SUBMISSION TO THE REVIEW OF ADULT SOCIAL CARE

COMMON WEAL'S SUBMISSION TO THE FEELY REVIEW

INTRODUCTION

The Common Weal welcomes the Adult Care Review and its wide-ranging remit. We particularly welcome the fact that the Review has been asked "to include consideration of a National Care Service" (NCS) and would be keen to engage with the advisory group about this.

We are concerned, however, that having been prompted in large part by the coronavirus disaster in Scotland's Care Homes, which has to date accounted for almost half of all deaths in Scotland from Covid-19, the remit does not include consideration of what has gone wrong. While we believe the crisis of the last six months has been a long time coming – the failures were predictable – and it is therefore right to look at its structural causes, the recommendations of the report will need to be judged by the extent to which, if implemented, they might have prevented the current and ongoing crisis in social care, from inadequately trained staff to the denial of human rights. We therefore include in our submission a list of the failings in the social care system exposed by Covid-19, most of which should now be considered by the Public Inquiry into the care home disaster which the Scottish Parliament voted for on 4 November. That reinforces the argument that the Review cannot ignore the immediate crisis.

We have two other major concerns about the Review's remit. The first is that it is restricted to adult care and omits any reference to its relationship with the Independent Care Review for Children[1], whose recommendations the Scottish Government accepted in February this year. Our analysis of the current care system for adults show there are very strong arguments for considering a single care system and most of the principles the Scottish Government has accepted for children are equally applicable to adult care. There is a real opportunity here for a joined-up system and we would urge the Review to look beyond its remit and consider this.

Secondly, we are concerned about the Review's timescales and the practicality of what it has been asked to do. It is clearly not possible for the Review to produce a blueprint for a National Care Service, similar to the Beveridge Report which led to the creation of the NHS, within four months. We also acknowledge that the timescales have made it impossible for the Review to consult and engage stakeholders except in a tokenistic way and that task has been made harder by the ongoing coronavirus restrictions. We believe, therefore, that the Review can be no more than a first step in a necessary process of reform and would hope that, whatever else the review recommends, it identifies areas where more work, consultation and political engagement is required. Common Weal is currently working to develop a blueprint for a National Care Service (models of care provision and governance, funding etc) which we intend to publish in the New Year and would be happy to share with the Review.

Meantime, this submission, covers three areas: the failures exposed by the corona crisis; the underlying structural problems and failings in the social care system; and, arising from these, a new set of principles to underpin a National Care Service. We have grouped the structural problems under a series of headings, under which we propose a key principle followed by an analysis which sets out our reasoning for why this is needed. We would hope that this will assist the Review consider the case for fundamental reform and that the principles might then be used as a basis for future work and consultation.

THE FAILINGS OF THE SOCIAL CARE SYSTEM EXPOSED BY THE COVID-19 PANDEMIC

This list is not exhaustive:

— The failures in emergency planning which left the entire sector, from civil servants, regulators and commissioners to providers and the workforce totally unprepared for the pandemic[2].

— The serious staff shortages, with no reserves to replace staff off ill or isolating, and a reliance on agency staff (who in part appear to have been responsible for the spread of Covid-19 in care homes).

— The absence of any system at the Scottish Social Services Council that would have enabled the recently retired and others to return to work

— The very low pay and poor working conditions of most frontline care staff, illustrated by Scottish Government's decision to pick up the bill for sick pay for staff who needed to self-isolate because of Covid

— The untrained private sector workforce. Six months after the start of the crisis, Care Inspectorate reports to the Scottish Parliament show many staff working in care homes have still not been trained in basic elements of infection control.

— The time it took to provide Personal Protective Equipment to staff, with National Records of Scotland statistics showing the death rate from Covid-19 of social care workers was twice that of health staff.

— The initial assumption, by Scottish Ministers and civil servants, which was left unchallenged by the regulator and commissioners, that the care home sector could be left to manage itself while government focussed on preparing the NHS for the crisis.

