

Commission for the Provision of Quality Care in Scotland



Report for the Scottish Labour Party

October 2015

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FOREWORD

I was invited by Neil Findlay MSP, who, at that time, was Shadow Cabinet Secretary for Health and Wellbeing, to chair a group with the aim of reviewing how we can improve the way adult social care is delivered in Scotland. More specifically we were asked to consider how we could:

- raise the standard and quality of care
- raise the status of care as a profession
- provide a road map to deliver world class health and social care for adults

This was against a background of significant change already taking place in the provision of health and social care in Scotland with the passage of the Public Bodies (Joint Working) Act leading to the integration of health and social care, the pooling of budgets and the strategic commissioning of services. The group was also aware that further work was being done in these and other areas of health and social care that may be relevant to any recommendations that we made.

While supporting many of the changes that are being introduced it would be over optimistic to think that this is an area of public policy that is both secure and cohesive against a background of an ageing population, an increase in multi-morbidity and constrained public finance. Having been a Director in West Lothian of one of the first Community Health and Care Partnerships I have seen at first hand the opportunities that the integration of health and care services can offer.

However integration in itself will not bring about the desired shift in the balance of care. The pressures on the acute hospital sector will not be resolved without greater investment in the social care sector. The Commission took the view that in order to deliver a service that meets the needs of the individual we need the following:-

- The development of a new social contract, framing a basic framework of rights and responsibilities whereby citizens with care and support needs receive personal care and healthcare free at the point of use; and citizens are responsible for their daily living cost, accommodation and meals.
- The adoption of a Scottish living wage by all providers of social care; and that consideration be given by commissioners to Unison's Ethical Care Charter when contracting with external providers.
- Greater devolution of budgets to localities within Health and Social Care Partnerships to empower local teams to coordinate and plan health and social care services on the basis of local knowledge.
- The creation of a long term plan to provide a sustainable funding model for health and social care.

More detail on each of these points and other recommendations is set out in the report and we do not claim to have done any more than a high level examination of how the funding gap could be closed. Much more detailed work is required on this as the list of options we included is by no means comprehensive. Nor should it be assumed that each of the options that we have set out for closing this gap would be supported by all members of the Commission. The difference of opinion within our group would I think reflect the difference of opinion within the wider population about how these services should be funded. What we do agree however is that politicians need to articulate a vision for our health and care system in the future and take decisions on how it will be adequately funded.

In closing I would like to thank all of the organisations who responded to our questionnaire and to the Royal College of Nursing, Alzheimer Scotland, and the Allied Health Professions Federation for their presentations to the group. I would also like to thank my fellow members of the Commission for the time and effort they freely gave, to Michael Sharpe, Eva Kestner and Rachel Hinds for the administrative support and to UNISON for publishing the report.

David Kelly
Chair

Executive Summary

Commission for the Provision of Quality Care in Scotland

1.1 The provision of social care in Scotland has changed rapidly over the last few years. The early days of the Scottish Parliament introduced landmark legislation such as the provision of Free Personal Care, but with the introduction of Self-Directed Support (2013), the passage of the Public Bodies (Joint Working) Bill in February 2014, and with the Scottish Government introducing legislation to support carers, we will see the delivery of social care transform over the next few years. It will introduce greater levels of personalisation and will firmly embed the principles of pooled budgets and strategic commissioning across health and social care.

1.2 However, it would be wrong to think that this is an area of public policy that is secure and cohesive – the changing structure of our population will fundamentally change the balance between the tax base and demands on the state, and yet little provision has been made for that. The working age population will become proportionately smaller over time, which is a strategic problem in itself, but when combined with further economic austerity, the public finances appear to be insufficient to bear the future cost of care.

1.3 And while there continues to be debate about trends in morbidity (i.e. whether our healthy lifespan will increase, reducing the period of ‘dependency’ at the end of our lives) we are seeing greater numbers of people living with long-term term conditions like dementia;¹ greater numbers of people with physical health problems because of obesity;² increases in the number of cancer diagnoses;³ the list could go on. All of this suggests that whatever else needs to change in the provision of health and social care over the next period, it will need heavy investment just to stand still.

1.4 Part of that investment needs to be directed towards the social care workforce. Minimum wage conditions remain all too common, as are exploitative nominal hours contracts. There is little in the way of a career structure that connects to professional occupations like nursing or social work. The Commission heard compelling evidence from trades unions, social care providers and commissioners that we need to reward professional care workers more effectively – and as a society place greater value on their role. Equally unpaid carers must be properly recognised as partners in the provision of support

1.5 This report also connects with two of the main themes of our time: how best to integrate health and social care; and how to keep communities resilient and individuals thriving. We argue for a much more localised approach to these matters, which empowers professionals to work with people to improve outcomes.

1.6 Towards the end of the report, we pick up on proposals for two national reforms: the extension of Free Personal Care to people aged under 65 and the reform of benefits recommended for devolution by the Smith Commission. We need to ensure that we have sensible connections between entitlements to health and social care support and the wider benefits system. We have an historic opportunity to make the system work seamlessly for those who need it most.

1 <http://www.alzscot.org/assets/0000/7138/statistics-dementia-scotland-2013.pdf>

2 <http://www.gov.scot/Topics/Statistics/Browse/Health/TrendObesity>

3 http://www.isdscotland.org/Health-Topics/Cancer/Publications/2014-10-28/Cancer_in_Scotland_summary_m.pdf

1.7 Finally, any serious contribution to the debate about the long-term sustainability of our health and social care services must say something about the growth in investment required and how it should be paid for. Within that, there is a need to rearticulate the social contract; to set out in a systematic way the rights and responsibilities of citizens, the importance – philosophically and practically – of the principle of reciprocity and a vision of a better system of care based on human rights, coproduction, and personalisation.

1.8 This Commission therefore holds to the view that in order to transform health and social care in Scotland, four broad tasks ambitions need to be satisfied:

- i. The development of a new social contract, framing a basic framework of rights and responsibilities;
- ii. The development of a well-paid, well-trained, professional workforce;
- iii. The decentralisation of health and care planning to support localities; and
- iv. The creation of a long-term plan to provide a sustainable funding model for health and social care over the next twenty years.

1.9 In pursuit of these ambitions, we recommend that the following actions are taken:

- Legislation should be prepared which extends the entitlement to Free Personal and Nursing Care to people aged 18 and above, rather than 65+ as it is just now. The current policy is unfair and offends against basic equalities duties.
- All providers of social care should be supported to become Scottish living wage employers. Unless and until this happens, we cannot expect that the workforce will consistently deliver high quality care.
- Action should be taken to give more power and control to local health and social care partnerships, to provide maximum flexibility to design services that meet the needs of local populations within a national strategic framework.
- Investment in health and social care as a proportion of GDP in Scotland should rise from the current level to 12% by 2025.
- In order to meet the investment costs of these proposals, and address the overall funding gap opened up by demographic change, we need a balanced approach to generating income, derived from a combination of income tax and direct charges.

1.10 We believe that if Scotland can move in this direction over the next ten years, then we will have secured the long-term sustainability of a publicly funded health and social care system that is free at the point of use.

Section 2

Demographic, Legislative and Financial Context

Introduction

2.1 The provision of social care in Scotland has changed rapidly over the last few years. The introduction of Self-Directed Support (2013), the passage of the Public Bodies (Joint Working) Bill in February 2014, and with the Government introducing legislation to support carers, we will see the delivery of social care transform over the next few years.

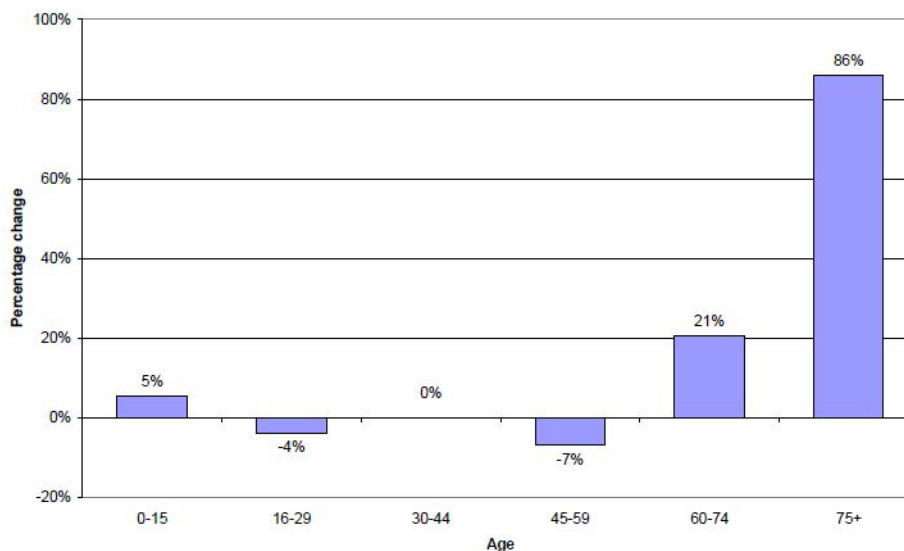
2.2 Some would argue that these legislative measures will go a long way to improve the quality of care and support provided and enhance the overall experience of people who need support. We will see greater levels of personalisation and the principles of pooled budgets and strategic commissioning will be firmly embedded across health and social care.

2.3 These measures are important because they recognise that the health and care systems are interconnected, and that for too long we have tried to manage them separately rather than as one. So under the Public Bodies (Joint Working) (Scotland) Act 2014, Health Boards and Councils will be asked to delegate functions and resources to an 'integration authority' – either through lead agency arrangements or through an Integration Joint Board. But it is fair to say that the Act merely describes the mechanics of integration – the hard work will come afterwards. This is especially true because, as outlined below, changes in the age profile and health of our population, will place increasing demands on our health and social care system into the future.

Demographic and Epidemiological Trends

2.4 It is clear that Scotland faces a significant challenge in meeting the health and care needs of our population, and in particular those in the population most exposed to issues of frailty and ill-health. Figure 1 below outlines the relative growth in Scotland's total population, the population aged over 65 and the population aged over 80 between 2012 and 2037.

Figure 1: The percentage change in Scotland's population by age group, 2012-2037



Source: National Records of Scotland

2.5 However, it is not simply Scotland's ageing population that will create pressure on our health and social care system into the future. Over two million people in Scotland have long term conditions and they are the principal driver for both chronic and urgent care and support. Multi-morbidity (two or more conditions) is the norm in Scottish patients over 50 and the prevalence is rising. Although multi-morbidity is particularly common in older people, it is a growing feature of the population aged under 65, particularly in deprived areas where the most common co-morbidity is a mental health problem. The combination of physical and mental health conditions has a strong association with health inequalities and negative outcomes for individuals and families.

2.6 As evidenced by the figure below (on page 9),⁴ the number of chronic disorders increases with age, and this is likely to continue to have a significant impact on the health and social care system into the future.

