Directors of Nursing, significant improvements have been made in the standards of care and infection prevention and control within our care homes. Also, the efforts of Executive Directors of Nursing and their delegated nursing leads working with multidisciplinary teams and the care home sector have driven reductions in both outbreaks and deaths from COVID-19 in the sector.

The value of multi-disciplinary working has been key to the response to the pandemic. Understanding the roles, responsibilities, knowledge, expertise, and the unique contribution of each professional within a person's care is essential to ensuring good outcomes for people. We know that people who live in adult and older people's care homes have increasing levels of health and support needs, and are likely to have increasing levels of complexity and co-morbidity, living with frailty, dementia, disability, and neurological illness. Care homes are also one of the largest providers for palliative and end of life care. The role of the wider multidisciplinary team, in particular registered nurses, are key to ensuring peoples full health and care needs are met.

Registered nurses also provide leadership and expertise to the wider social care team in supporting them with education and training, attainment of competencies, care planning, recognition of deterioration and supporting palliative and end of life care. Whilst it is acknowledged that care homes are not clinical settings and nor should we wish them to be, it is important to recognise that many people who receive social care have health and social care needs and to enable them to live their best life it is important that all their needs are met. To achieve this it is important that we have collective and seamless working across all professional groups within health and social care. Shared learning across health and social care teams is critical to ensuring that people across Scotland receive the best care possible.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 21: The National Care Service in close co-operation with the NHS should establish joint outcome measures to measure progress in health and social care support, through which to oversee delivery of social care in local systems via reformed Integration Joint Boards.

Recommendation 27: The safety and quality of care provided in care homes must be improved to guarantee consistent, appropriate standards of care.

What we propose

It is important that we have professional nursing governance and assurance across community health and social care services. This should be of a similar standard to that provided for registered nurses and healthcare support workers working in hospitals and would build on the role that Executive Directors of Nursing, Midwifery and AHPs and their professional leadership teams have taken during the COVID-19 pandemic in care homes.

We propose to maintain the current Executive Director role to provide professional leadership across community health and social care. Executive Directors of Nursing will continue to :

- provide professional leadership to support the health and care needs of care home residents supporting prevention, anticipation, early intervention, recognition of deterioration, and palliative and end of life care.
- use information from the safety huddle tool and other mechanisms through the oversight arrangements to identify where specific nursing support may be required
- facilitate assurance/professional support for quality outcomes and safety through the provision of professional and clinical advice on standards of practice, education requirements and quality of care.
- ensure provision of specific infection protection and control expertise and support including reviewing and recommending actions to be taken in relation to infection protection and control practice, cleaning regimes, and appropriate and effective use of personal protective equipment to prevent transmission of infection
- continue to support the identification of education and training needs of staff in care homes, supporting them to enhance their skill and knowledge in infection protection and control and other clinical aspects of care and maintain standards of care.

The advisory role provided by Executive Directors for Nursing, Midwifery and AHPs and their teams are currently focussed on adult care homes. However to, ensure parity of care and support and early intervention this could, be extended to include other social care environments such as care at home services, where it could improve outcomes for people in their own homes who have health and social care needs.

The role could also be extended from the current advisory and oversight role to a role of accountability, with the National Care Service overseeing and ensuring

consistency of access to education and professional development of social care nursing staff, standards of care, and governance of nursing providing within social care service. The National Care Service could also be responsible for the commissioning of nursing in social care.

Questions

Q34. Should Executive Directors of Nursing have a leadership role for assuring that the safety and quality of care provided in social care is consistent and to the appropriate standard? Please select one.

- ☐ Yes
- ☐ No
- ☐ Yes, but only in care homes
- ☐ Yes, in adult care homes and care at home

Please say why

Q35. Should the National Care Service be responsible for overseeing and ensuring consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing? Please select one.

- ☐ Yes
- ☐ No, it should be the responsibility of the NHS
- ☐ No, it should be the responsibility of the care provider

Please say why

Q36. If Community Health and Social Care Boards are created to include community health care, should Executive Nurse Directors have a role within the Community Health and Social Care Boards with accountability to the National Care Service for health and social care nursing?

☐ Yes

☐ No

If no, please suggest alternatives

Justice Social Work

How it works now

Community justice has a vital role in preventing offending and delivering effective interventions which keep communities safe and tackle offending behaviour. At the core of community justice is effective delivery of community sentences, other community-based interventions (such as supervision of those on bail) imposed by the courts, and the supervision of relevant individuals upon release from custody. Justice social work (JSW) services, as part of local authorities, take a lead role in the delivery of community interventions, with support from partners including third sector organisations.

A large number of people who come into contact with the justice system have a wide range of often complex needs. Holistic approaches are required which take account of an individual's health - including mental health, trauma, and drug and alcohol related issues - housing, employability, and risk of harm to self and others. Collaboration with victims organisations and communities is also needed to help increase public understanding of and confidence in community interventions. The Scottish Government has a long-stated ambition to take an approach to criminal justice that focuses on prevention, treatment, and rehabilitation, rather than a model solely focused on punishment and containment.

The current model for community justice came into operation on 1 April 2017, underpinned by the Community Justice (Scotland) Act 2016 (the 2016 Act), which places duties on a group of statutory partners to engage in community justice planning and to report against a set of nationally-determined outcomes. This relies on effective partnership working at both local and national levels. Community justice partnerships in local authority areas are made up of a number of statutory partners and are supported by Community Justice Scotland, which was established by the 2016 Act. Although some community justice partnerships are aligned to governance arrangements associated with Integration Joint Boards (IJBs), others are not. The proposed creation of a National Care Service (NCS) with directly funded Community Health and Social Care Boards (CHSCBs) to deliver services locally may provide an opportunity to improve accountability create more consistency, and improve outcomes for people working with community justice services.

A focus on prevention and effective community interventions has helped see Scotland's reconviction rate fall to its lowest level since comparable records began. The average number of reconvictions per offender has decreased by 23% over the past decade from 0.60 in 2008-09, to 0.46 in 2017-18. This approach is based on strong evidence that community interventions are more effective than short custodial sentences. The presumption against short sentences was extended to apply to custodial sentences of 12 months or less in 2019, to help enable a further shift to community sentencing and help prevent reoffending.

However, Scotland still has one of the highest prison populations per capita in Western Europe and a range of measures are being taken to increase availability of and confidence in community interventions. We will continue to take forward

commitments made by the Scottish Government in relation to community justice, whatever the outcome of this consultation.

In particular, the Scottish Government will review the National Strategy for Community Justice this year, and will consider how to build on progress over recent years to further encourage the use of community interventions where appropriate, including through a substantial expansion in the availability of diversion from prosecution and of community justice services.

The Scottish Government has also committed to exploring legislative options for a sustainable reduction in the prison population, with a focus on managing offending behaviour – and reducing re-offending – in the most effective way.

Social work services play a critical role in the delivery of adult social care and as such, if social work in general were to become part of the NCS, there could be value in considering the integration of JSW services as well, to ensure a consistent approach. This may also help address some identified issues around consistency and equity of access in relation to JSW services, and to enable a shift towards a public health based approach to preventing offending, community based interventions, and rehabilitation.

Issues and problems

There are a number of issues affecting community justice and JSW services which are relevant to consideration of future options.

Ensuring consistency of access to services across Scotland is a challenge, and has been a longstanding concern. With better coordination, a set of minimum standards, and the appropriate resources, the delivery of effective and person-centred community justice services could be made much more consistent across the country and improve outcomes for individuals, families, and communities. There are a number of ways to achieve this and one may be through inclusion of aspects of community justice in the NCS.

It is noted that the proposed changes will not preclude work on the strategic approach to community justice being taken forward, or work with Community Justice Scotland, Social Work Scotland, and others linked to the Recover, Renew, and Transform programme which is focused on the impact of coronavirus on the justice system.

Relevant Independent Review of Adult Social Care Recommendations

The Independent Review of Adult Social Care (IRASC) found compelling evidence of where current integrated arrangements were working well under IJBs and their delivery arm, Health and Social Care Partnerships (HSCPs). This was especially the case where all social care, social work and community based healthcare were delegated to its greatest extent. The review noted that there is scope to be more consistent in these arrangements and embed the effective working they saw throughout the country.

IRASC was clear that its focus was on adult social care - it therefore did not consider issues relating to JSW services.

However it did note that: “Social workers were also concerned about the impact possible fragmentation would have on children, families and adults needing support and who do not lead their lives according to administrative boundaries or arrangements. Careful consideration should be given to these concerns as changes are taken forward”.

As such, the establishment of a NCS could have a significant impact on JSW services, the delivery of community interventions, and accountability within community justice.

IRASC also recommended establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development (Recommendation 45). IRASC highlighted that training and professional development needs to be appropriately resourced.

What we propose

Including JSW services as part of the NCS could have some benefits, including addressing longstanding concerns about the consistency and availability of community justice services, and creating greater links to related public health services. The future model for the delivery of community justice services continues to be a live issue, particularly in the context of wider priorities around reducing the prison population and encouraging a further shift towards community interventions, and moving to a more national approach could aid these developments. In addition, if a NCS is established which includes some or all social work services with the exception of JSW, there is a risk that service provision could become more disjointed, and that JSW would not benefit from other reforms to the social work profession.

However, if JSW were to be included with the NCS, this would (as with other elements of social work and social care) involve transferring the relevant statutory responsibilities and revising highly complex funding and delivery arrangements, while ensuring that effective partnership working and service provision is not disrupted. This would require significant time and resources. If JSW services are to be included in the NCS, therefore, we suggest they might be transferred in a later phase of the process. However, we are inviting views now on whether they should, ultimately, be included.

Views from partners on the opportunities, risks, and potential benefits and challenges of any proposed changes that the NCS may bring to the model of community justice, and the relationship of community justice partnerships to CHSCBs, are crucial. Ultimately, the aim is to ensure the availability of community justice services that can command confidence, and better respond to the needs, and circumstances of individuals involved in the justice system, their families, and communities.

Questions

Q37. Do you think justice social work services should become part of the National Care Service (along with social work more broadly)?

☐ Yes

☐ No

Please say why.

Q38. If yes, should this happen at the same time as all other social work services or should justice social work be incorporated into the National Care Service at a later stage?

☐ At the same time

☐ At a later stage

Please say why.

Q39. What opportunities and benefits do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

☐ More consistent delivery of justice social work services

☐ Stronger leadership of justice social work

☐ Better outcomes for service users

☐ More efficient use of resources

☐ Other opportunities or benefits - please explain

Q40. What risks or challenges do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

- ☐ Poorer delivery of justice social work services
- ☐ Weaker leadership of justice social work
- ☐ Worse outcomes for service users
- ☐ Less efficient use of resources
- ☐ Other risks or challenges - please explain

Q41. Do you think any of the following alternative reforms should be explored to improve the delivery of community justice services in Scotland? (Tick all that apply)

- ☐ Maintaining the current structure (with local authorities having responsibility for delivery of community justice services) but improving the availability and consistency of services across Scotland
- ☐ Establishing a national justice social work service/agency with responsibility for delivery of community justice services
- ☐ Adopting a hybrid model comprising a national justice social work service with regional/local offices having some delegated responsibility for delivery
- ☐ Retaining local authority responsibility for the delivery of community justice services, but establishing a body under local authority control to ensure consistency of approach and availability across Scotland
- ☐ Establishing a national body that focuses on prevention of offending (including through exploring the adoption of a public health approach)
- ☐ No reforms at all
- ☐ Another reform – please explain

Q42. Should community justice partnerships be aligned under Community Health and Social Care Boards (as reformed by the National Care Service) on a consistent basis?

