**Response to the Scottish Parliament Health and Sport Committee Inquiry: The future delivery of Social Care in Scotland.**

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

One of the key challenges is that we have significant assessed and unmet need in social care. People have been assessed by social workers and identified as having social care needs but a service or provider is not available for them. In 2013 the Parliament enacted the Self Directed Support (Scotland) Act.

This should have heralded a new age for social care. Years of thinking and planning from the 2006 review of 21st Century Social Work had culminated in the launching of self directed support. Since then it has been an uphill struggle to see the original aim and vision of the act come into being. Therefore in relation to how people plan their own social care: We have the legislation, we have the policies and guidance but somehow we have not fully embraced the opportunity to truly shift the culture and practice of providing people with choice and control over how their social care is arranged, organised and delivered. Services need to be easily accessible and working to a more preventative and early intervention model and not simply responding to high levels of need and crises.

In relation to community's being involved in and planning social care, again we have good policies, good guidance. Integrated Joint Boards have various ways of involving communities and have representation from representatives of people using services and carers. However, community involvement is usually via consultation (online surveys, public meetings etc.) on an already drafted strategy or action plan that might or might not lead to changes in this plan.
Trusting communities to 'do the right thing' and being afforded the resources and opportunities to develop local social care opportunities via grants. The level of grant to community groups has diminished in the last few years as Local Authority budgets have been reduced. This leads to a loss of creativity and innovation and a loss/reduction in early intervention and preventative services in localities. Services such as lunch clubs, social and networking activities, interest groups and leisure and recreational activities have all found it difficult to survive. Yet we know they play a vital role in offering social connections, overcoming loneliness, alerting GP's or social workers early when they see someone who may have social care needs etc. We see the development of 'social prescribing', Links Workers, Navigators and Community Connectors but if the very services they are trying to connect people to are not funded or are impoverished then we have a problem.

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

As a third sector provider of community based mental health services across Scotland we have seen the introduction and evolution of social care commissioning and contracting over the last 25 years. The issues and concerns that we and others raised 25 years ago are still largely unresolved. The services that are now available in the community for people have largely come from the creativity and innovation of the third sector. Supported Living where people with long term conditions, learning disability or mental health problems developed originally by third sector organisations who

wanted to offer alternatives to institutional models of care. This has been tremendously successful and large numbers of people are now living fulfilling and active lives in the community. However these services are also subject to being retendered every 3-5 years. This can sometimes lead to positive changes as a new provider will bring creativity and redesign ideas to a service but more frequently it leads to reduced funding due to the competitive nature of tendering. We have created a quasi market where people's support is traded as a commodity. If the Self Directed Support (Scotland) Act 2013 had been fully embraced then people who require support over many years would be experiencing less volatility due to retendering. Under Options 1 and 2 they can select their provider when they choose and contribute to the planning and delivery of the service they receive. There are challenges for both commissioners and service providers in this. Commissioners have to give up some power and control to service users whilst providers have to ensure they have sufficient individual service contracts under Options 1 and 2 to ensure they can maintain sustainable services with the appropriate management and organisational structures in place.

Most commissioning and contracting of services still specifies a model of delivery based on an hourly rate for care at home/supported living/housing support. The rates across the country vary immensely and even within individual areas, rates can vary depending on the people to be supported. Many commissioners are seeking to introduce a model based on outcomes. However, this still largely relies on an assessment of need based on hours of support. It is also unclear what outcomes are being sought. Are they system outcomes, service outcomes or the personal outcomes of the supported people? Pricing for an outcomes model has proved problematic- how do you cost a personal outcome?

A further issue we have encountered is that even when commissioners seek to move to a personal outcomes model the back office systems in Local Authorities still require invoices showing the numbers of hours of support and the hourly rate for this. Effectively this removes any flexibility that providers might have to deliver services in different ways.

Scotland Excel received funding from the Scottish Government to develop a national framework for Supported Living that would seek to overcome some of these issues. They consulted with providers who identified the above and other issues as areas that needed to be resolved. However the resulting framework that was tendered by Scotland Excel last year has, in our view, not resolved these issues and has followed a fairly traditional procurement model seeking an hourly rate.