— The inability of primary care services to help treat older people in care homes who had Covid-19, for example through the provision of oxygen, or to assist with basic palliative care (in an unprecedented move the Care Inspectorate issued a general permission to providers to use other people's drugs given problems with obtaining prescriptions)

— The failure to provide ongoing health support, whether from primary or secondary care, to people in care services for non-Covid illnesses, which contributed to the

high number of excess deaths in care homes (the number of excess deaths for people in receipt of other services while recorded in England is not available in Scotland).

— The number of delayed hospital discharges in January, the highest for many years, and the consequent panic to free up hospital beds which led to the mass discharge from hospital to care homes.

— The failure to consider properly whether the mass discharge from hospital might introduce the virus into services not prepared to cope or whether people might be exposed to the virus services where there were already outbreaks. (The recent Public Health Scotland report into what happened is not credible.)[3].

— The extent of the curtailment of statutory assessment processes during the mass discharge process, which removed a key safeguard to protecting individual rights, and the apparent collapse of care management, which might have helped address some of the issues faced by service users (from cuts in service provision to people being prevented from seeing their relatives)

— The collapse of community services, as evidenced by the Scottish Human Rights Commission[4], including the closure of day services essential to mental well-being and the failure to replace them, in most cases, with services at home

— The consequent impact on service users and carers, which has been well evidenced in England but less so in Scotland[5].

— The failure to care for asylum seekers, as evidenced by the number moved to the Park Hotel in Glasgow without any assessment of vulnerability and the consequent mental breakdown of one which led to six people being injured.

— The shallowness of self-directed support and the policy attempts to give people control over services, exposed by the way in which people in receipt of services or their carers having been given little or no say over what happened.

— The failure of the Care Inspectorate to investigate what was actually happening in services, until forced to do so by the Scottish Parliament in May when it started to inspect care homes. Even now, less than half of all care homes have been inspected for Infection Control measures while other services have been completely neglected.

— The lack of transparency at all levels of government and reluctance to speak the truth about what has been going on, as is illustrated by the recent refusal of the Scottish Government to release information about when it first knew infected people were being discharged from hospital to care homes.

— The trampling over the human rights of those receiving services, as is illustrated by the many stories of relatives still being denied the right to visit people in care homes and the accounts of people being discharged to care homes where there were outbreaks of Covid-19 against their will..

— The inadequacy of community rehabilitation services, illustrated by the failure to make any attempt to failure to identify the number of people with long covid, including those who survived the disease in care homes, many of whom might benefit from rehabilitation[6].

— The inability of the leaders of the care system to work out what has gone wrong in care services – apart from some basic matters like lack of PPE and testing – and learn from this.

— The failure to invest in physical improvements, additional staffing and other measures (apart from PPE) to make services safer with the result that many community services are still closed and care homes remain a breeding ground for virus

Set against all this, one of the few successes of the system during the crisis was the temporary housing of homeless people who had been living on the streets.

WHAT IS WRONG WITH THE SOCIAL CARE SYSTEM IN SCOTLAND AND THE IMPLICATIONS FOR A NATIONAL CARE SERVICE

Inadequate resources

Proposed Principle: social care needs to be properly funded by government

The fundamental issue that needs to be addressed is that expenditure on the care system, however defined, is totally inadequate and has been cut year on year in real terms since the financial crash in 2008. While close to collapse, Health and Care Partnerships are still being asked to find savings, with Audit Scotland reporting in 2017-18 that required savings had gone up by 8.1 per cent to £222.5m[7]. Meantime, morale and pay in the workforce, as reported to the Scottish Parliament's Public Audit and post-legislative scrutiny committee in March this year have reached rock-bottom[8].