☐ Yes

☐ No

Please say why.

Prisons

How it works now

Responsibility for healthcare in prisons was transferred to the NHS in 2011 and is delegated to integration authorities as a result of the Public Bodies (Joint Working) (Scotland) Act 2014. However, social care in prisons is not integrated and continues to be delivered by the Scottish Prison Service.

Over the past two years the Health and Social Care Integration in Prisons Workstream of the Scottish Government's Health and Social Care in Prisons Programme has collaborated with key stakeholders to carry out a pilot in six prisons to look at ways to achieve better integrated health, social work, and social care services and support for people in prison. Work was also commissioned with the aim of better understanding the social care support needs of Scotland's prison population. A report on the workstream findings is due to be published later in 2021

Issues and problems

The workstream recognised the positive work already happening in prisons that supports people in custody and those being liberated. However, it also identified opportunities to improve and strengthen the multi-disciplinary approaches in key areas, including integrated services.

People in prison with physical health needs already receive personal care arranged directly by the Scottish Prison Service. However, those with needs that may be less visible, such as learning disability, mental health difficulties, and substance use are not getting access to integrated services that encompass health, social work, and social care which would include the opportunity for a holistic assessment of needs.

The issue of how to make best use of social work resources was present throughout the project. Whilst both social workers based in prisons and community-based social workers have distinct functions, opportunities were identified for a more cohesive approach to social work delivery. This could maximise opportunities for individuals to access treatment, care, and rehabilitation to support them to lead positive lives within prison and then to move on and seek employment, support their families, and contribute positively to their communities on liberation. With greater support on their return to the community the likelihood of crisis, and thereby return into the justice system, could be reduced.

Barriers to achieving integrated services were identified in the report with challenges relating to data sharing being one of particular complexity. There is a lack of joined up systems enabling data to be shared and often Integration Joint Boards (IJBs) and local authorities do not have robust data about the needs of people who are imprisoned.

Access to care and support

The workstream found that eligibility criteria designed to be applied in the community, which are heavily weighted towards physical needs, meant that some people may not be able to access support while in prison. These could include

people with complex needs, including chronic but low level mental health and substance use, or with cognitive decline who are unable to work, attend education, or maintain relationships. Also, whilst there are a number of wellbeing services in prisons, these have generally arisen organically rather than being based on strategic needs assessments and commissioning plans. Although there are some peer support opportunities and listening services in prison, opportunities to access informal support opportunities similar to those in the community are much reduced e.g. support from families, friends, libraries, and churches. The workstream identified the need for any future work on access to care and support to explicitly recognise the impact of the prison environment on the availability of informal and third sector support, and to take into account the capacity of individuals in prison to access such support

Services in prisons often seek to be similar to those in the community, for example in terms of access to healthcare. However the limited choice and restricted access to care services in prison can mean this is more difficult to achieve, making equivalence unachievable or unsuitable. Achieving equivalence may mean access to services being considered in a different way in custodial settings.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 4: People should understand better what their rights are to social care and supports, and “duty bearers”, primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.

Recommendation 19: The National Care Service should oversee social care provision at national level for people whose needs are very complex or highly specialist and for services such as prison social care that could be better managed on a once-for-Scotland basis.

Recommendation 26: The National Care Service should manage provision of care for people whose care needs are particularly complex and specialist, and should be responsible for planning and delivery of care in custodial settings, including prisons.

What we propose

The Independent Review of Adult Social Care recommends that the National Care Service (NCS) should oversee social care provision for people in prison and be responsible for the planning and delivery of care in prisons,

This will also form a part of work to create a single, outcomes focused approach to care and support which stretches from prevention and early intervention through to acute and specialist provision.

Questions

Q43. Do you think that giving the National Care Service responsibility for social care services in prisons would improve outcomes for people in custody and those being released?

☐ Yes

☐ No

Please say why.

Q44. Do you think that access to care and support in prisons should focus on an outcomes-based model as we propose for people in the community, while taking account of the complexities of providing support in prison?

☐ Yes

☐ No

Please say why.

Alcohol and Drug Services

How it works now

The responsibility for the provision of specialist adult drug and alcohol service provision is entirely delegated to the integration authority.

The services provided are generally a combination of clinical services, social work and social care provision. Elements of social care provision will be contracted from the third sector. Services will have varying degrees of integration and joint working. In addition there can be community, voluntary and mutual aid support for people.

People with severe and enduring issues with alcohol/drugs will often have other complex issues that overlap with mental health, children's services, housing, and justice as well as physical health issues. There is variation between different areas as to whether justice and children's services are delegated to the integration authority.

Specialist services for children who use alcohol/drugs would generally be provided through children's services rather than the specialist drug and alcohol services.

Each local authority area has an Alcohol and Drug Partnership (ADP). The ADP has a responsibility for strategic planning and performance across the spectrum of drug and alcohol issues including education, prevention, early intervention, treatment, support, recovery, and licensing/legislation. ADPs membership is made up from various public services, including the NHS, the local authority, Police Scotland, Scottish Prison Service, and the Scottish Fire and Rescue Service, plus third sector organisations and community representatives. There will be variation in chairing arrangements for ADPs and some have independent chairs. ADPs also have a role in some areas supporting the public protection agenda and reporting to Chief Officer Groups, which bring together the chief executives of relevant organisations. Governance, finance and procurement is provided via the integration authority.

Issues and problems

People with drug and alcohol issues often have multiple complex needs that span a range of health and social care issues. They may have experienced multiple adverse childhood events and be deeply affected by trauma which can make engagement and change difficult. Drug and alcohol issues can be chronic and relapsing meaning that people may need long term and/or multiple episodes of treatment, care, and support.

It can be difficult and complicated to create individual care plans for people across systems and ensure care is joined up across complex systems. For some, multiple services may need to "wraparound" people at acute stage and many people face stigma which can prevent them seeking help or progressing towards recovery.

Governance and accountability for alcohol and drugs services is challenging given that services range across the NHS, local authorities, and third sector organisations.

Many stakeholders feel that the system is focussed on treatment (which is mainly delivered by the NHS and local authorities), with recovery and wider support services (delivered by the third sector) not given the same level of priority. However, evidence shows that earlier connections to recovery services dramatically increase the likelihood of successful treatment. There is also evidence that many people can fall through the gaps of the system, for example when moving from hospital to the community, from treatment to recovery.

There is a need to ensure a “no-wrong-door” approach to accessing support for drug and alcohol issues, as the initial contact may not always be through specialist drug and alcohol services. Additionally, some elements of care may fall out with the remit of those services, such as housing/homelessness support, justice, children’s support, welfare, hospital, and acute care. Crucially as part of this approach, mental health and alcohol and drug services must be better connected to ensure that people presenting with multiple complex needs are not excluded from treatment and care at either of these services.

There is a need to develop a trauma informed workforce, with skills and knowledge across specialist and non-specialist services, and able to work with people with multiple complex needs presenting for help.

What we propose

People with problematic substance use are often one of the most marginalised in society, and those with lived and living experience of problematic use of substances should be included in a collaborative, rights based and participative approach to the design and monitoring of services. This should recognise that additional support may be needed to facilitate full participation.

We expect that Community Health and Social Care Boards (CHSCBs) will continue to be key partners in ADPs, taking the place of Integration Joint Boards (IJBs) and will continue to provide the governance, finance and procurement functions for them. However, we will consider whether changes can be made to make ADPs more effective and whether they should become part of the National Care Service (NCS) nationally and part of CHSCBs. We would like to hear your views on what changes might be helpful.

We are also considering whether it would be more effective for the NCS to commission specialist provision, such as residential rehabilitation services, on a national level. The aim of this would be to increase accessibility of rehabilitation programmes, and aid in developing good practice on referral pathways, and ensuring funding models are clear and deliver value for money. We are also interested in views on whether other alcohol and drugs services might be better organised on a national basis.

Questions

Q45. What are the benefits of planning services through Alcohol and Drug Partnerships? (Tick all that apply)

- ☐ Better co-ordination of Alcohol and Drug services
- ☐ Stronger leadership of Alcohol and Drug services
- ☐ Better outcomes for service users
- ☐ More efficient use of resources
- ☐ Other opportunities or benefits - please explain

Q46. What are the drawbacks of Alcohol and Drug Partnerships? (Tick all that apply)

- ☐ Confused leadership and accountability
- ☐ Poor outcomes for service users
- ☐ Less efficient use of resources
- ☐ Other drawbacks - please explain

Q47. Should the responsibilities of Alcohol and Drug Partnerships be integrated into the work of Community Health and Social Care Boards?

- ☐ Yes
- ☐ No

Please say why.

Q48. Are there other ways that Alcohol and Drug services could be managed to provide better outcomes for people?

Q49. Could residential rehabilitation services be better delivered through national commissioning?

☐ Yes

☐ No

Please say why.

Q50. What other specialist alcohol and drug services should/could be delivered through national commissioning?

Q51. Are there other ways that alcohol and drug services could be planned and delivered to ensure that the rights of people with problematic substance use (alcohol or drugs) to access treatment, care and support are effectively implemented in services?

Mental Health Services

How it works now

Mental health services include a wide range of activities and professionals, including primary mental health services, Child and Adolescent Mental Health Services (CAMHS), community mental health teams, crisis services, mental health officers and mental health link workers.

Some elements of mental health services are currently delegated to Integration Joint Boards (IJBs), however this is not consistent across Scotland and there is significant variation in terms of management arrangements and performance.

Issues and problems

The current model can cause difficulties for staff working within services and service users. It is also difficult to operate a consistent financial allocation model to support improvement. As a result there is evidence of inconsistent integration of mental health care and social care to the detriment of service users.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 20: The National Care Service's driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce.

The review specifically includes support for people with mental health problems in its scope. It states that mental health accounts for £187 million out of £3.8 billion spend on adult social care.

What we propose

We propose that appropriate elements of mental health services should be consistently delegated to the National Care Service. Responsibilities within and between organisations should be consistently applied in all parts of Scotland and understood by all.

Questions

Q52. What elements of mental health care should be delivered from within a National Care Service? (Tick all that apply)

- ☐ Primary mental health services,
- ☐ Child and Adolescent Mental Health Services,
- ☐ Community mental health teams,
- ☐ Crisis services,
- ☐ Mental health officers
- ☐ Mental health link workers
- ☐ Other – please explain

Q53. How should we ensure that whatever mental health care elements are in a National Care Service link effectively to other services e.g. NHS services?