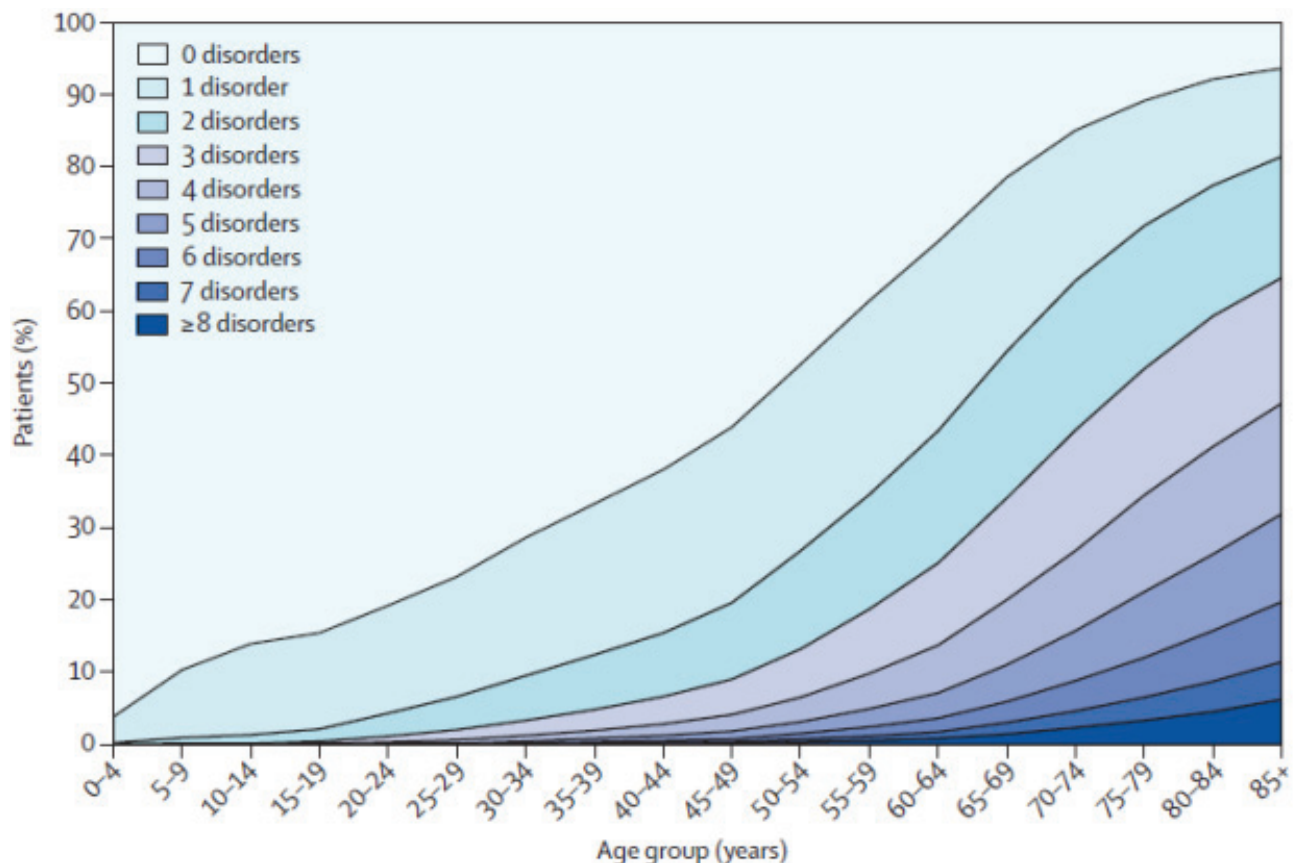
Future Resource Requirement

2.7 The reason that this is important is that our experience of illness and disability as we age will have a significant impact on the resources required by our health and social care system. If overall morbidity is compressed, then the changing structure of our population will produce lower levels of demand than would be the case if morbidity expands. Indeed, as evidenced by the chart below, bringing together population change, healthy life expectancy and the existing cost of health and social care, we anticipate that a real terms increase of up to £2 billion per annum will be required by our health and social care system by 2025, assuming current patterns of need continue in line with population projections.⁵

⁴ The Lancet, May 2012 (Barnett et al.)

⁵ 'Integration of Adult Health and Social Care in Scotland - Consultation on Proposals', Scottish Government, May 2012, page 68.

**Figure 2: Number of chronic disorders by age group (para 2.6 on page 8)
Future Resource Requirement**

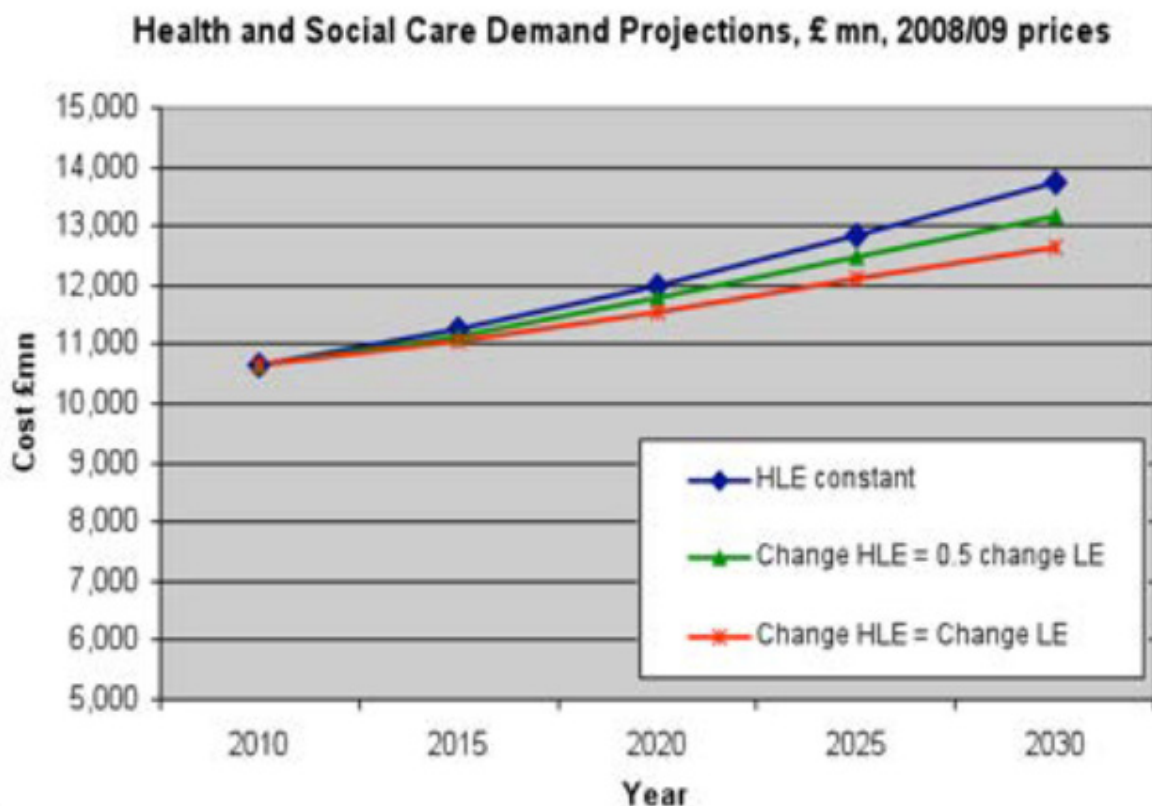


2.8 The changing structure of our population will fundamentally change the balance between the tax base and demands on the state, and yet little provision has been made for that. The working age population will become proportionately smaller over time, which is a strategic problem in itself, but when combined with further economic austerity, the public finances appear to be insufficient to bear the future cost of care.

2.9 The very small growth in the size of the overall population implies that the tax burden on those of working age will rise unless there is an unexpectedly rapid growth in productivity, an improvement in the efficiency of the health and care system or a decline in the quality of care it provides.

2.10 However, the slow growth in the overall population also implies that the costs of caring for those aged less than 65 will not be subject to the same upward demographic pressure. Scotland's share of the UK population aged 80+ will not vary hugely over the next 25 years. This implies that the additional tax costs that Scotland might have to meet to pay for the health and care costs of its oldest old will not be substantially different from those in the rest of the UK, and consequently is unlikely to drive a significant difference in tax rates between Scotland and the rest of the UK.

Figure 3: Projected increase in costs for social care up to 2030
HLE= healthy life expectancy.

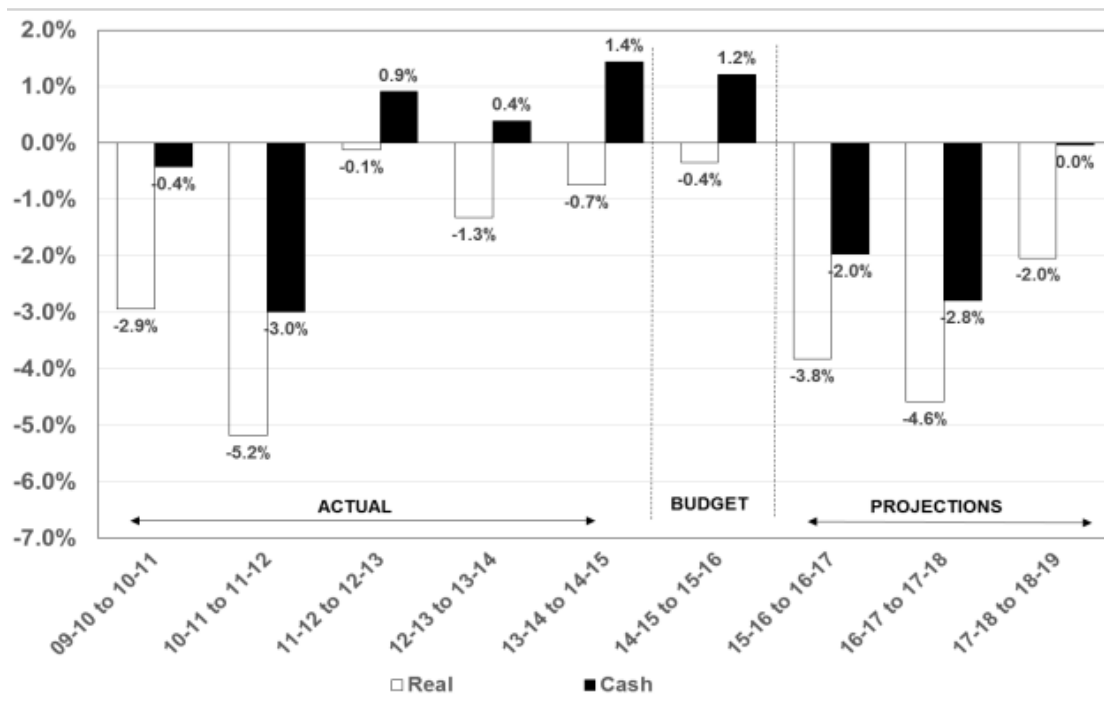


Current Financial Context

2.11 On its own, this would represent a significant challenge for the Scottish state; but when combined with constrained public finance, it becomes more difficult again. The latest analysis by Fiscal Affairs Scotland indicates that projections from 2015-16 to 2018-19 have the Scottish Barnett Block grant falling by -1.6% a year in cash terms and -3.5% a year in real terms, which is almost the same rate of decline as experienced in the first two years of austerity.

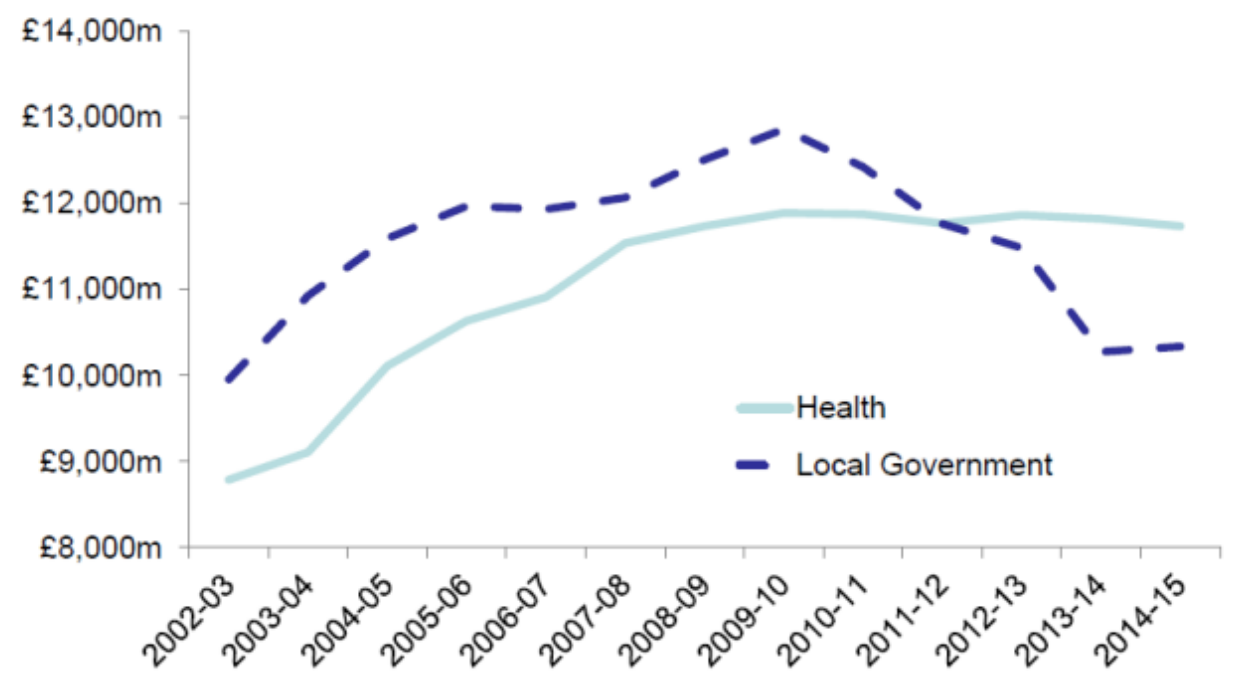
2.12 Indeed, while most of the intended cuts to the Capital budget in Scotland happened in the first two years of austerity (2010-11 and 2011-12), for revenue budgets, the biggest cuts are still to come.

Figure 4: Annual % change in Scottish Barnett Block Grant, 2009-10 to 2018-19



2.13 The difficult financial context has meant that the Scottish Parliament has had to take hard decisions about how best to distribute the Scottish budget. Over the last number years, this has led to the protection of the Scottish NHS budget – at the expense of other public services including social care. This also failed to recognise the inextricably linked relationship between acute hospital care and care in the community.