In the five years to 2017 NHS expenditure increased by 3.2 per cent compared to 1.8 per cent for social care[9], when both faced similar increases in demand and, if anything, social care required more resources to enable a shift in the balance of care. With NHS Boards now regularly being bailed out by the Scottish Government, social care is in an even worse position, but this has been concealed by cuts, including cuts in workers pay and terms and conductions and reductions in service. The latter is illustrated by the reduction in the number of people receiving home care services from 79,000 in 1998 to 59,000 in 2017[10].

While the total number of hours home care provided has gone up significantly, it is being concentrated on those in greatest need to prevent even greater expenditure on care home places. The needs of everyone else are no longer being met. The House of Lords Economic Affairs Committee report last year, with the telling title "Social care funding; time to end the national scandal" estimated that £8 billion was needed immediately in England just to bring services back to 2010 levels[11]. While the situation in Scotland does not appear quite as bad as England – there has been no similar inquiry – it is likely to be similar.

The Scottish Government's solution to this crisis, which was before the crisis generally supported by all political parties and driven by Audit Scotland, has been to focus on efficiency. Health and Social Care integration has been seen as the primary means to do this. So far this has failed to deliver and is unlikely to work because health provision, which focuses on treatment and rehabilitation, and care are very different things. The main area for potential savings is to stop unnecessary admissions to hospital. But that depends on new investment which is not within the gift of HSCPs to provide, so that care, like hospitals, can provide a service of last resort. At the same time neither the NHS nor Local Authorities are in a position to provide the extra funding to HSCPs that would enable them to improve services to make this happen. The reality is care is moving in the opposite direction, with longer waiting times and ever higher eligibility criteria.

The two main areas where there is real scope to make better use of existing resources are also not within the gift of HSCPs to address and require action from the Scottish Government. The first is inefficient and bureaucratic IT recording systems, which consume large amounts of the time of front-line workers and still fail to enable effective information sharing. The second, which is considered in more detail below, is the way the private sector has been allowed to extract money from the system. Neither however will address the funding gap.

Profit extraction from the care system

Proposed principle: care services should be not for profit

Until the 1980s care provision was effectively not for profit, but then new measures were introduced to enable greater participation of the private sector. This has developed over

the years[12], being at first concentrated in the development of the care home sector but subsequently spreading to other services, particularly home care. Commissioning, which initially developed on the back of Resource Transfer monies from the NHS and was used to stimulate new provision from the voluntary sector for adults, has increasingly become a means to drive down costs in both the private and voluntary sector. Constrained by the EC procurement rules, it has proved incapable of directing how public funding should be used once contracts are awarded.

The extent to which care services had been financialised became apparent in 2011 with the financial collapse of Southern Cross. In the previous nine years West Private Equity had made £82m and Blackstone £2 billion from the firm, before leaving it effectively bankrupt. This was all money that could have been spent on care. Across the UK in a large proportion of services profit, to a greater or less extent, comes before care. The corona crisis appears to have had very little impact on this, with three major sales of services based in Scotland taking place in the last six months[13].

While there is no specific Scotland research, a UK report last year[14] found that:

> "For 784 small and medium-sized care home companies **£7 of every £100** received goes to profit before tax, rent payments, directors' remuneration, and net interest paid out. For the 18 largest for-profit providers the level of leakage is more than double at **£15 of every £100** received."

And that in total 18 of the largest providers extracted £560 million a year in profit from across the UK. That is a considerable sum that could be re-invested in the sector. Within that context it is worth highlighting that the law in Scotland already requires Fostering Services to be not for profit and the Scottish Government in their response to the ICR for Children accepted that all children services should be not for profit.

There could even be financial benefits to doing this. Under our current system, no-one is ever likely to want to leave money to a private provider but self-funders, who currently often pay extortionate fees, might leave money to services that were devoted to care, not profit, as happens with the hospices that operate within the NHS.

The fragmentation of care

Principle: a National Care Service should be a unified service that provides from the cradle to the grave.