National Social Work Agency

How it works now

There is currently no national oversight or support for social work. Social work is dynamic and complex, requiring professionally qualified social workers to work alongside people and families during their most challenging times. Making sure there are enough social workers, and that they have high quality training and continuous professional development, is therefore essential to improving people's experience of social care.

In Scotland, there are currently around 10,000 registered social workers, with around 6,000 working in frontline services. The workforce relies on the supply of newly qualified social workers - approximately 500 per year. Most social workers are employed by councils.

Key to the professionalism of social work is education, continuous professional development, and improvement, all of which are supported and provided by several organisations and agencies.

Issues and Problems

There is no single national body tasked with having oversight and leading social workers' professional development, education, and improvement. Terms and conditions are set by individual employers, resulting in local variations in social workers' pay and grading.

Currently, social work is funded to deliver its statutory functions, but the workforce is facing increasing pressure from a growing demand for its services, for example addressing the population's growing mental health issues. The pressure on the workforce also means that their focus is primarily on people in crisis or with significant needs, with much less time spent on preventative and anticipatory work. This increasing demand on social workers makes workforce planning challenging, and restricts opportunities for professional development. Each year, securing over 1,000 social work student placements is reliant on employers' capacity and would benefit from national workforce planning.

As several organisations advocate, deliver and advise on social work education, development, and improvement and research it has not been possible to scale up good practice.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 45: Establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development. The current role, functions and powers of the Scottish Social Services Council should be reviewed and appropriate read-across embedded for shared and reciprocal learning with the NHS workforce.

The Independent Review of Adult Social Care (IRASC) also highlighted that training and professional development needs to be appropriately resourced.

What we propose

We propose that a National Social Work Agency (NSWA) should be established, in line with the recommendation, alongside a centre of excellence for applied research for social work to support improvement activity (see Improvement). Both should be part of the National Care Service (NCS) infrastructure and inextricably linked to wider planning and improvement activity.

The NSWA would have national oversight and leadership over social work qualifications, workforce planning, improvement, training, continuous professional development and pay and grading within a national framework. It would invest in and raise the profile of social workers throughout the NCS and partner organisations, ensuring parity with other professions.

Questions

Q54. What benefits do you think there would be in establishing a National Social Work Agency? (Tick all that apply)

- ☐ Raising the status of social work
- ☐ Improving training and continuous professional development
- ☐ Supporting workforce planning
- ☐ Other – please explain

Q55. Do you think there would be any risks in establishing a National Social Work Agency?

Q56. Do you think a National Social Work Agency should be part of the National Care Service?

- ☐ Yes
- ☐ No

Please say why

Q57. Which of the following do you think that a National Social Work Agency should have a role in leading on? (Tick all that apply)

- ☐ Social work education, including practice learning
- ☐ National framework for learning and professional development, including advanced practice
- ☐ Setting a national approach to terms and conditions, including pay
- ☐ Workforce planning
- ☐ Social work improvement
- ☐ A centre of excellence for applied research for social work
- ☐ Other – please explain

Reformed Integration Joint Boards: Community Health and Social Care Boards

The case for change

If we want a better system, we need to do things differently. For too long the current system has operated with multiple complex processes. It has been affected by inflexible supplier contracts, local supplier limitations, and the perception that resources are scarce.

We need to improve local discretion and decision making. We need to focus on people who need support and care, and people who currently receive support and care. To do that we must design focused services based on need. These must be produced together with people who need these services, and with those who support them, whether paid or unpaid. National standards must be clear and consistent, with robust performance monitoring of local systems through regulation, and a commitment to continuous improvement. New local structures would be funded by – and accountable to – the National Care Service (NCS) and Scottish Ministers. These clear lines of accountability will ensure that we can best address future concerns and challenges raised by the people we serve.

In this chapter we set out the plan for reforming current Integration Joint Boards (IJBs) to ensure the ambition for consistent, quality delivery across services.

How it works now

The Public Bodies (Joint Working) (Scotland) Act 2014 (PBJWSA) requires Health Boards and local authorities to work together to form integration authorities, which are responsible for ensuring that health and social care services are well integrated.

There are a total of 31 integration authorities in Scotland; Highland is the only area to adopt the lead agency arrangement, in which the local authority takes responsibility for children's health and social care services and the Health Board has responsibility for adult health and social care. Other areas have adopted the body corporate model of an Integration Joint Board (IJB). Clackmannanshire and Stirling local authorities have combined to establish a single IJB across their two council areas.

The PBJWSA sets out the governance and financial arrangements for these integration authorities, and sets out requirements about the membership of an IJB. This includes minimum required membership, and provision for additional members to be appointed. IJB membership consists of voting members, who are representatives of the local authority and the Health Board, and non-voting members representing various professional groups, social care providers, people who receive social care support, and unpaid carers.

The local authority and Health Board are required to delegate functions (and budgets) to the integration authority. The integration authority then plans what care is needed in its area and directs (and provides funding to) the Health Board and the local authority to deliver it. As a separate legal entity an IJB has full autonomy and capacity to act on its own behalf. IJBs retain strategic responsibility and "operational

oversight", but not operational responsibility which remains with Health Boards and local authorities.

The PBJWSA identifies the services for which integration authorities must be responsible, and also identifies some services that, with local agreement, integration authorities may take responsibility for.

Issues and problems

The Independent Review of Adult Social Care (IRASC) identified that a lack of collaborative leadership in both health and social care has affected the progress of integrated health and social care support for people in some areas. There is also a lack of strategic capacity and a high turnover of integration authority staff to support planning, commissioning and delivery.

Financial planning is not integrated, long-term, or focused on providing the best outcomes for people who need support. This limits the ability of integration authorities to improve the health and social care system.

There is flexibility available in the procurement legislation for social care services, however commissioning and procurement through local authorities are inconsistent in their approach. Using this flexibility has resulted in an implementation gap, and negatively impacted on their ability to support commissioning decisions and truly meet people's needs.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 17: The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from local authorities and third and independent sector providers. Integration Joint Boards should manage GPs' contractual arrangements…

Recommendation 23: Integration Joint Boards should be reformed to take responsibility for planning, commissioning and procurement and should employ Chief Officers and other relevant staff. They should be funded directly by the Scottish Government.

The IRASC also suggested that all members of the strategic planning group should be included as full voting members of reformed IJBs.

What we propose

In line with the relevant IRASC Recommendations, we propose that IJBs will become Community Health and Social Care Boards (CHSCBs) and will be the local delivery body for the NCS, funded directly by the Scottish Government. This will be the sole model for local delivery of community health and social care in Scotland. The functions of CHSCBs will be consistent across the country and will include all community health and social care support and services that the Scottish population requires.

CHSCBs will be accountable to Ministers and will have members who will represent the local population, including people with lived and living experience, and carers. We expect that CHSCBs will be aligned with local authority boundaries, unless otherwise agreed at local level. The members will include local elected members to preserve local democratic accountability. CHSCBs will employ their own chief executives and staff who plan, commission and procure care and support. Consideration will be given to employing other relevant staff to discharge their duties, such as chief finance officers. The chief executive of each CHSCB will report to the chief executive of the NCS.

CHSCBs will oversee the delivery of all community health and social care services and support within their local area, monitoring and improving impact, performance and outcomes for people. Their work will be guided by the strategic direction, quality standards and operational framework set out by the NCS.

CHSCBs will work together across Scotland, across local boundaries, and as part of the NCS and with the NHS, local authorities, and the third and independent sectors, to improve support for people at a regional and national level. In their local areas they will work with other public, third, and independent sector partners to ensure that support and services for people are safe, effective, seamless, and person centred. Local people will be embedded in the design, development, and delivery of support and services.

CHSCBs will have responsibility and authority for planning, commissioning, and procurement of community health and social care and other relevant support, and for the management of GP contractual arrangements. They will be able to commission services from local authorities, the NHS and the third and independent sectors. CHSCBs will commission and procure support and services based on people's needs and quality of service, and will apply the core requirements for ethical commissioning, once established.

It will still be necessary for the services overseen by the NCS to link closely to services provided by other organisations at the local level. CHSCBs will be members of community planning partnerships, taking the place of IJBs on those groups. This will support the wider integration and co-ordination of community health and social care services with other public services to improve local outcomes and reduce inequality. Similarly they will be members of other local partnerships which co-ordinate services to improve outcomes for people, such as Alcohol and Drugs Partnerships and Adult Protection Committees.

We will consider how best to ensure effective joint working with other services such as housing, education, and policing. One way to achieve this may be to make the CHSCB a statutory consultee for strategic planning on various issues. We also expect that CHSCBs will also be involved in joined up planning to tackle homelessness, and will be subject to the shared prevention duty that we are committed to develop under the Ending Homelessness Together Action Plan.

Questions

Governance model

Q58. "One model of integration… should be used throughout the country." (Independent Review of Adult Social Care, p43). Do you agree that the Community Health and Social Care Boards should be the sole model for local delivery of community health and social care in Scotland?

☐ Yes

☐ No

Please say why.

Q59. Do you agree that the Community Health and Social Care Boards should be aligned with local authority boundaries unless agreed otherwise at local level?

☐ Yes

☐ No

Q60. What (if any) alternative alignments could improve things for service users?

Q61. Would the change to Community Health and Social Care Boards have any impact on the work of Adult Protection Committees?

Membership of Community Health and Social Care Boards

Q62. The Community Health and Social Care Boards will have members that will represent the local population, including people with lived and living experience and carers, and will include professional group representatives as well as local elected members. Who else should be represented on the Community Health and Social Care Boards?

Q63. "Every member of the Integration Joint Board should have a vote" (Independent Review of Adult Social Care, p52). Should all Community Health and Social Care Boards members have voting rights?

☐ Yes

☐ No

Q64. Are there other changes that should be made to the membership of Community Health and Social Care Boards to improve the experience of service users?

Community Health and Social Care Boards as employers

"[Integration Joint Boards] should employ Chief Officers and relevant other staff." (Independent Review of Adult Social Care, p53). Currently, the Integration Joint Boards' chief officers, and the staff who plan and commission services, are all employed either by the local authority or Health Board. The Independent Review of Adult Social Care proposes that these staff should be employed by the Community Health and Social Care Boards, and the chief executive should report directly to the chief executive of the National Care Service.

Q65. Should Community Health and Social Care Boards employ Chief Officers and their strategic planning staff directly?

☐ Yes

☐ No

Q66. Are there any other staff the Community Health and Social Care Boards should employ directly? Please explain your reasons.

Commissioning of services

The case for change

How we identify need and then commission community health and social care services at a local level will look and feel different moving forward. Ethical Commissioning will become a cornerstone that the National Care Service will use to oversee continuity of approach at a local level. Continuity of approaches to commissioning, the process to determine needs and how we will deliver services, supports and solutions, will deliver better consistency of access across Scotland.