Figure 5: Investment in NHS and local government in Scotland, 2002-15 (SPICE)



2.14 Local government finance has flat-lined since 2010/11, meaning social work budgets are more stretched than ever. Despite councils' best efforts, these budgets have not been immune from the harsh demands of cost savings.

2.15 As scarce resources are stretched across a growing population of need, community care providers have struggled. Many organisations delivering care at home or housing support have not received an inflationary uplift for several years.

2.16 While the protection of the NHS has generally received cross-party support, it has had a consequential impact on social care budgets. What is more, we are beginning to see an increase in the amount councils are having to generate from charging income for social care in order to compensate for financial shortfalls.

2.17 COSLA reports¹ that a total of £3.8 billion was spent on social work services in Scotland in that year. Of this, £2.8 billion was spent on older people and adults, of which £1.3 billion was recorded as being spent on residential care and £1.6 billion on non-residential services for people living at home. Total income from charges to social work service users for non-residential services was £52.7 million in 2012/13, of which £25.4 million was for services for older people, £24.7 million for adults aged 18-64, and £2.7 million was for children and families social work.

Figure 6: Council charging income, 2008/09 to 2012/13 (COSLA, 2015)

	2008-09	2009-10	2010-11	2011-12	2012-13	Change in last year	
	£'000	£'000	£'000	£'000	£'000	£'000	%
Children and Families	1,441	1,543	1,665	2,323	2,680	357	15%
People aged 18-64, with:							
physical or sensory disabilities	3,279	3,663	3,444	3,571	4,708	1,137	32%
learning disabilities	11,513	12,366	13,934	14,631	16,899	2,268	16%
mental health problems	681	687	806	1,365	2,757	1,392	102%
addictions/ substance misuse	863	681	620	887	303	-584	-66%
HIV/ AIDS	2	0	0	0	0	0	0%
Subtotal: people aged 18-64	16,338	17,397	18,804	20,454	24,667	4,213	21%
Older Persons	25,478	25,241	23,068	24,782	25,355	573	2%
Criminal Justice social work services	1,812	1,368	1,299	179			
Service Strategy	29	126	79				
TOTAL SOCIAL WORK	45,098	45,675	44,915	47,738	52,702	4,964	10.4%
<i>Of which:</i>							
ADULT SOCIAL CARE	41,816	42,638	41,872	45,236	50,022	4,786	10.6%

¹ www.cosla.gov.uk

2.18 Income from non-residential charges for all social work services increased overall by nearly £5 million (10.4%) between 2011/12 and 2012/13. In other words, as local authority budgets get tighter, and as other revenue sources for local government have been removed (such as council tax increases), income generation has increasingly fallen on direct contributions from the users of social care services.

Conclusion

2.19 In conclusion, then, the financial and demographic context is extremely difficult. Three core trends – an ageing population, an increase in multi-morbidity and constrained public finance – means that the challenge of delivering high quality, sustainable health and social care services has never been greater.

Section 3

The Quality of Care in Scotland

What we mean by quality of care

3.1 Quality in care and support exists primarily in the relationship between people who use services and those who provide this support, and in the outcomes from this interaction.

3.2 It may have some tangible characteristics such as the physical environment, but it is predominantly about individual perceptions of these relationships, and the difference they make to people's lives. Quality in care and support is therefore not easily amenable to purely objective measurement by third parties or 'experts' in the way that other goods and services may be.

3.3 That said, good quality care is generally understood to incorporate three key elements:

- Safety (people are protected from harm or neglect)
- A positive experience of care and support (people are treated with dignity and respect)
- A positive outcome (a difference is made to people's quality of life, wellbeing is improved, independence promoted)

3.4 For registered services in the care and health sector, quality is usually defined in terms such as dignity, privacy and respect. There are also references to human rights, equality and discrimination. Most of this is directed towards frontline members of staff who have direct contact with people who need support, who are entitled to know what to expect from a service which states it will respect their dignity. However, other staff such as care managers and service commissioners also need to understand what this means in practice.

Current approaches to quality of care in Scotland

3.5 In care and support, the delivery, assurance and measurement of these three aspects of quality is the core work of regulatory bodies (ostensibly the Care Inspectorate and Healthcare Improvement Scotland) and an important dimension of the local authority's commissioning function. It should also be integral to all providers' agenda for improvement. The current system includes the following elements:

- National Care Standards for all regulated care services according to care 'groups' and settings, published by Scottish Ministers
- A system of registration and inspection of care services by an independent national body (the Care Inspectorate) based on the National Care Standards
- A (different) system of strategic inspection activity by the Care Inspectorate covering non-registered social work services and functions, including (for example) assessment, care management and strategic planning; these inspections are increasingly conducted jointly with other scrutiny bodies

- Service commissioning, contract compliance and monitoring activity by purchasing authorities locally
- Quality Assurance and outcome measurement systems adopted by providers themselves

3.6 Most of these approaches work on the assumption that the qualifications, training and development of care and support workers (and their managers) are critical to the quality of care: relevant standards have therefore been set and are overseen by a separate regulatory body for the workforce (the Scottish Social Services Council).

3.7 In addition, a series of tests are applied both by purchasers and by the Care Inspectorate to service-providing organisations wishing to operate in the market for care, in respect of their financial standing, organisational policies, leadership qualities and so on.

3.8 Meaningful judgements about service quality, whether made by the regulator, a purchasing authority or anyone else, need to be directly informed by the experience and the views of the person who uses services. Increasingly, they are taking control of their own arrangements for care and support, including forming their own view of quality, through self-directed support.

3.9 In certain circumstances under SDS, service users may enter into arrangements for care and support that are not subject to the National Care Standards and are provided entirely out with the regulatory system both for service provision and for the workforce. There are a range of views as to the wisdom of this, although it should be noted that all arrangements made under SDS still require professional social work 'sign-off' from the local authority with respect to their suitability to meet assessed needs. This will (or should) involve an element of judgement about quality.

3.10 A further significant aspect of any organisational approach to quality is for all relevant public bodies and providers to have in place an effective whistleblowing policy. Staff should always feel supported by their employer when raising concerns about any poor practice or abuse they witness or hear about in any care setting, including at home, in a care home or in a hospital.

3.11 Likewise, the availability of good advocacy services is essential to help support and protect particularly those with no friends or family to speak on their behalf.

Strengths and weaknesses of current approaches

3.12 National Care Standards offer clarity for people who use services and providers about what is expected of a service. The inclusive process through which they were developed provided an opportunity for consensus to be reached among stakeholders as to what a 'quality' service might look like, at least in terms of input, process and experience.

3.13 However, the care standards do not, by definition, address personal outcomes (which cannot be standardised) and there is always a tendency to regard them as minimum standards (and thus mostly about protection) rather than 'aspirational' (and thus about improvement).

3.14 They can quickly become dated, in relation to developing practice and models of support. They are also limited by their static nature, and tend to lead to a minimum level of achievement. They are currently under review by the Scottish Government. Most of those concerned with quality assurance prefer to work with quality indicators which have the capacity to demonstrate improvement over time.

3.15 Registration and inspection provides assurance that services meet the required standards. The system of service quality grading introduced by the predecessor body (the Care Commission) and continued by the Care Inspectorate represents, in effect, the only nationally-applicable, objective and independent assessment of comparative service quality that we have in Scotland. Gradings offer validation for high-quality providers, whilst the inspectorate's considerable enforcement powers enable it to address poor quality. The inspection of social work services is similarly graded on a six point scale.

3.16 The Care Inspectorate's enforcement powers, however, only apply to individual regulated services: the inspectorate has considerably fewer "teeth" in relation to its remit for scrutiny of social work services functions such as commissioning or care management although these can have a major impact on quality (for example imposing low hourly rates for contracted care at home provision). The direct involvement of Scottish Ministers with poor performing councils, has, however, had its own impact. A continuing critique of the inspection regime overall is that despite recent reforms, the Care Inspectorate has not been able to 'join up' its approach to scrutiny of regulated care services with its strategic inspection function.

3.17 The inspection process tends to position the inspector, rather than the person using services, as the expert; and despite improvements over the years, inspections do not always take advantage of (far less validate) the rich information available from providers' own quality assurance and user feedback systems. There are, however, good examples of involvement of a range of people in the process of inspection. These include people with learning disabilities, recovering addicts, care leavers, carers and others who act as 'lay assessors' following a period of induction. This is good practice but requires proper resourcing and support to ensure that the process is not tokenistic.

3.18 Moreover, the Care Inspectorate attempts to fulfil a variety of functions that in other fields are separated out into distinct roles. In the restaurant trade, for example, ensuring safety is the business of the environmental health authorities inspecting against standards relating to hygiene, equipment, storage, pest control, and so on; whilst assessing and rating the quality of the individual experience is the business of consumer guides.

3.19 The outcome might be said to be the business of both, but again they approach it in very different ways – for example, specific poor outcomes (such as food poisoning) will be investigated by environmental health, whilst general dissatisfaction (a poor customer experience) will not: that remains the business of the reviewer. Meanwhile public health agencies are increasingly taking an interest in outcomes in this field, for example by proposing that menus identify calorie count or salt content of dishes, and so on.

3.20 Clearly, care and support is a very different kind of business, but the commission's view is that we should reflect on whether a single body can simultaneously act as a regulator/enforcer of standards, and as an improvement agency.

3.21 Contract compliance and monitoring, and their clear connection to the commissioning process, offer potentially more scope for a focus on outcomes as a measure of quality (assuming, of course, that the contract or service specification includes appropriate outcome measures). In addition, purchasing authorities are arguably in a better position than inspectors to assess value for money, and more generally to consider the trade-off between cost and quality (which is in any case a legislative duty, i.e. Best Value).

3.22 However, in practice contract compliance tends to focus more on inputs and outputs (cost and volume) than on quality or outcomes, and where quality is a factor, an authority's processes for monitoring it can duplicate, conflict with (or indeed ignore) Care Inspectorate activity and information.

3.23 The reasons given for this are varied. They include that the Care Inspectorate standards are not high enough; that the inspection process is inconsistent and unreliable; and that they have procurement and contracting arrangements in place which should apply to all goods and services purchased by the council.

3.24 Quality Assurance systems and outcome measurement tools encourage providers from all sectors to take responsibility for service quality. Most high-performing providers across all sectors (by Care Inspectorate grading) have fairly sophisticated QA and feedback systems in place, and many are developing approaches to personal outcome measurement which enable them to evidence the difference their interventions are making to people's lives.

3.25 However these systems and approaches are not always recognised or valued by purchasers or inspectors. Providers report that evidence of high quality and/or positive outcomes do not always influence decisions made by purchasing authorities about what to commission, or from whom, nor about funding levels for services.

3.26 The current systems of scrutiny of health and care do not model seamless, integrated care and support. This is particularly relevant to developing care at home, where long term health care and end of life care is increasingly delivered.

The Quality of Social Care in Scotland

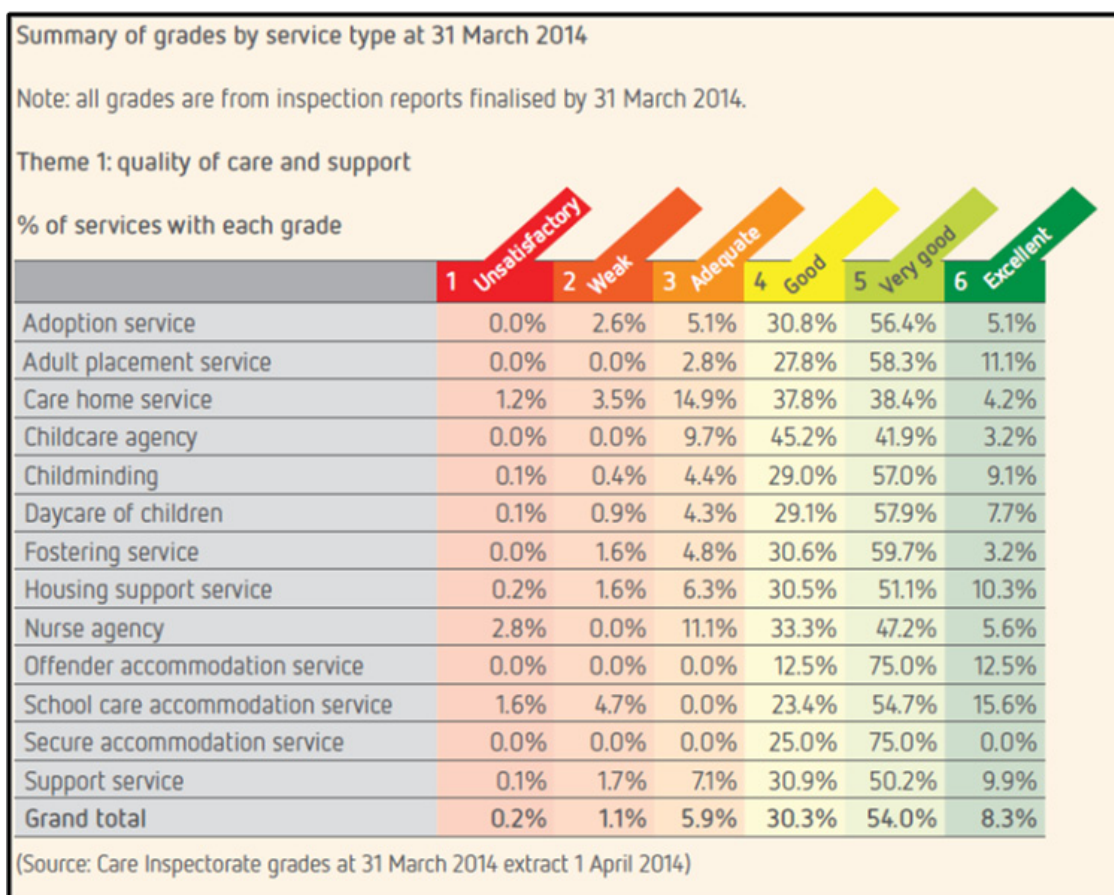
3.27 The Care Inspectorate regulates the provision of social care in Scotland. Regulated services cover all age groups and settings and are graded on a scale of 1 (unsatisfactory) through to 6 (excellent). As can be seen from the table overleaf, the quality of care varies widely across social care provision, although the vast majority of providers offer good or very good care across all sub-sectors. The evidence below suggests that the care home sector faces the most significant

challenges in respect of the quality of care it offers, with almost 20% of homes being graded as adequate or below – a much higher proportion than any other sector. It is no coincidence, in our view, that the care home sector also faces the greatest challenges around the quality of staffing. Indeed, one of our central arguments is that a well-paid, properly trained, professional staffing is a precondition of high quality care.