The Social Work (Scotland) Act 1968 was a revolutionary piece of legislation that unified previously disparate services under the aegis of Social Work Departments operated by Local Authorities. In the fifty years since then there has been increasing fragmentation of services, driven in part by increasing specialism. This has changed the focus from cross-generational social work with families to social work and services designed for specific care groups, such as children, young offenders, mental health, learning disability and older people. Within each of these care groups there has often been further specialism. The result has been a multiplicity of professionals and services directed at what previously would have been treated as "one family" or "network". There is no evidence to suggest these changes have helped improve outcomes for individuals or families and quite a lot to suggest the opposite.

Health and social care integration has, if anything, entrenched these discontinuities further. The primary purpose of the NHS is to treat the individual and it makes sense therefore for health service provision to be organised around specialisms dealing with specific condition. That is not the case for care, which is in large part concerned with supporting relationships between individuals who may have different health problems.

While the management of adult care has been merged with health, children's care has been left out of many HSCPs and is sometimes managed with education. That has helped cement a gulf between children's and adult services when all the evidence suggests that children with disabilities or those that need care and support because of Social Emotional and Behavioural Needs will continue to need care as adults as is

illustrated by the levels of suicide, addiction and mental health breakdown among young people who have experienced care. We need to develop a set of care principles that encompasses people of all ages.

That was in part recognised by the Scottish Parliament when it passed legislation to extend the legal obligations of Local Authorities to care for Look After Children to the age of 21 and beyond. That has unfortunately still not addressed the gaps in transition between services and is unlikely to do so until there is a single system. Similar problems are seen at the other end of the age spectrum with people with learning disabilities often facing a gap in services as they grow older, with problems frequently occurring when their parents die (families again)

A serious consequence of this specialisation in service provision is that carers have, despite all the policy announcement promoting their importance, been left out in the cold, with responsibility outsourced to Carers Centre which don't have the resources to cope. Carers were central when the focus of social work was on supporting families.

There have been some attempts and to maintain continuity, for example with a single Scottish Minister being responsible for mental health for both children and adults and another for carers. But the general direction of the last 20 years has been one of care fragmentation. A National Care Service would bring cohesion to care services that is currently lacking.

Ever-narrowing definitions of what counts as care

Principle: care must be broadly defined and is at heart relationship based.

Social Work used to be all about relationships. Social Work training was focussed on building relationships with families and social work interventions, while occasionally based on the need for protection, were primarily targeted at supporting relationships. Qualified social workers operated within Social Work Departments that took a holistic view of people's circumstances, recognising the importance of other interventions, and provided a number of other services including community work and group work.

That has been eroded with the primary focus of social work being shifted to child and adult protection rather than care and responsibilities for actual care provision often being outsourced. The Independent Care Review for Children recommended that relationships needed to be the foundation for all care provided to children. That was absolutely right, but it is equally true for adults.

Over the last 20 years care services have generally moved away from relationship to task based care, although this has been more the case for older people than the U-65s. In 2002 the Scottish Parliament introduced "Free Personal and Nursing Care" in order to address some of the anomalies created by Councils taking over responsibility for services that been free under the NHS. Eighteen years later, in many areas the only care councils now provide to older people is that which is included in the official definition of "personal care" tasks. That definition, inadvertently, helped create the 15 minute home care visit, where workers hardly had time to say hello, while ticking off tasks from the personal care list. Other forms of care, from practical support to helping a person with their social and emotional well-being, are now deemed low priority, with charges an additional deterrent for people who try to ask for assistance. The development of community alarm services, while helpful for emergencies is no substitute for personal contact. The result is that care has become increasingly inhuman. Among older people only the rich, who can afford to buy what they want, are in a position to receive the care they really need.

The trajectory of adult care over the last 30 years has been a bit different, driven by the programme to close long-term hospital provision. Enabling institutionalised people to live in the community was initially as much about relationships as life skills, but increasingly financial pressures have eroded the time spent on caring with the new mantra being that care is all about enabling people to survive themselves. The result has in many cases been increasing isolation, with the closure of day services where people used to meet, and there are now cases of people with disabilities confined to their houses, something that would have been unimaginable 15 years ago.