Third sector providers have been discussing and working with each other to identify different and more collaborative ways of commissioning services. Models such as Alliancing (http://lhalliances.org.uk/what-is-alliancing/) have been established in 2 service areas to date. Public Social Partnerships have had some success but they still inevitably lead to a competitive tender after 2-3 years of testing a new model and some experiences have been that the model has simply been used as a way to cut funding. Consortium approaches have also been tried by third sector providers but they can prove more expensive than single provider models, so often fail through the competitive tendering process.

Often providers have little input into the development of service specifications. Commissioners are sometimes advised that this is potentially 'anti-competitive'. The Third Sector has much to offer in terms of innovating and creating new solutions but the 'system' conspires to suffocate this by the processes and procedures employed which often simply reduce providers to being at the end of a supply chain where price can often be the deciding factor.

Variable rates of means testing of supported people across the country can also be a problem as providers experience people opting not to have a service if they have to make a financial

contribution. What is and is not means tested varies across the country as do rates of contribution. This is even more of a problem since integration as it can be difficult to identify if this is a service that should be free at the point of contact (i.e. a health service) or means tested (i.e. some social care services).

Indirectly connected to this issue is the legislation from the 2001 Regulation of Care (Scotland) Act which established the Care Commission (replaced by the Care Inspectorate in 2011) and the Scottish Social Services Council. Both bodies have done much to improve and ensure the quality of support and care in Scotland. However, the Care Inspectorate is, we believe, hampered in enabling more person centred support and care in line with the Self Directed Care Act and the new Health and Social Care Standards due to the legislation specifying specific types of services (Care Homes, Care at Home, Day Care etc). We feel that this act is long overdue revision to ensure that the Care Inspectorate does not have to classify services in this way.

If we genuinely want to deliver person centred support/care then we need to register the support/care people receive but not to confine this to a particular service model. This would ensure less emphasis on the registration of the service and more focus on the actual support/care the supported person receives. Simply put, we need to move from registering services to registering service to the person.

Registration of the workforce is also important but, again, we feel hampered by the legislative definitions that the SSSC have to work with. During the course of a working week some of our staff might work in two different types of registerable categories and have to ensure they are correctly registered for these. Again, we believe this could be simplified by reviewing and modernising the legislation to keep in line with more flexible ways of delivering social care.

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

The most essential element of a modern social care system is the workforce. They are undervalued and underpaid. They are also in short supply as recruitment and retention is a major current issue. Improving pay, creating more career development opportunities such as senior and advanced practitioner roles would go some way to addressing future needs. In Penumbra we have invested in developing peer worker roles. These are people with lived experience of mental ill health and recovery. Currently around 15-20% of our workforce are in Peer Worker or Peer Practitioner roles. We are however, an early adopter in this area and peer work roles need to be further embraced and developed in social care.

Technology already plays an important part in social care either where staff are able to remotely access systems and records and update records whilst on the move or where digital aids and adaptations have been used in smart assisted living. There will be further development of technology that can support people, however there will always be a need for human interaction as this is fundamental to supporting people to live fulfilling and valued lives.

Affordable housing is in short supply and this does not just affect people with social care needs. Future affordable housing needs to be based on a design model that allows flexible layouts and easy connection to digital systems that can provide support and reassurance to people.

A further essential element for the future is a shift in the culture and mindset of the system and citizens. We need to understand and communicate a modern compact between citizen and the state in relation to social care. We will all have contact with the social care system in the same way that we

all connect to the health system. A modern compact would describe the expectations citizens should have and what the state can support. It should reflect human rights and ensure equality for all. The 'welfare state' has moved on from the 1940's yet we have not always clearly articulated how things have changed and the public perception is that services are difficult to access, in short supply and being cut regularly.

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

An end to means testing for social care. More investment in communities so that more preventative support is available. We need to remove eligibility criteria for social care services so that people can access the right support at the right time. Otherwise we are constantly, simply reacting to crises. There should be 'no wrong door' in an integrated health and social care system