This chapter sets out the role the National Care Service will have in embedding ethical commissioning at a local level, including driving up quality and securing person centred outcomes and fair work practices. It will ensure full engagement with those who access care and support, those who support people to access care and support, families and friends, unpaid carers, the workforce and providers. It also proposes services for which a "once for Scotland" commissioning and procurement approach may benefit individuals.

Terminology

"Commissioning" and "procurement" are terms used generally to describe how goods and services are planned and obtained.

Commissioning is the process of assessing and identifying the needs and the market available; developing a vision, strategy, policy, and forward plan to meet these needs; and designing a service or system for delivery which includes monitoring and continually improving the effectiveness of how these needs are met in practice. Commissioning may include a decision on whether to buy something from someone else or provide it within the organisation, and will not automatically lead to a procurement - that's just one choice.

Ethical commissioning, in relation to social care services, has a person-centred care first/human rights approach at its core, ensuring that strategies focus on high quality care. This includes fair work practices which encourage the development of a quality, sustainable, and appropriately valued work force; climate and circular economy considerations in our service footprint to support a just transition to net zero; financial transparency and commercial viability of any outsourced services; full involvement of people with living experiences throughout, putting the person at the centre of making the choice; and a shared accountability between all partners and stakeholders involved in delivery.

Where a service is to be outsourced, **Procurement** is the process of engaging collaboratively with the market, key stakeholders, strategic partners, and representative users of the service to deliver the commissioning strategy, policy, and service in practice. **Ethical and Sustainable Procurement** ensures that these are not only delivered to the right quality, in a timely, efficient, legal, and commercially sustainable way, but that we use the power of procurement to meet those broader social, economic and environmental objectives agreed in the vision.

How it works now

For integrated health and social care services, at present, local authorities and Health Boards delegate commissioning responsibility for the agreed services to integration authorities. For all but one area, the integration authority is the Integration Joint Board (IJB) (Highland is the exception where services are delegated between the Health Board and local authority).

The IJB then agrees a budget with the local authority and Health Board for the delivery of those integrated services, and the ambitions set out in the Strategic Plan, within their area. Spend on these public services is significant: local authorities spend around £3.4 billion on adult social care alone, much of it with third and independent sector care providers, in addition to significant investment in primary and community healthcare. Once the budget is agreed the IJB allocates the approved proportion of the budget for the specific service (for example a specific social care service) back to the local authority and Health Board as necessary. The IJB then directs the local authority and Health Board to use that budget to deliver the agreed services as per the strategic plan. The teams delivering those services are often referred to as Health and Social Care Partnerships (HSCPs).

Under the Public Bodies (Joint Working) (Scotland) Act 2014 (PBJWSA), IJBs are required to draw up a strategic plan to meet Scotland's national health and wellbeing outcomes. This strategic plan is then used as the commissioning strategy and includes assessing and making decisions on the following:

- Models of care and nature of services needed
- Quality and outcomes of service as agreed with local authority and Health Board
- Budget available for service
- Estimating and forecasting the future need of the local area
- The capacity of the local market to provide services
- Recommendations on whether services should be delivered in house (by the local authority or Health Board) or by out sourcing,
- Whether out-sourced services should be obtained through Public Social Partnerships, by grants or by procurement
- How to spend the pooled budgets from local authorities and Health Boards
- IJB are also responsible for assessing the market and whether the outcomes within the commissioning strategy have been met
- Managing relationships with service providers where appropriate

Health Boards and local authorities take forward the delivery and implementation of social care services based on the needs identified in the commissioning strategy. As services are often considered both health and social care, or are interconnected to other services, IJBs bring staff together for the delivery of integrated services. These services may be delivered by the local authority and/or Health Board directly employing staff themselves, or they may pay other companies or organisations to do so.

Where the local authority or Health Board decides to pay another organisation or company to deliver the service, as a service provider, this may be arranged through

a grant or procurement process. Procurement is currently a key method used to establish these services, with local authorities contracting out as much as 80% of the care home and care at home provision to private and third sector providers. Alternatively they may also develop public social partnerships with third sector bodies (not commonly used and also known as alliancing).

Where a local authority or Health Board uses a service provider to deliver the service, the local authority or Health Board who entered into the agreement are responsible for the oversight and management of the services against the agreed specification (i.e. service description including how the organisation will deliver the service), quality standards, and terms and conditions.

Some people receiving support may also choose to receive direct payments, and buy their own care or employ staff themselves.

Where procurement is identified as the method of obtaining the service or support for social care, local authorities' procurement professionals will source the services and support from a range of private sector, third sector and other public sector bodies via a combination of the following methods. Health Boards will source services for health care, often through the NHS National Procurement:

- call off contracts from collaborative framework agreements. A framework agreement is an agreement with service providers to establish terms governing contracts that may be awarded during the life of the agreement. In other words, the framework agreement sets out terms and conditions for which local authorities can make specific purchases (call-offs)
- direct award contracts, for example using the National Care Home Contract which has agreed pricing, or where this method has been deemed appropriate by procurement professionals after the consideration of equal treatment and non-discrimination principles
- tendering services, through a variety of procurement processes which give multiple organisations the opportunity to submit bids to deliver the service or support, such as through using Quick Quotes, Open Procedures or the Light Touch Regime.
- Service Level Agreements with other public sector bodies
- Public Social Partnerships also known as alliancing as the end result of a procurement process

Currently the most commonly used method of procurement for social care services and supports are tendering and call-offs from frameworks agreements. Framework agreements are non-obligatory meaning the local authority does not need to use the framework agreement nor are they committed to a specific value of spend through the framework agreement. Once a local authority establishes a specific requirement, or has a confirmed budget it can call-off from a framework agreement to meet that particular local requirement. For social care services, framework agreements have most commonly been established by local authorities or by Scotland Excel, the Centre of Procurement Expertise for local authorities.

Public Sector procurement is required to comply with the following:

- Procurement Reform (Scotland) Act 2014

- Public Contracts (Scotland) Regulations 2015
- Procurement (Scotland) Regulations 2016
- The World Trade Organisation's Government Procurement Agreement
- Any relevant case law

The Public Contracts (Scotland) Regulations 2015 describe the detailed procedural rules that apply to the end to end process for awarding a public contract, and set the limited terms for applying the Light-Touch Regime that applies to social care and other specific services. In applying these regulations public bodies must adhere to the principles of non-discrimination, equal treatment, transparency, and proportionality.

The Procurement Reform (Scotland) Act 2014 requires additional transparency obligations, including an obligation to comply with the sustainable procurement duty to consider how to deliver on improved outcomes for the economy, the environment and society and to promote fair work practices, including payment of the real Living Wage.

Public funding through grants and procurement promote Fair Work First, which includes effective staff voice, workforce development, no inappropriate use of zero hour contracts, action to tackle the gender pay gap and diversity and fair pay, including the real Living Wage.

In respect of primary care IJBs are also responsible for planning, design and commissioning of the primary care functions (including general medical services) delegated to them under the 2014 Act based on an assessment of local population needs, in line with the IJB Strategic Plan.

This includes collaboration with Health Boards on the local arrangements for delivery of the 2018 Scottish GP contract. This involves development of a Health and Social Care Partnership Primary Care Improvement Plan, in partnership with GPs and collaborating with other key stakeholders, that reflects local population health care needs.

Issues and problems

The Independent Review of Adult Social Care (IRASC) identified we have world leading policies for delivering social care, but they are not effectively implemented throughout Scotland. There is a lack of consistency of services provided, integration of health and social care, and practices within commissioning and procurement to implement the policies. Differences in commissioning and procurement practices is also one of the factors considered to contribute to the lack of consistency and parity of service across Scotland and the ability to have portable packages of support, in addition to availability of services, and accessibility criteria. Access to service and support is addressed in more detail in the section of the consultation on Access to Care and Support.

The IRASC found that budget constraints, and a focus on price, lead to poor outcomes for people who use services and negatively impacts on the level of provision, including preventative and collaborative interventions. In particular, using

generic framework agreements or contracts where based on defined services or hourly rates does not work well for people with fluctuating needs for support, nor does it support sustainability for service providers. There is limited involvement of people with lived and living experience, including users of services and unpaid carers, in commissioning and procurement, and limited market engagement in service design

The market-led approach to commissioning and procurement can foster "competition, not collaboration", which, in turn, can lead to too much focus on costs rather than high quality, person-centred care and support. It can also result in poor conditions for the work force including a lack of fair pay. This is further aggravated with a lack of cost transparency.

"Short-termism" results in providers spending significant time and resources applying and reapplying for contracts. This results in uncertainty for providers and the workforce, which makes it difficult to attract and retain staff and impacts on the continuity of care and support provision.

The methods for service providers to challenge local authorities or Health Boards on the decisions to award contracts or frameworks agreements are deemed too difficult, therefore they need to be easier and more accessible.

There is inconsistent service monitoring and quality management by local authorities and Health Boards. Improvement across localities is therefore not consistent and is primarily driven by external verification processes such as Care Inspectorate inspections.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 32: Commissioners should focus on establishing a system where a range of people, including people with lived experience, unpaid carers, local communities, providers and other professionals are routinely involved in the co-design and redesign, as well as the monitoring of services and supports. This system should form the basis of a collaborative, rights based and participative approach.

Recommendation 33: A shift from competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace across Scotland. Commissioning and procurement decisions must focus on the person's needs, not solely be driven by budget limitations.

Recommendation 34: The establishment of core requirements for ethical commissioning to support the standardisation and implementation of fair work requirements and practices must be agreed and set at a national level by the new National Care Service, and delivered locally across the country.

Recommendation 35: To help provide impetus and support to the adoption of a collaborative and ethical approach to commissioning, the idea from CCPS (Coalition of Carers and Support Providers) of pressing pause on all current procurement should be fully explored in the context of a National Care Service, with a view to rapid, carefully planned implementation.

Recommendation 36: The care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role. Consideration should be given by the National Care Service to developing national contracts for other aspects of care and support. A 'new deal' must form the basis for commissioning and procuring residential care, characterised by transparency, fair work, public good, and the re-investment of public money in the Scottish economy.

Recommendation 37: National contracts, and other arrangements for commissioning and procurement of services, must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.

Recommendation 38: A condition of funding for social care services and supports must be that commissioning and procurement decisions are driven by national minimum quality outcome standards for all publicly funded adult social care support.

Recommendation 39: A decisive and progressive move away from time and task and defined services must be made at pace to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes, to have a good life and reach their potential, including taking part in civic life as they themselves determine.

Recommendation 40: Commissioning decisions should encourage the development of mutually-supportive provider networks as described above, rather than inhibiting co-operation by encouraging fruitless competition.

Recommendation 41: Commissioning and planning community based informal supports, including peer supports, is required to be undertaken by Integration Joint Boards and consideration of grant funding to support these is needed.

Recommendation 44: Putting in place national minimum terms and conditions as a key component of new requirements for commissioning and procurement by Integration Joint Boards. Specific priority should be given to pay, travel time, sick pay arrangements, training and development, maternity leave, progression pathways, flexible pathways and pension provision. The national evaluation of terms and conditions should be undertaken to inform these minimum standards and these should be reviewed as required.