Good care depends on the carer being able to spend sufficient time with a person to form a good relationship and in so doing to provide far more than just practical care and practical support. Relationships nurture people.

The failure to empower service users

Proposed principle: there should be a right to receive care akin to the right to receive treatment from the NHS. We need then to re-think how we empower service users and their carers to control the services they then receive

Thirty years ago, in the early days of community care, social workers were central to the provision of care and support for adults leaving long-term hospital and provision of care to older people in the community. Clients, as they were then called, may have had very few rights to choose or control over services but in practice were often able to negotiate what they wanted with professional social workers who would advocate in their interests within the constraints of the time.

As long-stay hospital wards for older people closed, demand increased exponentially and without any concomitant increase in resources, Social Workers were rapidly replaced by Care Managers, both trained and untrained, and then increasingly by other modes of intervention, like telephone help lines. That created problems, which in part prompted the creation of specialist advocacy services and fed the demand from the disability movement for control over services. Influenced by neo-liberal thinking, personal control over finance (rather than care) became seen to be central to empowering service users and that led first to the creation of Direct Payments and then Self-Directed Support. The latter coincided with austerity and has not had the impact that was intended and indeed in some Local Authority areas has had the opposite effect with individual budgets being cut across the board.

The Covid crisis has highlighted that unless there is a right to receive care, as there is with medical treatment and the NHS, the right to choose what you receive is of limited importance. It has also highlighted some longstanding tensions between individual rights to choose and collective provision. Who steps in if all the people a service user employs through a direct payment have to isolate because of Covid? How do we balance the wishes of users of services with what resources allow? For example, three quarters of all older people needing help to get to bed may want to do so between 9pm and 10pm but it would be totally impractical as well as undesirable to employ the majority of care staff for just one hour in the evening. Care needs to be based on some compromises between individual wishes and the wider collective good.

While acknowledging the crucial importance of service users having control of the services they receive – there can be no respect and no effective relationships without this – we need to rethink how we do this and cease treating self-directed support as the only means of doing so. Part of answer could involve re-instating the role that social work used to play in adult care. Another part of the answer might be giving service users and carers powers a say not just over their individual service, but an element of collective control over how a service as a whole is organised. If care home residents and their relatives, for example, had had a right to over how care homes were run, it is unlikely that so many older people would have been shut in their room for months and denied any chance to see their loved ones as has happened in the current crisis.

The impacts of charging for care

Proposed principle: the provision of care services should be free, with any accommodation charges leaving a person no worse off financially than they would have been living at home.

The introduction of Free Personal and Nursing Care failed to remove charging anomalies as original intended. The fixed payments towards the costs of personal and nursing care in care homes, though never sufficient to meet those costs (the current rates are lower than those produced by the care home cost calculator) were intended to reduce the net costs of care for self-funders. Instead, what happened is that Providers increased their fees and profit levels. The provisions for self-funders to choose to come under the local authority fee rates through the Route 2 contract were hardly utilised – in part because self-funders weren't aware of their

rights - and have now apparently been forgotten by those in power.

Alongside this there has been a general lack of clarity from the care home sector about fee levels. Despite an investigation from the Office of Fair Trading little has changed. Information on fees is rarely advertised, with fees instead being "negotiated", and fee uprating mechanisms are still missing from many contracts. While there have been attempts to address these issues through the National Care Home Contract, there are not the resources to enforce the contractual obligations. As a result providers have been able to ignore them.

While less is known about charges for people funding their own home care, it is unlikely to be such an issue, partly because people are more in control in their own homes and it is much easier to change a domiciliary provider than move care home.

Free personal care was also intended to remove anomalies in charging for home care services by making assistance with all personal care tasks free. From the start there were differences and disputes about what constituted a personal care task but after these were clarified it still did not prevent the development of a post code lottery in terms of Local Authority charges. Despite several attempts by Cosla to address this, significant differences still exist.