3.28 In addition to the objective assessment of quality of care, it is also important to consider satisfactions levels from the people who use services. While the Scottish population continues to express higher levels of satisfaction about the performance of the NHS than in the other countries of the UK,⁶ and while the majority of people of all ages who use social care services have valued them and think they have made positive differences to their lives,⁷ third-sector advocacy groups are increasingly critical of core parts of the system, including access to and charging for social care. Equally, Scotland's trades unions have been critical of the system and in particular the employment conditions of people working in social care.⁸

3.29 Indeed, the evidence collected by this commission indicates to us that while in the main health and social care services are provided at high or good levels of quality, there are still too many examples of poor quality. While isolated cases can be explained by poor quality leadership and management, we feel that there are general trends that cannot be ignored. In particular, the connection between the quality of staffing, working conditions, and quality of care is a matter of primary importance.

Figures 7&8 Social Work Inspectorate grades 2014 Improving Social Work in Scotland: A report on SWIA's Performance Inspection Programme



⁶ The British Social Attitudes Survey, NatCen Social Research, 2014. There is a wide split in satisfaction between England, Wales and Scotland. In Wales 51% were either very or quite satisfied. That compared with 65% in England and 75% in Scotland.

⁷ Improving Social Work in Scotland: A report on SWIA's Performance Inspection Programme

⁸ See UNISON Scotland <http://www.unison-scotland.org.uk/socialwork/timetocare/120514UNISONTimetocare.pdf>

Theme 3: quality of staffing

% of services with each grade

	1 Unsatisfactory	2 Weak	3 Adequate	4 Good	5 Very good	6 Excellent
Adoption service	0.0%	0.0%	5.1%	48.7%	41.0%	5.1%
Adult placement service	0.0%	0.0%	2.8%	27.8%	63.9%	5.6%
Care home service	0.6%	2.7%	14.0%	35.8%	43.9%	3.1%
Childcare agency	0.0%	0.0%	12.9%	41.9%	41.9%	3.2%
Childminding	3.3%	0.5%	4.5%	34.1%	51.3%	6.3%
Daycare of children	0.1%	1.1%	3.7%	34.6%	54.5%	6.0%
Fostering service	0.0%	0.0%	3.3%	34.4%	55.7%	6.6%
Housing support service	0.1%	1.1%	7.1%	31.7%	52.7%	7.3%
Nurse agency	0.0%	2.8%	11.1%	38.9%	41.7%	5.6%
Offender accommodation service	0.0%	0.0%	0.0%	12.5%	75.0%	12.5%
School care accommodation service	0.0%	0.0%	1.6%	23.4%	60.9%	14.1%
Secure accommodation service	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%
Support service	0.1%	1.5%	6.3%	33.7%	51.9%	6.4%
Grand total	1.5%	1.0%	5.7%	34.2%	51.6%	6.0%

(Source: Care Inspectorate grades at 31 March 2014 extract 1 April 2014)

Recognising the value of citizen voice

3.30 Leaving aside the possibility of reforming the improvement, scrutiny and inspection landscape, the commission holds that working with people, as opposed to viewing them as passive recipients of services, and empowering them to have control over their future allows us to consider new ways of looking at how we design services fit for the future. Citizens need to be actively engaged in health and social care at all levels, through participative democracy.

3.31 Progress in person centred approaches, particularly self-management, co-production, self-directed support, community-led health, independent living, personalisation, mutuality and a focus on human rights must be at the heart of such a shift in emphasis. Key to this is drawing on the voice, experience and expertise of people who use support and services. This brings our focus toward a number of key concepts:

- **Supported Self-management.** The self-management agenda requires a change in culture so that people – those receiving and those delivering services – have the capacity and confidence to work together as partners. To date that change has not been quick enough. Self-management aims to empower and ensure that people have ownership over the management of their life and long term conditions. There is significant evidence that it improves outcomes for individuals and services. Likewise, on the health agenda people must take increased responsibility for their own health supported by enabling health education.

- **Self-directed Support and Person-centred Care.** Recent developments in health and social care emanate from a strong conception of individual autonomy and the person's right to direct their own care and support. While this has arguably gone further in respect of social care since it gives the individual control over their own resources (SDS allows for the use of personal budgets and direct payments) person-centred care has started to realign how health professionals work with people to optimise health outcomes.

• **Human Rights.** Far from simply outlining basic legal entitlements, the human rights agenda provides a framework for the delivery of quality care. The 'PANEL' approach, which is endorsed by the United Nations, emphasises the rights of everyone to: Participate in decisions which affect their human rights; the Accountability of those responsible for the respect, protection and fulfilment of human rights; Non-discrimination and equality; Empowerment to know their rights and how to claim them; and Legality in all decisions through an explicit link with human rights legal standards in all processes and outcome measurements. This agenda has led to the practical examination of how quality can be improved through an examination of rights, as described in the case study below:

Case Study – Care about Rights

Care about Rights is a training and awareness raising resource relating to the care and support of older people developed by the Scottish Human Rights Commission. Care about Rights explains the benefits of applying human rights principles to everyday situations.

The training is designed to increase awareness and knowledge of human rights issues, and give practical advice about how to apply human rights principles in the delivery of care. The approach assists social care workers to involve service users, their families or their advocates in decision-making and deliver more personalised services, thus helping to shift the balance of power relationships between providers and users.

The Care about Rights resources look at:

- What human rights are and how they are applicable in care settings;
- The relationship between human rights and other legislation and standards;
- How human rights can help to balance risks and rights in decision making;
- How human rights can support the delivery of person centred care;
- How human rights can help resolve conflict and improve communication with people using services, their families and others.

Around 1,000 care staff and managers have taken part in training for Care about Rights since September 2010, as well as around 80 older people and older people's advocates across Scotland.

More than half of care staff respondents to the follow up survey on Care about Rights felt that it was helping them to deliver better person centred care, whilst also helping older people and their representatives to articulate concerns and provide a framework for change. Care plans had been enhanced, even if the agreed approach did not change significantly, and the satisfaction of both care users and the workforce increased. The evaluation included a recommendation that using person centred, human rights based approaches becomes a core competence for the care workforce.

Conclusion

3.32 It is evident that there is a complex system of assurance in place to protect the quality of care in Scotland. This involves external scrutiny and inspection bodies that monitor and enforce minimum standards and contribute to the wider quality improvement agenda. However, the greater focus into the future must be around supporting partnerships to focus on self-improvement and taking responsibility for quality in their part of the wider system. As part of that, the Commission holds that quality needs to be understood primarily on how far it has impacted positively on peoples' lives. Whilst it must include issues of safety and risk it should be increasingly about the extent to which we involve people in decision making, the degree to which people's rights are promoted. That is the future of quality care in Scotland.

Section 4

Developing a 21st Century Workforce

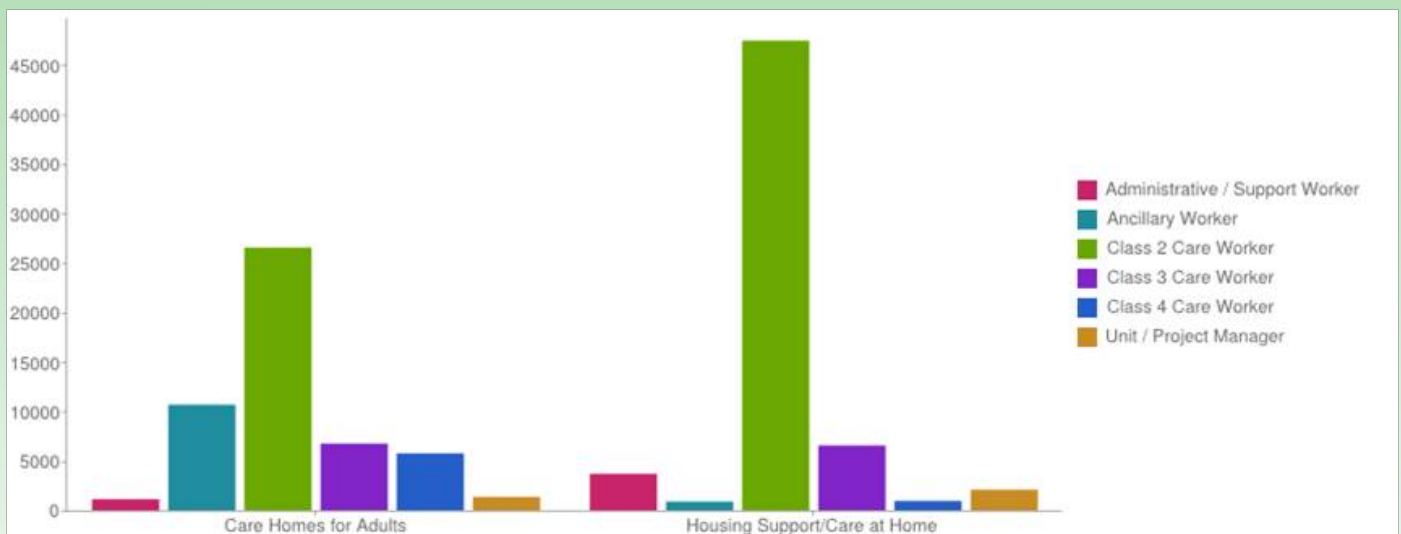
4.1 There is a growing recognition of the importance of having a well-trained, qualified, professional health and social care workforce. While recognising that there will continue to be workforce planning challenges such as the balance between medical specialists and generalists delivering healthcare, the number of nurses and AHPs working across different care venues, it is widely recognised that our primary challenge is to improve the status and performance of entry-level care workers across the health and social care system.

4.2 The Scottish Social Services Council (SSSC) registers, regulates and promotes high standards of conduct, education, training and practice among social service workers. The SSSC's role in raising the knowledge, skills and qualifications of current and future care sector workers will help to move towards an equal footing with other regulated professionals.

4.3 Information provided by SSSC indicates that 189,670 people are employed in the social care sector, which accounts for approximately 7.4% of Scottish employment. The workforce is predominantly employed on permanent contracts (79%). The median figure for the typical weekly hours worked by staff is close to full-time at 32.5. Women account for 85% of the workforce.

4.4 The commission has taken a particularly strong interest in the care home and home care/housing support sub-sectors – because these are the sub-sectors which we think have the greatest prevalence of low pay. As evidenced by the graph below that there is a significant number of Class 2 (entry level) care worker positions within these sub-sectors – which covers routine care and support work and which typically pays minimum wage (£6.50) or just above.

Figure 9 Care staff by grade



4.5 We commend the work that has been taken forward at a national level by the Scottish Government, COSLA, CCPS, and Scottish Care to increase wages in the care home sector – which has introduced a new industry floor of £7 per hour; but this must be improved on in years to come and indeed replicated across all social care subsectors. Our ambition must be to see all employers in the sector become Living Wage employers – currently £7.85 in Scotland.