What we propose

The Scottish Government has committed to implementing the recommendation to create a National Care Service (NCS), and to reform IJBs to become Community Health and Social Care Boards (CHSCBs) to be the delivery arm of the NCS.

We propose that the NCS will develop and manage a National Commissioning and Procurement Structure of Standards and Processes for ethical commissioning and procuring of social care services and supports.

The Structure of Standards and Processes will:

- define the approach to national and local level ethical commissioning and procurement
- provide templates to support decision making and procurement processes
- detail core criteria that must be considered when decisions are being made on how to meet the needs of the individual and deliver the service, including quality standards for the evaluation of services. Core criteria will include emphasis on workforce terms and conditions that support, develop, empower, and value their staff, the need to meet personal outcomes, and requirements for a level of financial transparency of publically funded service providers.
- be driven by national minimum quality outcome standards
- define stakeholders who must be engaged as part of the co-production process, including unpaid carers and those with lived and living experience
- embed standard terms and conditions
- support work to create a single, outcomes-focused approach to care and support which stretches from prevention and early intervention through to acute and specialist provision
- identify best practices examples and lessons learned and provide a space to share this on a national level
- expect and benchmark people standards (skills, capabilities and capacity) required to commission and procure quality services

The purpose of this is to ensure commissioning and procurement delivers a person-centred, human rights based approach that supports the outcomes and needs of the individual, meets minimum quality standards established for social care services, ensures fair work, promotes sustainability and ensures consistent implementation and equitable quality of service throughout Scotland.

The NCS will be responsible for governance and assurance that CHSCBs comply with the Structure of Standards and Processes, through oversight of commissioning and procurement processes at a local level. CHSCBs will report their progress to the NCS national commissioning and procurement team.

The NCS will create and manage a professional development programme to ensure all commissioning and procurement professionals working within social care have the appropriate skills to effectively implement ethical commissioning and procurement.

The NCS will be responsible for market analysis and will work with partners to develop a thorough understanding of the market and share this information with CHSCBs.

The NCS will be responsible for the commissioning, procurement and contract management of national contracts and framework agreements for complex and specialist services including the following:

- care for people whose care needs are particularly complex and specialist
- custodial settings including prison
- residential care homes
- care home contract

The NCS will establish a national commissioning and procurement team to deliver this role.

Questions

Structure of Standards and Processes
The National Care Service will develop a Structure of Standards and Processes for ethical commissioning including procurement which Community Health and Social Care Boards will follow and provide assurance against to the National Care Service. The Structure of Standards and Processes will:

- define the approach to national and local level ethical commissioning and procurement
- provide templates to support decision making and procurement processes
- detail core criteria that must be considered when decisions are being made on how to meet the needs of the individual and deliver the service, including quality standards for the evaluation of services. Core criteria will include emphasis on workforce terms and conditions that support, develop, empower and value their staff, the need to meet personal outcomes, and requirements for a level of financial transparency of publically funded service providers.
- be driven by national minimum quality outcome standards
- define stakeholders who must be engaged as part of the co-production process, including unpaid carers and those with lived and living experience
- embed standard terms and conditions
- support work to create a single, outcomes-focused approach to care and support which stretches from prevention and early intervention through to acute and specialist provision
- identify best practices examples and lessons learned and provide a space to share this on a national level
- expect and benchmark people standards (skills, capabilities and capacity) required to commission and procure quality services

Q67. Do you agree that the National Care Service should be responsible for the development of a Structure of Standards and Processes?

☐ Yes

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☐ Scotland Excel

☐ Scottish Government Procurement

☐ NHS National Procurement

☐ A framework of standards and processes is not needed

Q68. Do you think this Structure of Standards and Processes will help to provide services that support people to meet their individual outcomes?

- ☐ Yes
- ☐ No

Q69. Do you think this Structure of Standards and Processes will contribute to better outcomes for social care staff?

- ☐ Yes
- ☐ No

Q70. Would you remove or include anything else in the Structure of Standards and Processes?

Market research and analysis
The National Care Service will be responsible for market research. This will include market analysis to identify the structure of the market, behaviours, supply chain risks, barriers to market entry, environmental factors, and ethical considerations, to better understand how the health and social care market works, the direction in which the market is going, the competitiveness and the key suppliers within the market**.** In addition to this the National Care Service will work with the national regulatory and market oversight body to share information and use shared data to support ethical commissioning, decisions making on procurement routes and processes and contract management to minimise the risk of supplier failure.

Q71. Do you agree that the National Care Service should be responsible for market research and analysis?

- ☐ Yes
- ☐ No

If no, who should be responsible for this?

- ☐ Community Health and Social Care Boards
- ☐ Care Inspectorate
- ☐ Scottish Social Services Council
- ☐ NHS National Procurement
- ☐ Scotland Excel
- ☐ No one
- ☐ Other- please comment

National commissioning and procurement services
The National Care Service will establish a national commissioning and procurement team to commission and procurement national contracts and framework agreements where it is deemed that individuals needs and outcomes will be better met through national service provision.

Q72. Do you agree that there will be direct benefits for people in moving the complex and specialist services as set out to national contracts managed by the National Care Service?

☐ Yes

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☐ NHS National Procurement

☐ Scotland Excel

Regulation

The case for change

National regulators will continue to play an important role in ensuring consistent and high standards of social care and support. Through regulation we will continue to scrutinise the quality of care in Scotland to support consistent and high standards. It is important that the role of regulating both services and the workforce remains independent of the National Care Service (NCS). This independence will also allow the regulator to operate and to regulate any services commissioned directly by a NCS.

Once established the NCS will be responsible for setting national care standards, which will provide the framework for regulation moving forward. Future regulation at its heart needs to support better outcomes for people. The views of individuals accessing services and people supporting individuals to access services should be embedded and prioritised within the process.

This chapter sets out what we need from a modern and ambitious regulation process that drives quality, improvement, and the best outcomes for people. It covers arrangements for scrutiny, assurance and inspection of care services provided under the National Care Service (NCS) and for the education and professional development of those working within these sectors. It sets out proposals for how to strengthen and improve enforcement powers when services fail to provide the quality of care people require and to ensure the social care workforce is supported.

The Care Inspectorate, Scottish Social Services Council, and Healthcare Improvement Scotland.

The Care Inspectorate is the national scrutiny body responsible for the registration and regulation of care services. It scrutinises and inspects services, to ensure they meet high standards. Where the need for improvement is identified, they support services to make positive changes. Improvement notices can be issued and enforcement action taken.

The Scottish Social Services Council (SSSC) is the professional regulator of social service workforce and maintains registers of social workers, social care and early years workers. The SSSC has a statutory role in setting standards for their practice, conduct, training and education and by supporting their professional development and collecting workforce data from across the sector. Where people fall below the standards of practice and conduct they can investigate and take action.

Both the Care Inspectorate and the SSSC are established in statute, by the Public Services Reform (Scotland) Act 2010 and the Regulation of Care (Scotland) Act 2001, respectively. They are independent bodies which report directly to the Scottish Ministers.

During the pandemic the Care Inspectorate has worked even more closely with a range of health and social care partners, including Chief Social Work Officers and Healthcare Improvement Scotland, on a wide variety of important social care matters.

Healthcare Improvement Scotland (HIS) was set up under the Public Services Reform (Scotland) Act 2010 (PSRA) and took over the functions of NHS Quality Improvement Scotland and the regulatory functions of the Care Commission in relation to independent healthcare services. HIS is the national scrutiny and improvement body for all health services and is accountable to Scottish Ministers for the delivery of its strategic objectives.

The establishment of HIS was part of the drive to improve the scrutiny of public services in Scotland, following the Crerar review, and was intended to promote the use of improvement and evidence to support the scrutiny process and to identify, develop and implement continuous quality improvement at ground level rather than focus solely on compliance against minimum standards.

Issues and problems

A number of issues have been raised, through the Independent Review of Adult Social Care (IRASC) and previously, highlighting improvements which could be made to national scrutiny of the quality of community health and social care to ensure consistent and high standards of care and support for everyone using community health and social care. Some of these issues, for example, in relation to the regulator's enforcement powers, are likely to require changes to primary legislation, and therefore the Bill for creation of the NCS offers an opportunity to address them.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 24: The role of existing national care and support bodies – such as the Care Inspectorate and Scottish Social Services Council – should be revisited to ensure they are fit for purpose in a new system.

The Review envisaged these agencies becoming national care bodies for social care under the NCS. However, we believe it is more appropriate for regulation and scrutiny functions to operate independently of the NCS.

Recommendation 36: The care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role….

Core principles for regulation and scrutiny

We propose that scrutiny, inspection, and regulation of care services and the workforce should be undertaken independently of the National Care Service (NCS). The design and arrangements for regulation should be guided by an important set of principles shared by people who use services and the sector. A people centred and human rights based approach should be at the heart of the principles and inform their design. These arrangements should ensure consistent and high standards of care and support are delivered and robust and effective action is taken, particularly when there is a risk to the safety and wellbeing of people.

We propose the following core principles. We have numbered these to make it easier when answering the questions, but they are all equally important.

1. Scrutiny and assurance should support human rights-based care, focus on outcomes for people, and the positive impact community health and social care services are making to their lives, including the relationships staff have with them.
2. Activity should be targeted, proportionate, intelligence-led, and risk-based. This approach will allow the regulator to choose different types of scrutiny, assurance, or quality improvement intervention relative to the individual service and how it is performing.
3. The NCS should generally seek to review, update, and improve standards and practices as an organisation and across the care sector on a regular and ongoing basis (this is a separate role and process from any improvements which those who have responsibility for delivering social care services (or overseeing those) may be required to make arising from enforcement or other action by the regulator).
4. There should be a strong link between the regulation of the workforce and their professional standards and the inspection and scrutiny of the services they work in.
5. Overall national scrutiny should involve the regulator working collaboratively, where possible, with other professions and agencies and continue to be informed by lessons learnt and good practice arising from the experience of the pandemic.
6. Regulation is fundamental to ensure a qualified and skilled social care workforce which enables employers to deliver high quality, responsive care and support.
7. Regulation is a key element in ensuring the safety of vulnerable people, ensuring high standards for practice, conduct, training and education across the workforce.
8. Scrutiny and assurance should aim to reduce inequalities with an emphasis on people, prevention, partnership and performance.
9. Where possible, regulators should involve people in the development and delivery of scrutiny approaches and amplify the voice of people experiencing care.
10. Where appropriate, scrutiny and assurance should take account of legislative requirements, Scottish Government policy, national standards, and codes of practice.

Questions

Q73. Is there anything you would add to these core principles?

Q74. Are there any principles you would remove?

Q75. Are there any other changes you would make to these principles?

Strengthening regulation and scrutiny of care services

The enforcement powers at the disposal of the Care Inspectorate, as the current regulator, are set out in the Public Services Reform (Scotland) Act 2010 and originate from the Regulation of Care (Scotland) Act 2001.