The National Assistance Regulations have also served to drive people into poverty. The personal allowance for residents of care homes who are publicly funded is very low and, for people without savings, is insufficient (£28.75) to pay for activities of daily life, let alone pay for say a weekend away with their family.

Again, contrary to neo-liberal thinking, charges don't appear to make people value services but instead either deter people from asking for support, suppressing demand, or impact on their quality of life. Part of what people value about the NHS is precisely that it is free and open to all. While there is a case for charging for accommodation costs, free personal care should be extended to cover all care.

The de-skilling of social care

Proposed principle: all social care staff should be required to undertake (paid) training prior to commencing work and be paid to undertake a minimum number of days training each year.

We also need to think about the professional skills gap at the heart of social care and consider making social workers and social work as central to a NCS as Doctors and medicine are to the NHS

While the establishment of the Scottish Social Services Council in 2001 was intended to improve the skills of the social care workforce, in practice the opposite has happened. This is clearest in respect to professional staff. Reference has already been made to how Local Authorities have reduced the role of qualified social workers in adult social care so that their primary role is now limited to specialist areas, mainly adult protection and statutory mental health work. At the same time professional nursing staff have been removed from the care home sector, while attempts to develop a professional qualification for staff involved in commissioning have failed. Moreover, apart from qualified social workers and qualified nurses, other posts such as Care Home Managers which require the equivalent of a professional qualification can do so on the job through the SVQ process.

It is a similar story for front-line staff providing care and support. As long as staff register for the appropriate vocational qualification within a fixed time period, they can start work without any qualifications or training. With high staff turnover, a large proportion of the workforce at any one time appear to have no qualifications (unfortunately data on this is poor). That quality care has still been provided is probably attributable to the predominantly female workforce being good at relationships and asking service users how to perform care tasks. That can work until someone has dementia or other complex cognitive problems... or there is a pandemic like Covid-19. In 2020 there is nothing to prevent a new recruit being sent to provide care to someone with dementia without have any understanding of the illness or the person's legal rights.

The outsourcing of services appears to have made the situation worse. While many local

authorities used to provide some in-house training, most private providers are not in a position to do so and it appears that many now require workers to do Vocational Qualifications in their own time or online, increasing the levels of workforce turnover.

Partly in response to these deficiencies in 2019 the Scottish Parliament passed the Health and Social Care (Staffing) Act which requires providers to employ suitably qualified staff. It is yet to be implemented, but provides no means by which those "suitably qualified staff" will be trained.

Unfair workforce pay and conditions

Proposed principle: pay and conditions for the social care workforce should be based on national pay scales and national terms of employment agreed through national collective bargaining.

The pay and conditions of the social care workforce is divided by sector, with those employed by public authorities significantly better paid and retaining far better conditions, even after 10 years of austerity, than those employed by the private sector. The private sector generally has paid the legal minimum, which has led to Scottish Government interventions to get providers to agree to pay the Scottish Living Wage. While a welcome start, considering the demands and skills required by the job, the pay is still pitiful.

Payment of the Scottish Living Wage has also failed to tackle wider issues relating to income, most seriously zero hour contracts (estimated by the SSSC to be 10 per cent of all adult social care contracts in Scotland), the failure to pay staff travel time in the home care sector (which reduces pay below the minimum wage). There is also generally a failure to pay anything more than Statutory Sick Pay and often a failure to pay workers for time off to undertake vocational qualifications. The voluntary sector has traditionally rewarded its workforce somewhere in-between the public and the private sector, although as a result of financial pressures, including re-tendering for contracts, increasingly pay is coming to resemble that of the private sector. Arguably, the single greatest contribution the Scottish Government could make to increasing pay equality between men and women in Scotland would be to improve the pay of the social care workforce which is predominantly (83 per cent) female[15].