4.6 The Living Wage enjoys broad cross-party political support and increasing numbers of leading employers, currently over 1,300 in the UK, have signed up to the Living Wage. In contrast to this positive trend, HM Revenue and Custom's evaluation of over 200 enquiries of social care employers carried out over a two-year period identified higher and increasing levels of non-compliance with the National Minimum Wage legislation than has been previously found in the sector in the last 5 years indicating that employers need to be much more diligent in ensuring workers' pay is compliant with NMW legislation. So there is evidence that while incremental progress is being made in some quarters, this is not universally true.

4.7 As such, the Commission recognises that more than anything else, the payment of the living wage and a general improvement of terms and conditions will be required to deliver a social care workforce consistent with our aspirations for quality care. The commission heard from Scottish trades unions just how challenging it can be for their members to deliver domiciliary care, moving from one house to the next, without payment of travel costs, without giving care workers the space and time to provide quality support to people who use services, for low levels of pay. We heard from provider organisations like CCPS who have tracked the drift in remuneration within third sector organisations away from statutory sector levels of pay. It was put to us that this is a consequence of cycles of retendering, funding cuts and compliance requirements. Social care workers in the private sector have particularly low rates of pay, with entry-level care work typically paying minimum wage.

4.8 **We are therefore recommending that this position is urgently addressed and that all providers of social care should become living wage employers.** We believe that a phased approach is necessary because of the potential cost involved. Although detailed work will need to be undertaken at a local and national level, we anticipate the full costs of implementing living wage conditions to be between £35m-£70m. We think it is important that these costs are met through a partnership between the state and non-statutory employers.

4.9 The benefits of paying the living wage are several:

- It would play an important role in tackling health inequalities⁹
- It would improve staff retention and add value to the reputation of employers¹⁰
- It supports a move away from reliance on in-work-benefits and creates greater choice and flexibility for employees in respect of working patterns¹¹

Wider Conditions of Employment

4.10 We recognise, of course, that remuneration is but one element of fair work. Indeed we were impressed by the charter that UNISON has drafted in respect of the wider considerations that commissioners of home care should account for when contracting with external providers:

⁹ The full cost needs to be modelled in detail. Initial work done by SPICE indicates a potential cost of £37m but this was based on a number of debateable assumptions. Industry representatives, having looked at the actual accounts of providers, would argue that the true cost will be much higher, closer to £70m

¹⁰ SCOTPHO, January 2011

¹¹ University of Strathclyde, January 2011

Case Study: UNISON's Ethical Care Charter

- The starting point for commissioning of visits will be client need and not minutes or tasks. Workers will have the freedom to provide appropriate care and will be given time to talk to their clients
- The time allocated to visits will match the needs of the clients. In general, 15-minute visits will not be used as they undermine the dignity of the clients
- Homecare workers will be paid for their travel time, their travel costs and other necessary expenses such as mobile phones
- Visits will be scheduled so that homecare workers are not forced to rush their time with clients or leave their clients early to get to the next one on time
- Those homecare workers who are eligible must be paid statutory sick pay

Stage 2

- Clients will be allocated the same homecare worker(s) wherever possible
- Zero hour contracts will not be used in place of permanent contracts
- Providers will have a clear and accountable procedure for following up staff concerns about their clients' wellbeing
- All homecare workers will be regularly trained to the necessary standard to provide a good service (at no cost to themselves and in work time)
- Homecare workers will be given the opportunity to regularly meet co-workers to share best practice and limit their isolation

Stage 3

- All homecare workers will be paid at least the Living Wage
- If Council employed homecare workers paid above this rate are outsourced it should be on the basis that the provider is required, and is funded, to maintain these pay levels throughout the contract
- All homecare workers will be covered by an occupational sick pay scheme to ensure that staff do not feel pressurised to work when they are ill in order to protect the welfare of their vulnerable clients.

4.11 The commission was pleased to hear that this charter is beginning to be implemented in practice. Renfrewshire Council, for example, has adopted an innovative procurement strategy, using post-tender negotiations to work openly with its partners in the third and independent sectors to deliver a home care contract that complies with the UNISON charter – so with sufficient political will, we can make this a reality. We therefore recommend that commissioners work with providers and trade unions to make this a reality across Scotland.

Section 5

The Decentralisation of Health and Social Care

5.1 In 2014, in recognition of the inefficiencies within the health and social care system, the Scottish Parliament passed bold and radical legislation in respect of the health and social care integration agenda. The fundamental idea expressed in the legislation is that the Health and Social Care Partnerships will have an integrated budget that can be deployed flexibly through a single strategic commissioning process to meet population need. It recognises that historical spending patterns are unsustainable and increasingly unlikely to produce positive outcomes for citizens.

5.2 Given the importance of this agenda, we can anticipate significant time, resource and energy – nationally and locally – being put into the development of strategic commissioning. This remains a concept that is looked on suspiciously within some parts of the NHS – evoking notions of internal markets and privatisation. It exposes uncomfortable truths about the way the ‘commissioning’ decisions of clinicians generally - and GPs in particular - consume vast amounts of NHS resources in a highly variable way.

5.3 By contrast, strategic commissioning is better understood within local government social work services – but practice does not always meet with expectations. The former Social Work Inspection Agency 2010 report remains the most authoritative statement on commissioning practice in social work. While it found that the majority of people of all ages who use services have valued them and think they have made positive differences to their lives, it also revealed significant room for improvement across population groups. Older people were twice as likely to be in care homes as they were to be supported by intensive care in their own homes. Repeat, unplanned admissions to hospital continued to rise despite a national target to reduce this. Levels of home care and intensive home care were falling in some parts of Scotland against a backdrop of growing numbers of older people who were physically very frail, or had dementia. In adult services, there was variability of provision in different parts of the country, with wide differences in levels of services and funding for all the main adult groups. The range and quality of services and support available to carers, especially young carers, was inconsistent across Scotland. Although there were good examples of carer involvement, unpaid carers were not always treated as equal partners. While we may have made incremental progress since the SWIA report was published, unfortunately, these observations resonate as much today as they did in 2010.

5.4 That we will finally see a shift in the balance of care and a flow of resources out of the hospital sector remains difficult to imagine. Senior NHS managers already talk of constraining demand for secondary resources, as opposed to reducing it in absolute terms. And history suggests that there is indeed reason to be sceptical about reducing the size of the hospital sector. Since the landmark and sadly-forgotten Kerr report in 2005, we have seen little in the way of the transformation promised within the health and social care system in Scotland. A prospectus which was founded on de-institutionalising the NHS and delivering more community-based support has

only been partially realised. We have not been able to break the public perception that everyone should have a district general hospital within ten minutes of their house – nor the political pressure to satisfy that thirst.

5.5 What is more, the shift towards prevention – even with the advent of the Change Fund for Older People - has been slow and uneven. Audit Scotland reports that there is little sign of shift in resources into community care – partly because NHS targets are dominated by access to the acute sector. This fuels a vicious cycle. People continue to turn up at A&E because that's the 'only place where the lights are on' and because they get quicker access to medical care than they might have done via community services. The development of Minor Injuries' units for non-emergency care has provided a positive alternative that needs to be extended.

5.6 The current structure of a centrally planned NHS is clearly failing to deliver sustained improvement. As evidenced by the recent Audit Scotland report on the management of the health service,¹² resources are being pulled into acute services at a time when the ambition of government is to channel resources in the opposite direction, in support of the Scottish Government's 2020 vision. NHS Scotland is failing to maintain performance across a host of key performance areas, including the four hour emergency care target, the 18 week Treatment Time Guarantee, and the four week delayed discharge standard.

5.7 Our view is that health and social care partnerships, many of which will have significant spending power, need to further devolve budgets to the localities, to ensure that professionals are properly empowered to coordinate and plan health and social care services with local communities on the basis of local knowledge and understanding the health and wellbeing of that population. This, in turn, should enable front line professionals to provide faster, more flexible responses to individual patient's needs.

5.8 Much has been written about the role of strategic planning within the new partnerships – the idea that a true assessment of population need will allow resources to be re-profiled away from historical spending patterns in order to improve outcomes. While we would want to support the methodology and principles that sit beneath strategic planning, we believe that there is an untapped potential to 'push down' these principles to locality level.

5.9 We believe that if the strategic planning process is implemented as a top-down approach to the commissioning of services, we will largely have failed in our ambition to deliver responsive care and support. We see the partnership-level strategic planning function as building on locality planning, which in turn takes its direction from the individuals who need care and support, as described in the following graphic: (see page 27)

¹² http://www.audit-scotland.gov.uk/docs/health/2014/nr_141030_nhs_finances.pdf

Figure 10 Strategic Planning Model



Locality Planning

5.10 The locality planning process, we think, ought to exhibit three central characteristics: building capacity in the community and the systems needed to draw from that; the formal coordination of care from local professionals situated in locality teams; and the formation of locality budgets that build incentives and tariffs into the commissioning of care.

5.11 As indicated above, the commissioning role of Health and Social Care Partnerships extends beyond the development of formal services. Indeed, with the a growing recognition of the importance of early interventions and preventative support for personal independence, the role of the commissioner into the future will increasingly be about stimulating local organisations to work with communities to enhance resilience. While this can be achieved in part at partnership level, it is the interface between locality teams (GPs, community nurses, AHPs, social workers, housing staff), community organisations and users of services that will make the real difference.

5.12 There is a huge opportunity to develop approaches to supporting people in communities through locality planning mechanisms, which build on the knowledge and capacity of local people about their own wellbeing. We anticipate that these will be based around natural communities and will have a strong role for professionals locally to work with those communities to innovate and to coordinate care and support arrangements.

5.13 It is at locality level that the principles of the Christie commission will be capable of finding true expression: an empowerment agenda which focuses on working with individuals to

enhance personal resilience and improve health and well-being outcomes. Locality arrangements will, we hope, provide support arrangements that are grounded in people's lives - helping them contribute socially and economically; communities and services will work together to decide what needs to be done, and how it is going to be done - so that services fit people's needs, rather than the other way round; best use will be made of all the resources available, building the capacity of all those involved; and locality arrangements will take a long-term view, anticipating and preventing problems wherever possible - saving human and financial costs over the longer term.

5.14 Locality planning will sometimes find expression in community development activity, working with people at neighbourhood level to build on the natural assets and support arrangements in their lives. At other times, it might involve professional coordination and support. For example, to draw on the BMA's perspective, locality planning will work best where 'those working at grassroots have shared goals and aims for patients, working to agreed outcomes. For example:

- community mental health teams where health and social care staff work together seamlessly as part of one team;
- in general practice where social workers are part of the extended primary care team, attached to GP practices or a cluster of practices, attending multi-disciplinary meetings to discuss the needs of patients in the community; and
- in local authorities where rapid response social care teams are in place to implement urgent care packages to people who might otherwise have to be admitted to hospital.'

5.15 Beyond this, the effectiveness of Joint Strategic Commissioning will be determined by the extent to which it empowers health and social care professionals at locality level to deliver the right care in the right way. That means professionals at locality level need to be able to go beyond the coordination of care to proactively shaping the services that will best serve neighbourhoods and communities – and have a stake in the consumption of different types of care. An important element of this is that there must be parity of esteem amongst health and care professionals involved in locality decision making. There needs to be mechanisms in place where all professionals feel involved and included in the process.

5.16 To offer a case in point, a GP presented with an older person who has fallen during the night can make a judgement that it would be unsafe to leave that individual untreated. In principle, effective strategic commissioning at partnership level could have made available to that GP a range of options, including step-up care, or an emergency response team, in addition to conventional options like an A&E attendance. Having made those arrangements, the GP has to draw on his or her clinical judgement to determine the best care option. Were there a suspected fracture, or some other need for diagnostics, then it would be that use of secondary care is desirable. In other circumstances though, careful monitoring and short-term support may be sufficient. In this circumstance, admission to hospital is potentially disadvantageous and therefore it may be more appropriate to use an intermediate care facility or home based emergency care. The point of strategic commissioning in part is to make available to the responsible GP or locality team an array of options that can be tailored to clinical need.

5.17 However, it is insufficient simply to strategically commission and then provide a menu of care pathways; the GP/locality team needs to be accountable for decision-making and bought into the care outcomes. If, over time, one GP practice routinely decides to draw on the services of the local hospital, thereby drawing down on the most expensive (and often least effective) care option, then a pattern of poor outcomes and high resource usage may well be detected. By contrast, if another GP practice elsewhere in the partnership area is making use of the full range of care options, then that practice will typically deliver better quality care and make less use of resource intensive interventions.

5.18 The work undertaken over the last few years on the Integrated Resource Framework (IRF) exposes some of these variations – and in particular the high level of variation that can often exist in clinical commissioning. However, while the IRF begins to expose the data, it does not of itself suggest a solution. Some of the more innovative partnerships have started to use this information to facilitate benchmarking conversations within general practice about outcomes and resource use – and these are positive developments which should become standard as a form of public accountability.