Since the enforcement provisions were enacted, the shape of care in Scotland has changed. For example, we have seen a shift towards more people being supported to live at home and those living in older people's care homes having increasingly complex needs. This has required a corresponding shift in the approach to scrutiny and the skills and professional knowledge required by regulators and care workers, with an increased focus on clinical needs and, for example, provision of care and support to people with dementia.

Experience of using enforcement powers both prior to, and during COVID-19, raises issues of whether or not they are fit for purpose in a changed care environment and if they provide the best way to ensure people who use care and support services are protected from poor practice and failing services.

There are a range of options to strengthen the enforcement powers of the regulator. These should be considered alongside work already underway to enable the remodelling of scrutiny and inspection with changes to the frequency of inspection and a review of care service definitions. There may also be scope to create a new market oversight function for the regulator and views are welcomed on what shape this might take.

Enforcement powers
The Public Services Reform (Scotland) Act 2010 (the 2010 Act) sets out current enforcement options including: (a) Condition Notices**,** (b) Improvement Notices, (c) Cancellation of registration, and (d) Emergency cancellation of registration. As currently formulated, each one has its limitations which can hinder the ability of the regulator to support strong oversight.

A number of issues concerning the current powers have been identified. These include:

- **Condition Notices** – These notices enable parameters to be placed around the operation of a care service, for example, by preventing the use of parts of premises. Appeals against their imposition can be lengthy and cumbersome. If an appeal is lodged, the decision does not take effect until the appeal is determined or abandoned. A condition notice is likely to take around 4 weeks to impose if not appealed. A separate process is available for "emergency" conditions but the test for that process is the same as that for "emergency" cancellation of registration (serious risk to life, health, or wellbeing). There are situations where a faster approach may be needed albeit the "emergency" test is not met, but this also needs to be proportionate to the enforcement action which is proposed.
- **Improvement Notices** – These notices set out that services must improve in certain ways by designated dates or registration may be cancelled. In some cases, they are not properly promoting sustained improvement. Services can

receive several Improvement Notices (which may identify a consistent pattern of breaches or in some cases new breaches) which are never fully resolved or are only resolved for a short period before re-emerging. The 2010 Act sets out that the service must make “a significant improvement” or the Care Inspectorate can seek cancellation under section 64. There is no reference to a requirement for improvements to be “sustained” so these services do not currently reach the bar for cancellation but may consistently perform poorly over time.

- **Cancellation of service registration**– (following failure to comply with Improvement Notices) can be a protracted process. Any cancellation decision made does not take effect until the period for lodging an appeal with the sheriff elapses, or until any appeal is determined or abandoned. Getting to this point in the process can take several months and sometimes years.
- **Emergency cancellation** – The statutory test is predicated on “serious” risk to life, health, or wellbeing. Poorly performing services may expose those receiving them to multiple risks of a lesser nature, or to poor living conditions which are wholly unacceptable, while not constituting serious risk. In certain cases (particularly those involving child protection issues) there is a delay before an emergency cancellation application can be heard by a Court when service users could be left at serious risk.

In summary, there are options to reform current enforcement powers in the following areas:

(a) Condition notices under section 66 of the 2010 Act (this process is too slow)

The test could be made less stringent, or an “intermediate” category could be added.

(b) Improvement notices under section 62 of the 2010 Act (this process is too weak)

Changes to require sustained improvement would strengthen this provision. For example, one possibility is that even if improvements are made, the notice could remain “on the service’s record” for a set period, and further action provided for, if the same issue arose while the notice remained extant.

(c) Cancellation of a service under section 64 of the 2010 Act (this process is too slow)

The statutory process is fair and reasonable and allows the opportunity for representations by services affected, but appeals in the Sheriff court are likely to be protracted. One possible solution is to review court processes to govern the conduct of proceedings, as is the case with other types of court actions. Such a review could provide for clear timetabling of action with a view to avoiding the lengthy appeals currently experienced by the regulator.

(d) Emergency cancellation of a service under section 65 of the 2010 Act (the legal bar is too high)

The Sheriff considering an application for cancellation of registration under this provision has a wide discretion. They “may” (and therefore may not) make the order, even if satisfied that there will be serious risk unless the order is made. We would also highlight that in a number of cases there may be issues relating to the length of the process in which applications for emergency cancellations are heard by the court.

We welcome views on the impact, effectiveness and speed of the current enforcement powers set out above and the proposals for improving them. In making changes to current legislation the regulator would be enabled to ensure they can speedily take action with poor performing services, better protect residents of care homes and other social care users, and drive up the consistency and quality of care expected across all social care services in Scotland.

Questions

Q76. Do you agree with the proposals outlined above for additional powers for the regulator in respect of condition notices, improvement notices and cancellation of social care services?

☐ Yes

☐ No

☐ Please say why.

Q77. Are there any additional enforcement powers that the regulator requires to effectively enforce standards in social care?

Market oversight function

A lack of strategic understanding of the care market, and the sustainability of providers, can prevent effective contingency planning and other action by Health and Social Care Partnerships (HSCPs), Scottish Government and other partners that would prevent users of care services and care workers being impacted by care service closures and other market failures.

The Independent Review of Adult Social Care (IRASC) also proposes that the care home sector becomes a more actively managed market. In making this recommendation, the IRASC advocates the regulator taking on a new market oversight function that provides a long term strategic vision and an overview of the care home market, taking into account local needs and the balance of providers in the market.

Developing an oversight of the market, through gathering financial information, developing market intelligence, and assessing financial risk would enable the regulator to map the social care sector, the vulnerabilities and the good practice within it. It would also enable the identification of where specific support and/or action is required to ensure that outcomes for people experiencing care can be fully met.

The development of an effective market oversight capability could potentially contribute to the following:

- **Identifying financial risk –** The regulator could gather intelligence on financial risks at a strategic level in the sector through the collection of financial data, comparators and trend analysis. The regulator could determine the level of scrutiny and/or improvement support required using detailed financial metrics to assess the level of risk associated with a provider. This could support an anticipatory approach and determine the interventions required. Further, this information could be used to inform commissioning discussions and support HSCPs in the planning and provision of care.
- **Scrutiny, assurance, and quality improvement –** The regulator could build on information gathered through scrutiny and other means to assess financial and operational threat at the registration, service, provider, and strategic levels to target improvement at appropriate levels. This could increase the ability to identify potential issues associated with providers and help the regulator to focus their resources effectively in providing scrutiny, assurance, and support where it is needed most. There is potential for the regulator to be provided with a statutory power to further enable scrutiny of providers as a whole, in addition to inspection of discrete care services.
- **Collaboration and market insight –** Working across the sector, the regulator could capture, evaluate, and consolidate its knowledge, expertise, experience, and information from dialogue and engagement with others, potentially through an extended relationship-manager role, and use that information to build a wider intelligence picture. This could enable them to assess the market's utility and capacity to provide for the population's needs in order to inform government, and to influence, target, and evidence quality improvement at a

strategic level. Working with local and national teams, the information can be shared with commissioners and procurement professionals to support ethical commissioning, decision making on procurement routes, and processes and contract management to minimise the risk of supplier failure.

- **Contingency Planning –** The regulator could inform contingency planning arrangements to achieve a risk-based focus on intervention to establish facts and support improvement or manage closure, as appropriate.

These changes are intended to enable the further development of an intelligence led risk based approach to scrutiny and inspection and support the sustainability of the sector. This helps to ensure that scrutiny and quality improvement support is targeted where it is most needed to protect people accessing social care services and help to prevent and manage disruptions to services.

In England, the Care Quality Commission (CQC) maintains a 'market oversight' function that acts as an early warning system to protect people using adult social care services from having their care interrupted where a large or specialist care provider that could be difficult to replace is at risk of financial failure and has to close or sell one or more its services. Under the scheme, providers are legally required to provide the CQC Market Oversight team with financial information which will inform the level of engagement required. The CQC may also consider enforcement actions against providers should they fail to comply with the requirements of the market oversight scheme.

In Scotland, the Care Inspectorate does not have a similar function to CQC and they do not have the legal powers to require care providers registered in Scotland to routinely submit financial information, in a prescribed form, for this market oversight purpose.

We welcome views on the necessity of a market oversight function for the regulator, its scope and the potential form of any additional powers the regulator should have to ensure this function is effective.

Questions

Q78. Do you agree that the regulator should develop a market oversight function?

☐ Yes

☐ No

Q79. Should a market oversight function apply only to large providers of care, or to all?

☐ Large providers only

☐ All providers

Q80. Should social care service providers have a legal duty to provide certain information to the regulator to support the market oversight function?

☐ Yes

☐ No

Q81. If the regulator were to have a market oversight function, should it have formal enforcement powers associated with this?

☐ Yes

☐ No

Q82. Should the regulator be empowered to inspect providers of social care as a whole, as well as specific social care services?

☐ Yes

☐ No

Please say why

Enhanced powers for regulating care workers and professional standards

The Regulation of Care (Scotland) Act 2001 established the Scottish Social Services Council (SSSC) as the regulator of the workforce in Scotland. This founding legislation has been in place with little change thereafter. Whilst this has supported the registration of the workforce, the legislative powers relate largely to the individual worker (through the conditions for registration) rather than the employer's role in supporting this. The current powers therefore have limitations which hinder the ability of the regulator to ensure that employers fully support the workforce in meeting the requirements of registration.

Currently the vast majority of the social services workforce are regulated through SSSC, however there are some groups that remain unregulated including health care assistants, day care of adult services and personal assistants – the latter being highlighted by the Independent Review of Adult Social Care (IRASC) as an issue. Given the overarching purpose of regulation is public protection there is merit in further considering the expansion of regulation to additional categories working with vulnerable groups.

Employers are required to adhere to the SSSC's codes of practice, however there is no power for the SSSC to enforce this, nor is there any statutory obligation on employers to ensure staff attain the qualifications required for registration within the necessary timescale. Where SSSC have investigated the fitness to practise of an individual, SSSC can impose a range of sanctions on them but has no power to compel or support the employer to ensure these sanctions are implemented within the required timescale. The provision of these additional powers will ensure staff are supported by employers in meeting their regulatory requirements.

Strengthening the requirement on employers to fulfil their obligations in line with the codes of practice would be improved by enhancing regulatory powers to ensure that employers have a duty to ensure that any fitness to practise decisions relating to employees are fully implemented, and to support those employees to undertake all necessary qualifications and continuous development within the required timescales to achieve and maintain registration.

In undertaking fitness to practise investigations, SSSC are required to gather information from a number of external organisations to support their enquires. A failure to provide this information can, and does, impact on their ability to conduct fair and transparent investigations, impeding their ability to investigate cases, with knock-on consequences for public protection. Additional powers to compel these organisations to provide the regulator with the required background information when investigating cases of a worker's fitness to practise is also recommended.

Questions

Q83. Would the regulator's role be improved by strengthening the codes of practice to compel employers to adhere to the codes of practice, and to implement sanctions resulting from fitness to practise hearings?

Q84. Do you agree that stakeholders should legally be required to provide information to the regulator to support their fitness to practise investigations?

Q85. How could regulatory bodies work better together to share information and work jointly to raise standards in services and the workforce?

Q86. What other groups of care worker should be considered to register with the regulator to widen the public protection of vulnerable groups?

Valuing people who work in social care

The case for change

Scotland's dedicated primary/community health and social care workforce provide critical support to people across Scotland every day. We need to do more to ensure that there is a greater understanding of the role that they play in the economy, the skills strength of their response to the needs of individuals, and the compassion and care they bring every day to the job they do. There is a need to grow the workforce in line with the increasing demand for support and care needs. The workforce need to be valued by all of us and they need to consider their job a career with opportunities to grow and develop. Our current workforce are our best advocates to encourage new entrants and promote working within the sector.

We know that to enable advocacy of this nature by the workforce we need to continue to embed our Fair Work expectations. Scotland's ambition to become a Fair Work nation by 2025 is underway, with many industries and sectors making positive steps towards this, and there is a commitment to ensure that social care is central to this work. Training and development, pay, terms and conditions and a better understanding of the plan for the future skills the sector will need should be the focus of national work moving forward.

This chapter explores the longer term system changes needed to support the workforce, within the wider context that there is already considerable work underway in this space to secure early progress.

Fair Work

How it works now

There are thousands of social care providers across adult, children's and justice services. Many of these provider services are commissioned by Integration Joint Boards (IJBs), and each social care provider is responsible for setting their workforce terms and conditions.

The desire to do a job that makes a difference is the main reason why people are motivated to take up a career in social care. However the general levels of pay within the social care workforce are low, with the majority of workers at the lower end of the pay scale, regardless of position, tenure, or experience. Staff have indicated this leaves them feeling "undervalued" and "underpaid". Having a workforce who feel valued will have positive impacts on people's experience of care. Stability of staff and continuity of care is important for people who access support, and progression and professional development for social care workers will result in better quality services.

There is currently no ability to set minimum standards for workforce conditions within individual providers; this leads to variety of workforce conditions across the sector.

While employment rights are reserved to the UK government, the Scottish Government is committed to promoting and supporting fair working practices wherever possible.

The social care sector is generally not well unionised. Whilst legally, every staff member is free to become a union member, many providers do not recognise a trade union, nor provide ongoing opportunities to engage. This can lead to poor membership in the workplace, and lack of representation in the sector as a whole. This is especially so regarding personal assistants.

Trade union recognition is more prevalent in larger, established workplaces (such as local authorities). These working relationships can support positive change for the workforce, however improvements in larger trade union recognised workplaces further cause disparity with the experiences of the workforce in smaller, non-unionised settings.

Issues and problems

The vast number of different social care providers has led to inconsistency and variation in pay and terms and conditions across the workforce. There is also a lack of parity for third and independent sector social care staff compared with those employed by local authorities, and more broadly between the health and social care sectors. This includes pay, terms and conditions, and role definition.

There has always been a lack of data regarding why staff leave their roles, and we need to fully understand this to address retention, however poor rates of pay can lead to a perception that social care is not an attractive career. A Scottish social care labour market report published in March 2020 found that one in ten social care

employees indicated they would like to leave the sector in the future. This was reported to be mainly due to the stress and workload of their current job. The perception was that the main reason why people leave the workforce is for better terms and conditions, particularly pay levels, and another driver was in order to do a less demanding job for similar or better rates of pay. These drivers are likely to contribute to the longstanding difficulties with recruitment and retention in the sector.

Since 2016, the Real Living Wage policy provides annual funding to providers to ensure that staff in direct care roles earn at least the Real Living Wage, however this has meant that for some, there has been a stagnation of wages for more senior or experienced care workers, due to funding being focused on the lower pay-bands, which tend to be less experienced or tenured staff members.

Some members (or parts) of the workforce suggest they are not always valued or well treated by employers and there is no collective voice of the sector. This again can be especially so for personal assistants.

Many providers, when surveyed, have indicated they would want to do more to enable their workforce to have an effective, collective voice at a local level, enabling them to comment on and address matters of importance, such as their terms and conditions, with their employer. Many providers however suggest that much of the changes the workforce request rely on increased funding or changes which cannot be made at a local level.

Many staff, when surveyed, note frustration with changes not being implemented, which can lead to a loss of staff engagement and innovation.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 43: Conduct a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles. This should take account of skills, qualifications, responsibilities and contribution.

Recommendation 44: Putting in place national minimum terms and conditions as a key component of new requirements for commissioning and procurement by Integration Joint Boards. Specific priority should be given to pay, travel time, sick pay arrangements, training and development, maternity leave, progression pathways, flexible pathways and pension provision. The national evaluation of terms and conditions should be undertaken to inform these minimum standards and these should be reviewed as required.

Recommendation 46: Establishing a national forum comprised of workforce representation, employers, Integration Joint Boards and the Scottish Government to advise the National Care Service on workforce priorities and to take the lead in creating national sector level collective bargaining of terms and conditions.

What we propose

To address the issues outlined above, we propose and seek your views on the following:

To ensure the workforce is recognised as a central pillar to the high quality outcomes expected, the National Care Service (NCS) could take the lead in the development, administration, and assessment of national workforce quality standards that support the practical delivery of Fair Work principles. This could include rates of pay, security of employment contracts, and training and development within the sector. This could take the form of a "Fair Work Accreditation Scheme", which would enable providers, staff, clients, and funders to easily identify where Fair Work practice is embedded within an organisation.

The NCS could oversee the creation of a National Job Evaluation framework/scheme which providers can opt into, to ensure they are able to confidently assess and reward staff on the basis of recognised job families (which align to long term workforce planning needs). The NCS could provide the opportunity to implement a national pay-band structure similar to that within the NHS.

We propose that the NCS will develop and manage a National Commissioning and Procurement Framework of standards and processes for social care, which will include templates and core criteria to base decisions and award of contracts on. Core criteria will include an emphasis on workforce terms and conditions that support, develop, empower, and value their staff, and requirements for a level of financial transparency of publicly funded service providers. Commissioning and procurement will therefore be a driving force to ensure the workforce, including personal assistants, is appropriately valued.

Questions

Q87. Do you think a 'Fair Work Accreditation Scheme" would encourage providers to improve social care workforce terms and conditions?

☐ Yes

☐ No

Please say why.

Q88. What do you think would make social care workers feel more valued in their role? (Please rank as many as you want of the following in order of importance, e.g. 1, 2, 3…)

	Improved pay
	Improved terms and conditions, including issues such as improvements to sick pay, annual leave, maternity/paternity pay, pensions, and development/learning time
	Removal of zero hour contracts where these are not desired
	More publicity/visibility about the value social care workers add to society
	Effective voice/collective bargaining
	Better access to training and development opportunities
	Increased awareness of, and opportunity to, complete formal accreditation and qualifications
	Clearer information on options for career progression
	Consistent job roles and expectations
	Progression linked to training and development
	Better access to information about matters that affect the workforce or people who access support
	Minimum entry level qualifications
	Registration of the personal assistant workforce
	Other (please say below what these could be)

Please explain suggestions for the “Other” option in the below box

Q89. How could additional responsibility at senior/managerial levels be better recognised? (Please rank the following in order of importance, e.g. 1, 2, 3…):

	Improved pay
	Improved terms and conditions
	Improving access to training and development opportunities to support people in this role (for example time, to complete these)
	Increasing awareness of, and opportunity to complete formal accreditation and qualifications to support people in this role
	Other (please explain)

Please explain suggestions for the “Other” option in the below box

Q90. Should the National Care Service establish a national forum with workforce representation, employers, Community Health and Social Care Boards to advise it on workforce priorities, terms and conditions and collective bargaining?

☐ Yes

☐ No

Please say why or offer alternative suggestions

Workforce planning

How it works now

Workforce planning across social care employers is varied and complex, which makes accurately planning workforce requirements difficult.

Issues and problems

The complexity of health and social care, given the number of employers, makes workforce planning difficult and lessons learned from the pandemic should be an initial priority.

A lack of consistent, robust, and easy to access data across the social care sector is a continuing issue that needs resolved, making it difficult to workforce plan nationally, regionally, and locally.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 47: National oversight of workforce planning for social work and social care, which respects the diversity and scale of employment arrangements while improving resilience and arrangements for mutual support should be a priority for a National Care Service.

What we propose

To address the issues outlined above, we propose and seek your views on the following:

The development of a consistent approach to integrated workforce planning with health, supported by a national tools/framework and an agreed data set.

A National Care Service could ensure a longer term strategic approach to meeting social care workforce requirements across the public, private and third sector social care providers in Scotland.

Questions

Q91. What would make it easier to plan for workforce across the social care sector? (Please tick all that apply.)

- ☐ A national approach to workforce planning
- ☐ Consistent use of an agreed workforce planning methodology
- ☐ An agreed national data set
- ☐ National workforce planning tool(s)
- ☐ A national workforce planning framework
- ☐ Development and introduction of specific workforce planning capacity
- ☐ Workforce planning skills development for relevant staff in social care
- ☐ Something else (please explain below)

Training and development

How it works now

There is variation in access to workforce development and the support offered to achieve qualifications and learning.

The current regulation framework covering over 200,000 employees cannot compel providers to ensure workers gain the required qualifications or undertake ongoing development. It is the responsibility of the individual worker to obtain the qualification necessary for their registration and continued employment.

There are specialist courses and qualifications available for people considering a career in social care, however there may not be great awareness of these. For example, how to access information on what qualification may be required for specific roles or specialisms.

There is a projected shortfall of training provider capacity to meet the demand for qualifications required for social services registration over the next five years, particularly in relation to a key qualification required for adult social care workers. Work is underway to explore solutions to this.

Issues and problems

The end of freedom of movement following the UK's exit from the EU could exacerbate existing staff capacity issues and impact continuity of care. Social care workers (other than senior care workers) are not currently in scope for the new UK Health and Care Visa nor included in the Shortage Occupation List. To backfill a loss of staff, the sector is heavily reliant on agency workers which incurs inflated costs for providers, possibly reducing available funding which could be invested in other areas.

Whilst apprenticeships are used in the sector, particularly by private providers, there is concern that social care is not seen as a priority for allocation of funding for apprenticeships or qualifications at higher and further education levels.

The five year period to achieve the required social care qualification is seen as too long and a disincentive for some employers to invest in the learning and development of the workforce. This has led to variation in standards and may have contributed to the high turnover.

Skills and training do not always follow a clear pathway and there are inconsistent approaches to training, as it is not a requirement within contracts.

Whilst there are specialist qualifications available in the sector, the titles they are given may make it difficult to understand which ones are required for particular roles or specialties.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 45: Establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development. The current role, functions and powers of the Scottish Social Services Council should be reviewed and appropriate read-across embedded for shared and reciprocal learning with the NHS workforce.

What we propose

Workforce training and development is inextricably linked to quality delivery and continuous improvement. To ensure that there is appropriate and relevant training and development the National Care Service (NCS) will set training and development requirements that support both entry to the workforce and continuous professional development.