5.19 However, we believe that we need to go further and introduce the notion of locality budgets based on a fair share of the total partnership resource. In the example above, the first locality team are using a greater level of partnership resource and delivering poorer outcomes; in other words, they are consuming more than their fair share. The second locality team, by contrast, uses less than fair share and yet consistently achieve better results. Our question is this: should we not then be introducing censure to the first locality team and reward to the second?

5.20 While there are traditional reward mechanisms available for this – for example, through the contractual relationship with GPs – these tend to be rather blunt, input based and focused on individual reward. It would be much better if the reward was based on allowing locality teams to benefit from their own efficiency by way of an expanded locality budget. This would create a virtuous cycle, allowing the locality teams to work with local communities to put in place additional service and support arrangements. Equally, a poorly performing locality team would lose resource to the institutions from which it commissions care (notably secondary care) and would come under pressure to improve performance.

5.21 As such, the commission recommends that further work is undertaken to ensure that all Health and Social Care Partnerships develop arrangements based on rewarding the best locality teams and working with poorly performing locality teams to improve outcomes.

Individual Care Planning

5.22 The ultimate success of all health and social care activity lies in the delivery of responsive, personalised services that improve outcomes. This speaks to the idea that individuals, as autonomous agents, have the right to draw on their priorities to determine the nature of care and support that best supports them in their day-to-day life. The job of professional health and care workers is to support that process – to support physical and mental well-being to enable people

to live in line with their priorities and have maximum control over their lives.

5.23 The commission heard from a number of organisations about how best we should co-ordinate and deliver care at locality level. We were particularly impressed by the '8 pillar' model promoted by Alzheimer Scotland over the last few years. This in essence builds support around the individual, focussing on maintaining what they can do rather than what they cannot and continuing as far as possible with the life they want. The model recognises that this is a key function in care coordination. It also builds in a recognition of the personal capacities of the individual and supporting network of friends and family. This is illustrated in the diagram below:



5.24 While this model has been created to support people with dementia, it is our view that it just as easily applies to other care groups. Indeed, it is remarkable in its similarity with the GIRFEC model used to support children. While it is not the role of this commission to prescribe models of care coordination, would think that the development of models like the one highlighted above would go a long way to improve the quality of the care experience.

5.25 We also heard about the growing importance of AHPs – occupational health, physiotherapy, speech and language therapy, pharmacy, podiatry, to name but a few – to ensuring that the individual is properly supported in community settings. For example, falls prevention is becoming an increasingly important theme in older people's care, and is the type of preventive activity that needs to play a larger role in our commissioning activity into the future.

Self-Directed Support

5.26 This principle has recently been enshrined in legislation through the Social Work (Self-Directed Support) Scotland Act 2013, which requires people who are assessed as needing social care to be given a range of support options, from a direct payment through to directly arranged.

5.27 Self-Directed Support represents a key opportunity to change the way that we support people with health and social care needs. Along with the integration of health and social care, the roll out of SDS has the potential to reform public services to ensure they are flexible and personalised, and that individuals are able to exercise choice and control over the way their needs are met.

5.28 We believe that there is potential to give fuller expression to the principles of SDS over the next decade by making two strategic connections more transparent – with health and with welfare. Indeed, when the idea of self-directed support was first conceived, it was built on the idea that an individual could draw-down on a range of income streams – from social work, from health, from DWP – to maximise the choice and control he or she had over care and support arrangements.

Personal Health Budgets

5.29 Our joint ambition for health and social care is to ensure that services are organised around citizens' needs, and not institutional boundaries. If we are to realise this ambition, the principles of choice and control need to extend across all relevant health and social care services.

5.30 The key aim of health and social care integration is to provide services that are seamless at point of use. This requires the joining up of health and social care budgets, and the Scottish Government's consultation on proposals for integration asserted that resource should 'lose its organisational identity'. We would therefore argue that SDS packages should be able to draw down both health and social care monies, with this flowing from a duty that is placed on both local authorities and the NHS. Otherwise we could face a situation where individuals will be receiving care from integrated health and social care partnerships, yet only have a right to SDS options for certain parts of that integrated package.

5.31 While we would argue that the principles of SDS should be extended to the NHS, we recognise that there are particular issues in relation to extending the principles of choice and control to all healthcare services. There will be many NHS services where SDS options will not be appropriate and would be of limited benefit - for example, in relation to acute services. In general terms, the more short-term, clinical and acute the health need, the less relevant SDS becomes.

5.32 However, for people with on-going health needs arising from disability or a long term condition, the extension of SDS to community health and palliative care could deliver significant benefits. For example, people with long-term conditions could enter into a transparent discussion about the broad resource envelope services are operating within, what outcomes are most important to them, and how that translates into different intervention options. We arrived at four general categories of healthcare, which are certainly not exhaustive but which are, prima facie, compatible with SDS arrangements: nursing and palliative care; non-clinical equipment like a wheelchair; mental health; and therapeutic care, such as occupational, physiotherapy and speech & language therapy. Therapeutic support could also include counselling and talk based therapies and areas such as fitness and weight control classes.

5.33 There are many examples of how individuals have benefited from being able to access SDS options for support to meet their health needs, both from research in England and from NHS pilots funded by the Scottish Government. These benefits have included improved health outcomes and a reduced need for health care services that could lead to reduced costs to the system over time.

This area of extending the principles of SDS to some NHS services was the subject of some considerable debate within the group and not supported by all.

Welfare Reform

5.34 The Smith Commission recently proposed that Attendance Allowance, Carer's Allowance, Disability Living Allowance (DLA) / Personal Independence Payment (PIP), Industrial Injuries Disablement Allowance and Severe Disablement Allowance are devolved from Westminster to Holyrood. The Scottish Parliament will have complete autonomy in determining the structure and value of these benefits or any new benefits or services which might replace them. For these benefits, it would be for the Scottish Parliament to agree a delivery partnership with DWP or set up separate Scottish arrangements.

5.35 We believe that the Scottish Parliament should be the final arbiter of the structure of these benefits - including the financial value that attaches to them. However, there is opportunity to unify the benefits above with the health and social care system by devolving the administration of benefits to health and care partnerships.

5.36 People who use social care services often have heavily fragmented and disjointed financial support mechanisms to help meet the costs of their disability, frailty or caring responsibilities. Many will often draw down support from local authority social work departments, NHS Scotland and the DWP, but access to that support doesn't take place via a single assessment, and nor does it lend itself to the configuration of a personal budget that can be framed in a way that supports personal outcomes. As such, the Scottish Parliament has an opportunity to pass the responsibility for assessment to local authorities, thereby providing a gateway to a range of resources and - where relevant - care planning. In short, we are envisaging a single assessment that acts as a gateway to formal state resources. However, we recognise that the reform of the benefits system could demand an entire Commission report of its own and therefore we deliberately have resisted expanding on this subject. We await with interest how the soon-to-be devolved benefits take shape over the next few years.

Section 6

Place, Housing and Technology

6.1 The creation of local health and social care partnerships seeks to draw upon the resources, knowledge and experience locked within the public, private and third sector and places responsibility for decision making at a local level. The concept of place-shaping is about the creative use of powers and influence to promote the general well-being of a community and its citizens.¹³

Housing

6.2 Key to that success is the role that housing can play in developing effective housing and community based solutions that not only prevent increased ill health but also are capable of delivering more intensive health and social care solutions. Local Health and Social Care Partnerships need to engage with local housing providers to address the priorities in local communities and this could be met by making it a requirement for housing to be represented on partnership boards at locality level.

6.3 Scotland's housing market will profoundly change as a result of an ageing population. The current housing stock is not well suited to future needs. Housing providers will need to be incentivised to focus their activity towards the increased provision of suitable dwellings if we are to break away from the traditional response to the escalation of need: too often, a person will move from their family home into a care home via a period in hospital. This is partly because of the lack of suitable alternatives at local level.

6.4 The Commission believes that national policy in this area is relatively sound. It recognises the need to ensure that older people in particular know about the housing options and support services that are available to them, and how to get them. High quality information and advice services will be vital to ensuring older people have access to the right housing and support.

6.5 We also need to recognise the importance of existing housing for older people, and ensuring we make best use of that housing. The great majority of the population will live their lives in homes which are already built. As the population ages, more people will need housing adaptations, but there are issues about the time taken to get them and questions about the equity of current funding arrangements.

6.6 Preventative support services are particularly useful for people who need a small amount of help to live independently. They contribute to health and social care objectives of reducing unplanned hospital admissions and delayed discharge. They can also make a big difference to quality of life and are cost-effective. Housing support services currently play a small, but significant, role in supporting older people to remain living at home, but could do a lot more. Handy person services are provided by a range of organisations, including most Care and Repair projects. A supportive local community and strong social networks are recognised as important in supporting older people, particularly single older people, to reduce loneliness and live independently at home. Many

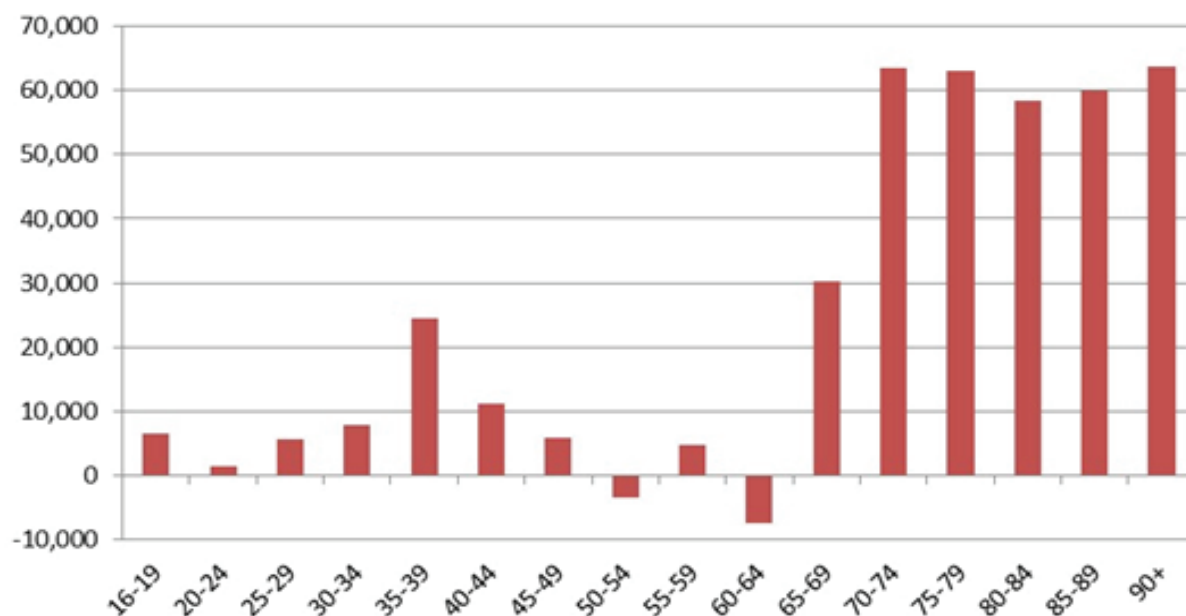
¹³ Lyons Inquiry into Local Government, 2007

older people receive telecare services, most frequently in sheltered housing. Telecare can provide significant benefits for older people and carers, as part of a package of support to maintain independence and wellbeing.

6.7 Finally, we need to build new, affordable and sustainable housing, with a range of house types and sizes that encourages mobility in the housing system and enables downsizing for those that wish it. As evidenced by the work of Stirling University economist David Bell, we anticipate a significant growth in the number of 75+ households over the next twenty years:

Figure 11

Projected Change in Number of Households by Age of Head of Household 2012-2037



Total Change in Number of Households 2012-2037 = 396 thousand \approx 20,000 per annum

Technology

6.8 Long term solutions for achieving sustainable health and care communities should include not only housing solutions but also the use of linked technology as part of a package of low cost interventions that prevent or at least delay the need for far more expensive acute interventions.

6.9 There is clear evidence that technology enabled care can significantly contribute to preventing delayed discharges and avoiding unnecessary hospital admissions. We are also aware of the current £10m investment programme to embed and expand technology enabled care across Scotland. However, given pressures on existing budgets, the requirement to find match funding, the focussing of resource on just a few partnerships and the need to support a number of submissions, it is unlikely to be sufficient to move from technology pilots to a major change programme that will see technology enabled care as a key element of core business across Scotland. Success in moving this agenda forward will also be dependent upon leadership, vision, culture and training as well as funding.

6.10 We also believe that significant work needs to be undertaken to support the health and social care workforce to deliver technology based care – not just in supporting people who use social care services but also the use of telehealthcare within medical practice to support people with long-term conditions.

Section 7

A new social contract

7.1 In order to ensure that quality is properly understood and delivered, the commission holds that we need to fundamentally rearticulate the basic social contract between the citizen and state based on the principle of reciprocity. That people contribute to the wider social good through payment of tax and direct contribution to care and support – and in return people receive high quality care and support when they need it and irrespective of their financial circumstances.