To ensure access to training is sufficient the NCS will provide and/or secure the provision of training and development for the social care workforce. This will complement the leadership and development role proposed for social work.

Questions

Q92. Do you agree that the National Care Service should set training and development requirements for the social care workforce?

☐ Yes

☐ No

Please say why

Q93. Do you agree that the National Care Service should be able to provide and/or secure the provision of training and development for the social care workforce?

☐ Yes

☐ No

Personal Assistants

How it works now

Personal assistants are individuals directly recruited by people in receipt of direct payments of Self-directed Support (SDS) and/or Independent Living Fund (ILF) funds from among the general population. Personal assistants may, or may not, have qualifications or prior experience as these are not always required by their prospective employer. Some personal assistant employers may prefer workers who have not been pre-moulded by prior regulated employment or formal training.

Personal assistant workers provide a key role in the care and support for individuals who require support. This work is unique, centred upon the individual's needs and enabling them to exercise choice and control in the decisions about their life. The role of the personal assistant is very much in-keeping with the ethos of SDS, allowing an individual to participate in life with dignity. However, as a workforce offering paid support to a personal employer they share some of the employment profiles of "domestic service", despite often carrying out complex care needs for individuals with significant support requirements. Examples of this can include catheter care or managing challenging behaviours sometimes reserved for qualified staff. Personal assistants have no supervision, or complaint/personnel mechanism, other than directly with their personal employer. They have no collective bargaining.

Personal assistants are paid for by the person who is in receipt of funding from SDS option 1 and/or ILF. Personal assistant support is not a service regulated by the Care Inspectorate. Nor are Personal assistants registered through the Scottish Social Services Council (SSSC). Personal assistants may be employed by means of other funding sources, such as state benefits or private funds/savings.

It is the responsibility of the direct payment/ILF recipient or their guardian/responsible adult to comply with employment legislation.

In the future there will be a requirement for non-family Personal assistants to complete a Disclosure Scotland Protecting Vulnerable Groups (PVG) check.

Personal assistants are dispersed throughout Scotland, in personal employment and are non-unionised.

Issues and problems

There is currently no accurate data on publicly funded personal assistants, estimates are upwards of 6,000 in Scotland based on available data on personal assistant employers collected by NHS National Services Scotland, and an estimate of the average number of personal assistants per employer.

As personal assistants are not registered, it makes it difficult to identify, engage, and support them. Whilst there has been previous work done to consider registration of personal assistants, some independent living movement organisations and disability led organisations representing the personal assistant employer have views to be taken into account.

There is no requirement for personal assistants to receive clear and consistent information, training, and capacity building in supporting and delivering self-directed approaches, other than from their employer. There is currently no consistent standard or checks or support on relevant and appropriate values, skills, knowledge, confidence, and training for personal assistants, other than from their employer.

A lack of knowledge and understanding of SDS across the social care workforce in Scotland leads to situations where SDS option 1 is not fully understood, and the need for the personal assistant and the personal assistant's employer to receive sufficient training in the requirements of employment law.

If the decision is made for any form of registration of personal assistants then this will need to be legislated for.

Due to the lack of profile of this workforce, there is significant difficulty in reaching personal assistants in order to provide further support.

Some people accessing SDS option 1 – direct payment have spoken of the administration burden of securing personal assistant support and also of struggling to secure the right care at the right time. There is some evidence that providing further administrative, recruitment, or employment support (such as a bank of personal assistants) may encourage greater adoption of direct payments of self-directed support or ILF.

Relevant Independent Review of Adult Social Care Recommendations

Recommendation 48: The recommendations listed above [relating to Fair Work] should apply to personal assistants employed by people using Option 1 of self-directed support [or Independent Living Fund], who should be explicitly recognised as members of the workforce, as well as employees of providers in the public, third and independent sectors. This recommendation should be delivered in full partnership with the independent living movement.

What we propose

In order to understand the extent of personal assistants operating across Scotland and improve and ensure appropriate support across the workforce, we propose that processes will be put in place to require personal assistants in Scotland to register centrally.

In addition, there has been consideration of national minimum employment standards for personal assistants to ensure parity and fairness across Scotland. The National Care Service (NCS) could have a role in supporting these as part of future care standards.

Consideration of provision of further administrative, recruitment or employment support may encourage further adoption of the full range of SDS options. Any changes should ensure that personal choice about how care is delivered is protected and should smooth the process rather than making it more bureaucratic.

There is also a desire to ensure that personal assistants are able to access training and development opportunities to ensure they are have the necessary skills to provide support.

Questions

Q94. Do you agree that all personal assistants should be required to register centrally moving forward?

- ☐ Yes
- ☐ No

Please say why.

Q95. What types of additional support might be helpful to personal assistants and people considering employing personal assistants? (Please tick all that apply)

- ☐ National minimum employment standards for the personal assistant employer
- ☐ Promotion of the profession of social care personal assistants
- ☐ Regional Networks of banks matching personal assistants and available work.
- ☐ Career progression pathway for personal assistants
- ☐ Recognition of the personal assistant profession as part of the social care workforce and for their voice to be part of any eventual national forum to advise the National Care Service on workforce priorities
- ☐ A free national self-directed support advice helpline
- ☐ The provision of resilient payroll services to support the personal assistant's employer as part of their Self-directed Support Option 1 package
- ☐ Other (please explain)

Q96. Should personal assistants be able to access a range of training and development opportunities of which a minimum level would be mandatory ?

☐ Yes

☐ No

Glossary

Advanced Practice models (in nursing) involve nurses providing clinical leadership and having autonomous decision-making authority including assessment, diagnosis, treatment and prescribing for people with complex health needs. Advanced nurse practitioners must be qualified to Masters level and have demonstrated competence across the four pillars of advanced practice.

Age of criminal responsibility (for children). This is the age at which a child can be arrested or charged with a crime. At present this is 8 years old in Scotland, it will rise to 12 years old when the relevant sections of the Age of Criminal Responsibility (Scotland) Act 2019 come into effect.

Alcohol and Drug Partnership (ADP). Each local authority area has an ADP which is a partnership of various public services including Health Boards, local authorities, police and voluntary agencies. An ADP has responsibility for strategic planning and performance across drug and alcohol issues.

Allied Health Professionals (AHPs). Includes a range of jobs such as radiographers, paramedics, and physiotherapists, working in hospitals, clinics, housing services, people's homes, schools, and health centres.

Care Inspectorate (CI). The independent national scrutiny and assurance body responsible for the registration and regulation of care services.

Community Health and Social Care Boards (CHSCBs). We propose that Integration Joint Boards (IJBs) will be reformed to become Community Health and Social Care Boards (CHSCBs), and that CHSCBs will be the local delivery body for the National Care Service.

Community Justice Partnerships (CJPs.) Statutory partners who cooperate at a local level in the preparation, implementation and review of a community justice outcomes improvement plan for the local authority area.

Fair Work Convention. An independent advisory body to Scottish Ministers, with an aim of ensuring fair work for individuals, businesses, organisations and society.

GIRFE National Practice Model: Getting It Right for Everyone. A proposed multi-agency approach of support and services from young adulthood to end of life care.

Getting It Right For Every Child (GIRFEC). A multi-agency, child-centred approach of support and services for children.

Health and Social Care Partnership (HSCP). The operational and delivery aspect of integration. The HSCP brings together the staff from the Health Board and local authority to deliver integrated services under the direction of the Integration Authority. The HSCP itself is not a statutory body.

Healthcare Improvement Scotland (HIS). The national scrutiny and improvement body for all health services, accountable to Scottish Ministers for the delivery of its strategic objectives.

Healthcare support workers (HCSWs). Assist nurses, therapists, midwives, hospital doctors and other healthcare professionals to deliver high-quality person-centred care.

Independent Living Fund (ILF). A national scheme of direct payments to support independent living by disabled people in Scotland. Following the closure of the UK ILF in 2015, the Scottish Government established a new organisation, Independent Living Fund (ILF) Scotland, to administer ILF for existing recipients of the fund in Scotland.

Independent Review of Adult Social Care (IRASC). An independent review commissioned by the Scottish Government which made recommendations on improvements to adult social care in Scotland in a report published 3 February 2021.

Integration Authorities (IAs). The statutory body responsible for ensuring that health and social care services are well integrated. The IA is the decision making and governance body for the delegated functions, services and budgets identified in individual integration schemes, jointly agreed by the relevant local authority and Health Board. At present, there are two types of IAs which have been created across Scotland, either through establishing the local authority or Health Board as a 'lead agency' or by setting up an '**Integration Joint Board' (IJB).**

Integration Joint Board (IJB). The majority of integration authorities are Integration Joint Boards. These are statutory bodies responsible for the planning and commissioning of delegated services, separate from both local authorities and Health Boards.

Justice social work (JSW) services. Takes a lead role in the delivery of community interventions in local authorities, with support from partners including third sector organisations.

National Care Home Contract (NCHC). Negotiated annually between local authorities and care home providers and provides a national framework for charging for residential care.

National Care Service (NCS). We propose to establish a new National Care Service, accountable to Scottish Ministers, to oversee the provision of social care and support in Scotland.

National Integration Joint Board. A proposed joint board with the aim of improved joint working between the NHS and the proposed NCS to agree national strategies and priorities.

National Taskforce for Human Rights Leadership. A Scottish Government led Taskforce with membership from the public sector, civil society and legal and academic experts in human rights, established in 2019, to take forward the

recommendations made in the 2018 Report of the First Minister's Advisory Group on Human Rights to prioritise actions to progress human rights and equality in Scotland. In March 2021, the Taskforce published their 30 recommendations for a new human rights framework for Scotland, which are being taking forward by the Scottish Government.

Personal Assistants (PA). Individuals employed by people in receipt of direct payments of Self-Directed Support and/or ILF funds.

Public Bodies (Joint Working) (Scotland) Act 2014 (PBJWSA). This Act requires Health Boards and local authorities to work together to form integration authorities (IAs), which are responsible for ensuring that health and social care services are well integrated.

Real Living Wage. A voluntary (non-statutory) wage rate, based on the cost of living.

Scottish Social Services Council (SSSC). The professional regulator of the social service workforce.

Self-Directed Support (SDS). An approach for people who are eligible for social care support, with the aim of giving those people choice and control over how their care and support can be delivered.

Self-Directed Support (SDS) Framework of Standards. A set of standards written by the Scottish Government specifically for local authorities, to provide an overarching structure, aligned to legislation and statutory guidance, for implementation of the self-directed support approach and principles.

The Promise. The Promise outlines a vision for Scotland which calls for change in response to the Independent Care Review, shaped by the voices of children and families with care experience, and of those who work in the 'care system'.

United Nations Convention on the Rights of the Child (UNCRC). Sets out the human rights of every person under the age of 18 and is the most complete statement on children's rights in history. It was adopted by the UN General Assembly in 1989. The UK ratified the UNCRC in 1991.

Alternative formats are available upon request.

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