7.2 In framing a new social contract, we should begin by recognising the tensions within the current policy landscape. There has been a long-held and cherished recognition of the value of healthcare being provided free at the point of need, funded from general taxation. Citizens contribute to the public purse on the basis of ability to pay and everyone benefits from healthcare on the basis of need.

7.3 However, it has been consistently more difficult to articulate the same basic contract in respect of social care. The landmark Free Personal and Nursing Care legislation came closest to that position: citizens contribute over the course of their lives to the public purse and are able to access personal care free at the point of use towards the end of their lives if they happen to become frail, ill or develop a disease. After all, if it makes sense to offer free care and support to cancer sufferers then the same must be true for older people who develop dementia.

7.4 In trying to eliminate that inequality, we merely created another. Why would the state provide free personal care for someone over 65 but not for younger adults with similar levels of needs or diagnoses? In other words, the current Free Personal Care legislation is very difficult to justify from an equalities and human rights position.

7.5 **The commission therefore recommends that all adults assessed as having needs that call for the provision of care should be entitled to free personal care.** This allows us to draw a more sharply defined social contract: the responsibility of the state is to ensure that citizens with care and support needs receive personal and healthcare free at the point of use; and citizens are responsible for their daily living costs – accommodation and meals. Payment of these daily living costs should be funded from personal wealth or income, or for those citizens who are less well off, from welfare support.

7.6 We also recognise that this policy would greatly limit the range of social work services that local authorities can charge for – and therefore careful thought is needed to determine whether charging for health and social care services should be abolished altogether. Local authorities currently receive in excess of £50m in income from people paying a contribution towards their social care support – and a significant part of that charging income will be accounted for in personal care charges to people aged under 65, which would be waived under our proposals.

7.7 There are two main arguments in favour of the abolition of charging. First, from an equalities perspective, why should a disabled or frail older person have to pay to achieve the inde-

pendent life that other citizens can achieve without financial detriment? If we are serious about independent living, then the state should mitigate this inequality.

7.8 Second, the abolition of charging could remove a cost barrier that prevents some people accessing support – and therefore improve health and well-being outcomes. This is especially true in respect of those low-level support mechanisms that might come with a charge but which would otherwise reduce isolation and maintain personal independence. Equally, there is a strong case to say that technology based services (telecare) should be free as part of an invest-to-save strategy.

7.9 Against this, there are two main arguments in favour of keeping charging. The first is purely economic: with the growing pressure on the health and social care system, can we load the total cost onto the tax base? If we make the argument that co-payment is a principle that needs to be set aside, would we continue to ask for payment for dental services, for example, and would we rule out other revenue generating measures such as charging for prescriptions? In short, it is prudent to preserve the principle of co-payment within the health and social care system.

7.10 The second argument is based on the principle of economic and intergenerational justice. Are we content, for example, that a wealthy older person would make no direct contribution to the cost of their care and in effect displace the cost of that provision onto a diminishing working age population? It is the view of the commission that 'ability to pay' is just as legitimate a principle to anchor our policy to as 'order of need'. Our job is to make sure that people on low incomes are not asked to contribute to the cost of their wider support – and so the debate becomes more focused on tackling poverty.

7.11 These are difficult issues to balance but the commission has come to the view that the economic necessity of generating income from private citizens to supplement the tax base, along with a principled view that people with a certain level of wealth or income can reasonably be asked to support their own care costs means that it would be imprudent to commit to all care and support being provided free at the point of use – no western European country makes that offer that to its citizens. What is more, our fear is that this if operating within tight fiscal constraints, this would lead to tighter rationing of care and hence poorer outcomes.

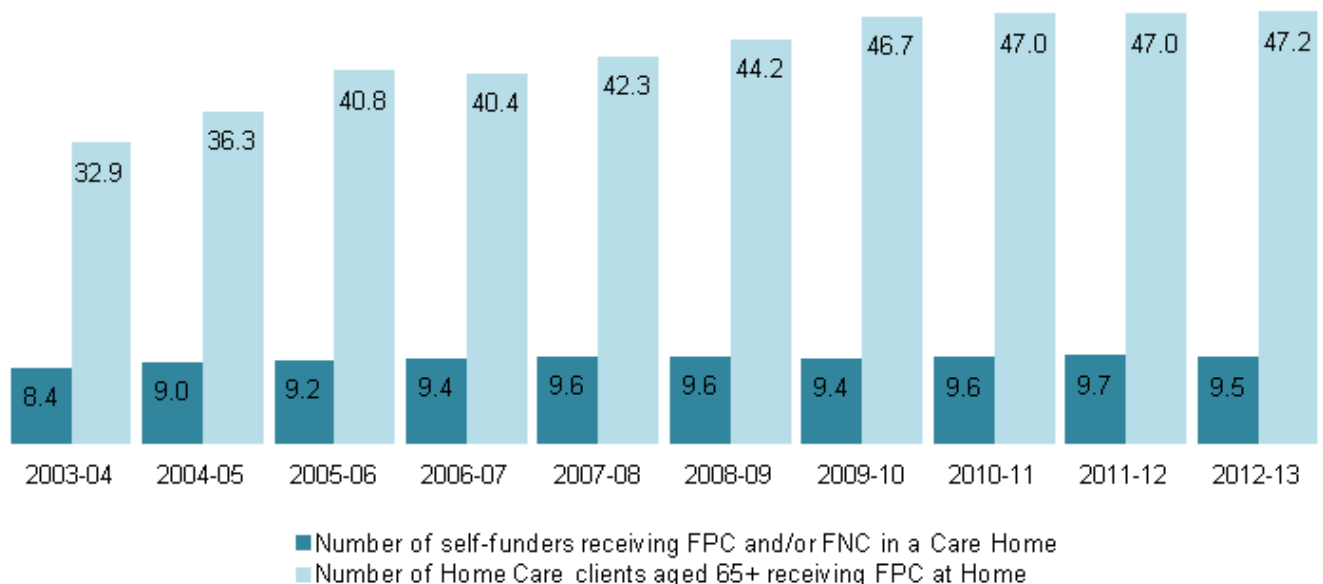
7.12 This would mean that the range of service inputs defined under the Free Personal Care legislation would be extended to all adults. Therefore, support with personal hygiene, continence management, meal preparation, mobility, counselling, and the administration of medication would need to be provided without charge. On the other hand, local authorities would be able to charge for wider support arrangements such as help with housework, laundry, shopping, day care centres or lunch clubs, meals on wheels. It is important to note however that many older people opt for purchasing some of these services from the independent sector as local authority charges may be deemed to be too high. We think there should be one exception to this arrangement: community alarms and telecare services should be free given their pivotal role in ensuring safety and contribution to the prevention of higher level need, as well as being a cost effective option.

7.13 As such, we arrive at a new and more robust social contract: the responsibility of the state is to ensure that citizens with personal care needs receive that care free at the point of use; and that citizens are otherwise responsible for their daily living costs and additional support requirements, funded from personal wealth or income, or for those citizens who are less well off, from welfare support.

Cost of Extending Free Personal and Nursing Care

7.14 Free Personal Care costs have stabilised in recent years. This is largely because the number of recipients has levelled off (see below). The rapid initial increase in the number of personal care clients was perhaps due to higher than expected level of unmet need in the community when the policy was first proposed. It may be that this unmet need has now been accommodated: alternatively it is possible that personal care is still being rationed due to the financial constraints under which local authorities now find themselves. It remains the case however that if an older person is assessed as having personal care needs these must be provided free of charge. This is capped for those living in care homes but has no upper limit for those living in their own home.

Figure 12: Number of Free Personal Care Recipients 2003-04 to 2012-13



Source: Scottish Government

7.15 The main growth since the introduction of the policy has been in the expansion of home-based care, reflecting the original policy intention of the legislation. Free personal care in care homes has grown very slowly: from 8.4 thousand in 2003-04 to 9.5 thousand in 2012-13. Not only have the numbers in care homes been relatively static, the growth in support payments for free personal and nursing care in care homes has lagged behind both the growth in prices, and the growth in the minimum wage. Since many care workers are paid close to or at the minimum wage, its more rapid growth suggest that care homes will have experienced increasing cost pressures since the introduction of the policy, which in turn perhaps contributes to the lack of growth in supply of the sector.

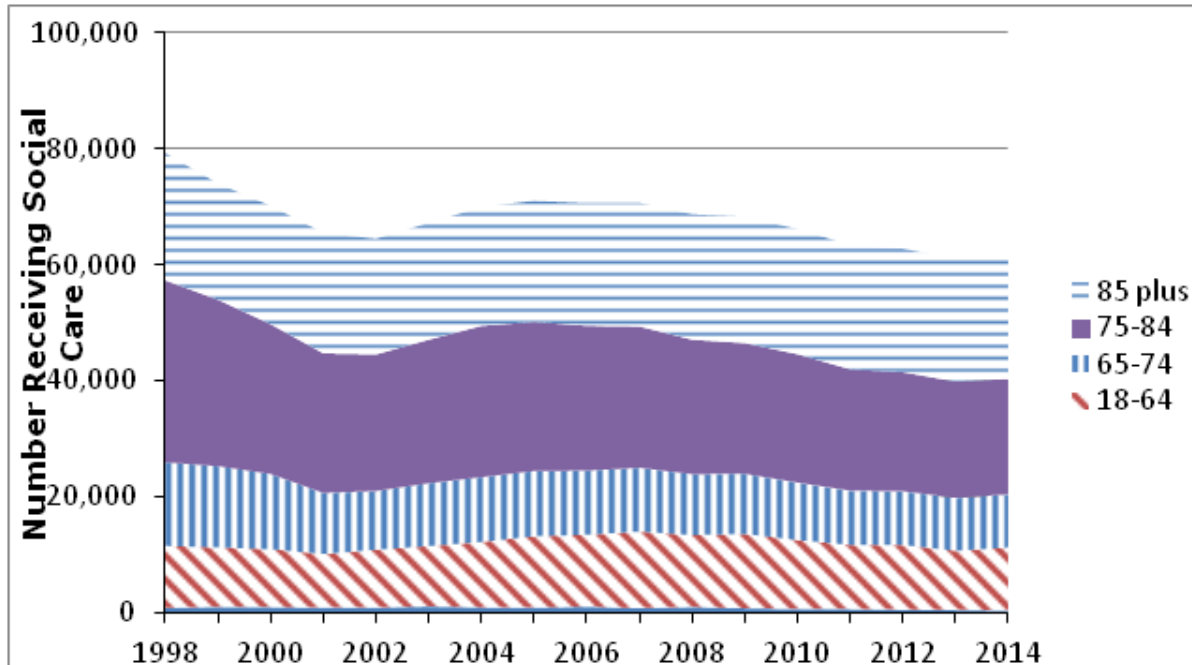
7.16 Furthermore, with allocations to local authorities from the Scottish Government being flat-lined in recent years, there is evidence to suggest that the funding of the policy is being eroded. The Sutherland report in 2008 led to the Scottish Government correcting an under-investment of £40m, and it is clear that a similar case could be made again. Before any discussion about extending Free Personal Care, therefore, we need to make sure that the current policy is fully funded.

7.17 Attempts to estimate the potential cost of extending free personal care to the under 65 in Scotland are fraught with difficulty. The initial estimates of providing personal care for the over 65's significantly underestimated the eventual costs, partly because of underestimates in population projections for the 65+ age group. The costs of providing free personal care at home have risen from £131 million in 2003-04 to £351 million in 2012-13.

7.18 The original cost projections of the Care Development Group understated the costs of unmet need and/or the costs of the switchover from informal to formal care. The estimated increase in spend on community services by 2012 was £64 million. The outturn was £347 million. The growth in provision over the last decade may reflect unmet need amongst those that would previously have been expected to contribute towards the costs of their care, based on a means test.

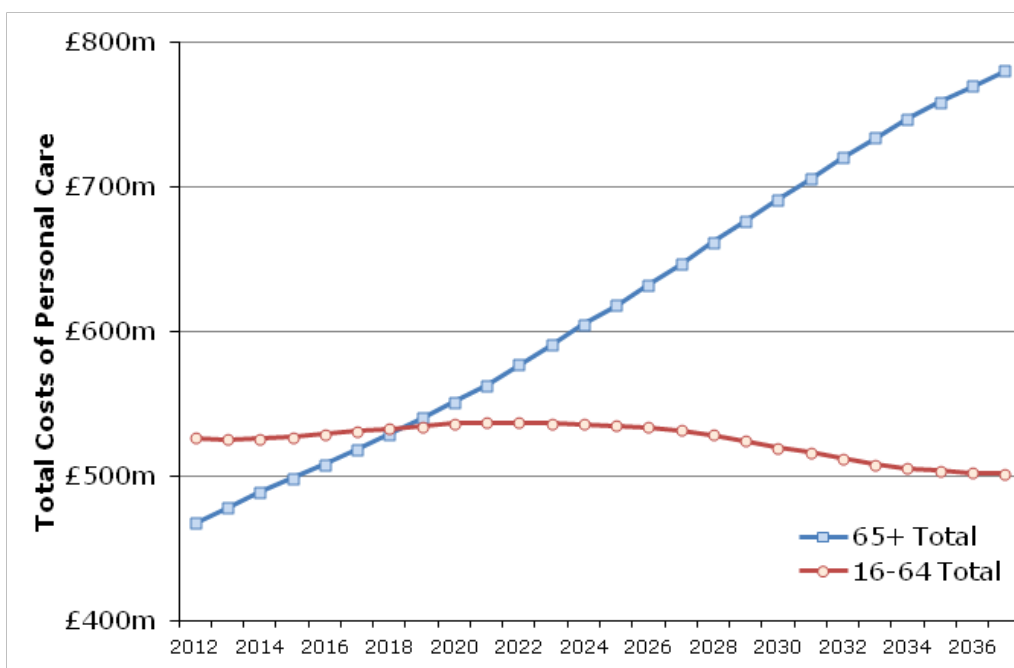
Figure 13 (next page) shows the number of social care clients in Scotland by age group between 1998 and 2014. It is clear that those aged 18 to 64 form a relatively small proportion of the total client base.

Figure 13: Social Care Provision in Scotland by Age Group



Source: Scottish Government

Although the demographics suggest that this group might be occupying a declining proportion of the total provision, there has been a small uplift in the share of total home-care clients aged 18 to 64 from 15% to 18%. However, as evidenced by the figure below, we anticipate that the overall cost of support people aged under 65 will actually reduce over the next twenty years:



7.19 Given these projections, along with the over-riding arguments in favour of extending Free Personal and Nursing Care to people aged under 65, the Commission believes that we should move immediately to legislate for this provision.

7.20 Detailed work would need to be done to cost this policy. Initial work undertaken by this Commission suggests an initial year one cost of £15m – but this is likely to grow over time as need grows and those who fund their own care switch to state supported care.

Section 8

Closing the funding gap

8.1 As for the broader question of funding, it is necessary for any serious contribution to the development of health and social care in Scotland to propose options for how it should be paid for – and perhaps more ambitiously about the social contract between citizen and state. Little work has been done on this question in Scotland, although considerable attention has been given to the matter south of the border.

8.2 The UK Government commissioned Andrew Dilnot to consider the long-term sustainability of the social care system and has since translated his main ideas into the UK Care Bill (albeit using different financial thresholds). Dilnot argued that as a society we should fund a set of guarantees: that no person would pay more than £35,000 for their care over their lifetime; that this would apply to people with ‘substantial’ social care needs, defined by national eligibility criteria; and that those who enter adulthood with a care and support need should be eligible for free state support immediately rather than being subjected to a means test. All of this would be augmented by a private insurance market, to allow people to cater for their particular needs into the future. Dilnot accurately observed that we can insure ourselves against risk in almost every area of our lives – other than the development of frailty or illness in old age (which is the same argument, as it happens, for Free Personal Care, although interestingly, Dilnot did not think that was an affordable policy).

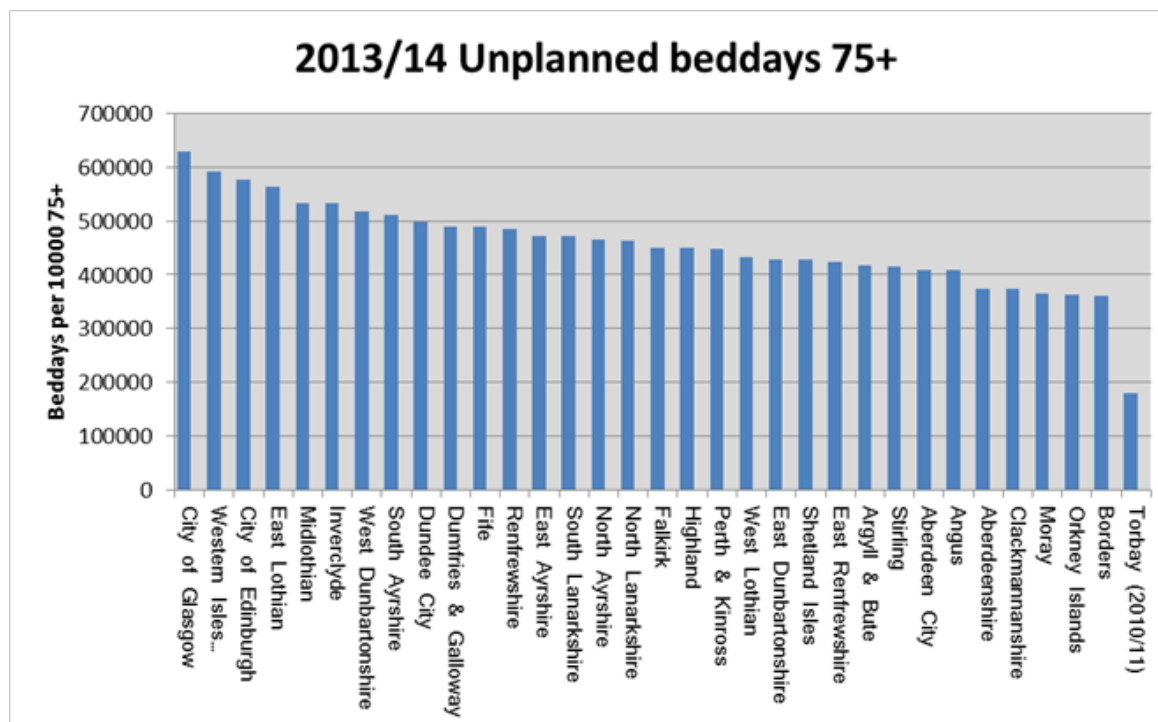
8.3 Ultimately, however, this prospectus which fails to convince: the development of a private insurance market shows no signs of taking-off (people find it difficult enough committing to private pension contributions, let alone voluntary care insurance). Dilnot also seemed drawn to principles about protecting people’s assets rather than delivering first class social care. The proposal which was accepted did not look greatly improved on what we already have in place in Scotland – and that is without the provision of Free Personal Care. Notwithstanding these points, there is as yet no persuasive narrative about how the provision of social care in Scotland can be placed on a more sustainable footing into the future. What we know, however, is that (constitutional matters aside), the UK Care Bill, which is likely to introduce some of Dilnot’s recommendations, will produce significant Barnett consequential. It may be that this resource provides an opportunity to anchor the reform agenda in social care.

The Funding Gap

8.4 As we highlighted earlier in the report, we anticipate that a real terms increase of up to £2billion per annum will be required by our health and social care system by 2025, assuming current patterns of need continue in line with population projections.¹⁴

8.5 A more efficient health and social care system, which reduces hospital admissions and tackles variation has the potential to reduce this figure. For example, if we compare the unplanned bed day rate for each partnership in Scotland against Torbay in England, which has delivered significant improvements with its integrated service, we can see that there is the promise of far greater efficiency:

¹⁴ ‘Integration of Adult Health and Social Care in Scotland - Consultation on Proposals’, Scottish Government, May 2012, page 68.



8.6 The NHS Cost Book indicates that a bed in District General Hospital costs in the order of £2,500 per week, as compared with £500-£800 per week for a care home. In short, by reducing hospital admissions, eating into delayed discharge and generating greater support mechanisms at home, we think that an efficiency target of £600m per annum is stretching but achievable. Allowing for additional costs of £100m to pay for pay and conditions (living wage) and the extension of Free Personal Care, we therefore propose that work should begin on bridging a gap of £1.5bn per annum by 2025.

8.7 Considerable work has been done south of the border about how best to meet the anticipated funding gap. We were particularly impressed by the Commission on the Future of Health and Social Care in England, published by the King's Fund. It outlined a number of broad commitments which we think should also be implemented in Scotland. In particular, the broad ambition that by 2025 public expenditure on health and social care combined should reach somewhere between 11 and 12 per cent of GDP, is something that is worthy of consideration. This should be kept under regular review.

8.8 The King's Fund report indicates that future costs can be met in number of ways:

- from tax increases, particularly changes to National Insurance
- by reducing the number of people exempt from payment.
- free TV licences for the over-75s and Winter Fuel Payments should be restricted to the least affluent pensioners
- the existing complete exemption from National Insurance for those who work past state pension age should end (with payment of National Insurance at a lower rate)
- those aged between 40 and 65 should pay an additional 1 per cent in National Insurance, introduced to match the phasing in of the settlement
- a comprehensive review of wealth and property taxation.

Prescription charges

8.9 The Barker Commission makes the case for targeting prescription charges towards the more affluent. There are approximately 100 million prescriptions dispensed each year in Scotland (approximately 20 per person). The average cost of a prescription is close to £10. Thus, even if 50% of prescriptions were exempt from charging, £100 million could be raised by imposing a £2 charge per prescription. The power to change prescription charges resides with the Scottish Government.

Attendance Allowance

8.10 The Barker commission makes the case that more affluent pensioners can afford to contribute more towards the costs of health and social care. Under the provisions of the draft Scotland Bill, the Scottish Parliament will be allocated funding equivalent to current expenditure on Attendance Allowance in Scotland (£490 million). It will have the power to allocate this additional funding as it sees fit. Note that this sum would have been greater had DWP not removed eligibility for attendance allowance to those receiving free personal care in Scottish care homes. Attendance Allowance is intended “to help with personal care”, so there is clearly a question as to how this benefit interacts with the policy of “free personal care”. If this funding stream is allocated to Scotland it will be necessary to review the financial support for personal care at home.

Winter Fuel Payments and free TV licences for the over 75s

8.11 The Barker commission has made the case that the Winter Fuel Payment and free TV licences for the over 75s should be restricted to those receiving pension credit. This would raise approximately £110 million in Scotland. Both these benefits are scheduled to be transferred to Scotland under the draft Scotland Bill

National Insurance

8.12 The Barker commission has made a number of proposals regarding national insurance. These involve increased charges, mainly for older workers: the intention is to hypothecate these towards meeting additional health and social care costs. National Insurance will remain a reserved issue under the proposed Scotland Bill. Nevertheless, any changes made to national insurance at the UK level, would generate additional revenues from Scottish workers: if the case for hypothecation is accepted in England, then there would seem to be a strong case for hypothecating the additional Scottish revenues towards Scottish health and social care costs.

8.13 The specific proposals are:

- Those aged between 40 and 65 should pay an additional 1% in National Insurance. The Barker commission suggested that this would raise around £2 billion per year, which would imply around £180 million for Scotland.

- Those working beyond the state retirement age are currently exempt from national insurance. This exemption should be removed, but those working beyond this age should pay a reduced rate of 6% of income, rather than the standard 12%. This is to encourage individuals to continue to work beyond the state retirement age if they are able. This latter provision might raise around £35 million in Scotland.
- The rate at which national insurance is payable for those earning more than £42,000 drops from 12% to 2%. The Barker Commission recommended that this latter rate be increased to 3%, and suggested that it would raise around £800 million per year. The equivalent for Scotland would be around £70 million
- Thus if all of these changes were made additional funding of around £285 million would be available to the Scottish Parliament. However, since National Insurance remains reserved, these changes could only be made if there was agreement in England to implement the Barker recommendations.

The Scottish Rate of Income Tax

8.14 An alternative fundraising strategy would be to raise the Scottish rate of income tax (SRIT). This power will become available from 2016-17 under the Scotland Act 2012. Under the assumption that there are no negative consequences from the increased rate of tax, an additional 1p on the SRIT would likely have raised around £500 million in 2015-16. This estimate is based on a microsimulation model developed at the University of Stirling for modelling Scotland's tax and benefit system.

Wealth and Property Taxation

8.15 We also recommend that a comprehensive review of wealth and property taxation be undertaken. While we recognise that some of these tax raising powers – such as inheritance tax – are not yet devolved to the Scottish Parliament, there is a strong moral and economic argument to base the contribution people are asked to make to the cost of care on wealth and property, as well as income. Given that we have a diminishing working age population and given that the older population are the primary beneficiaries of policies like free Personal Care, such a review will be important if we are to find a balanced funding package.

Conclusion

8.16 Some of the measures outlined above may be unpopular and therefore politically challenging for any political party. We list the suggestions of others to highlight the urgent need for a conversation in Scotland about how we pay for our health and care system into the future. We have up until now largely ignored this challenge, but if we continue to do this, quality will erode and access will reduce.

8.17 That national conversation needs to be informed by a detailed examination of the spending gap and how that might be funded. We do not claim that our work is sufficiently detailed to be a definitive statement on this issue. However, we are confident that it is sufficiently large that it cannot be wished away or ignored.

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