What the differences between sectors disguises is that local authorities have over the last twenty years outsourced many of the services that used to deliver care to adults. The result is that the majority of frontline care staff now receive no more than the Scottish Living Wage and generally have very poor conditions of employment. The situation provides a stark contrast to the NHS where Agenda for Change established a set of national pay scales and national terms and conditions. A similar solution is required for social care

The shortcomings of commissioning

Proposed principle: under a not for profit National Care Service, commissioning should be based on ethical principles and establishing robust and costed models for services based on evidence of what works and what inputs are required to meet care needs.

We note the helpful paper presented to the Review on commissioning and procurement and agree that the time has come when we can no longer expect to do more with less.

The early days of commissioning were inspired by great intentions and resulted in new models of service, mainly financed by Resource Transfer monies from the NHS. This, for a time, helped transform the quality of care and support services, particularly for adults (where the NHS had spent and transferred far more money per head). Other monies transferred by central government, first the social security payments that had been used to stimulate the development of a private care home market, and later transitional housing benefit, were less helpful. The income was attached to services which had never been commissioned and which were very variable in quality; commissioning was handed responsibility for sorting out the mess.

A significant amount of effort, first led by the Joint Improvement Team and later endorsed by Audit Scotland, was then invested in trying to

make commissioning more strategic while at the same time complying with the EC's procurement regime. Unfortunately, it has never delivered, with insufficient resources to undertake the four phases of the commissioning cycle, analyse, plan, do and review. Engagement with services users and providers, for example, is very labour intensive. At the same time it became apparent that effective contract management required significant resources and aspirations to report on the performance of services/outcomes for the people using them have never been delivered. Increasingly commissioning has become focussed on delivering savings and standardising services rather than on articulating the case for services to meet a diverse set of care needs.

This change in focus has been driven too in part by the EC procurement regime, which was partly responsible for race to the bottom in terms of staff pay and conditions (the other factor driving this was the desire of private providers to increase profit levels). It was generally accepted by local authorities that they could not include pay or conditions of employment in the evaluation of tender processes. This put pressure on the voluntary sector to lower pay to win tenders, though some have now started to walk away from contracts. The tendering regime has meant that many private home care providers, in particular, are now on a financial cliff edge and can only survive by not paying staff for travel time, training etc. The dilemma for commissioners, however, is that because of the way procurement rules are interpreted, if providers are offered more money for services, there is no mechanism to require this to be invested in services rather than taken as profit.

Among adult social care services, care homes for older people have long been an anomaly, due to the specific legal regime under which they operate, the parameters of which are determined by the National Assistance Regulations and the Choice of Accommodation Directions. The legal right of older people to choose their own care home raised the possibility of Local Authorities having to pay different fees for each care home so they quickly established their own approved rate which eventually evolved into one national rate negotiated with providers. Along with that rate, a national care home contract was developed which specified what service would be provided in return for that fee. Over time, this has involved various experiments – such as paying higher fees to care homes which met higher standards of care – but also seen the development of a cost of care calculator in order to work out what fee level would be required to enable providers pay the Scottish Living Wage. None of this, however, has so far prevented profits from continuing to be extracted from the sector

The absence of effective regulation

Proposed principle: effective regulation should be driven by the empowerment of the service users, their carers and the workforce and support that through compulsory interventions where necessary

We note the paper presented to the ICR by the Care Inspectorate on its role. In our view it lacks any critical analysis, including whether the resources available to it are sufficient to fulfil its responsibilities.

The regulatory regime established by the Scottish Parliament in 2002 had some unintended consequences, particularly for the care home sector. The development of new standards for accommodation favoured providers with access to finance, helped financialise the sector and led to the creation of very large providers who have often provide the lowest standards of care. It helped drive many voluntary sector providers, whose services were in old buildings and who did not have the financial know-how to leave the sector. The abolition of the legal distinction between nursing and residential homes also enabled providers to reduce the numbers of qualified nurses working in their services, reducing costs and increasing profits. There was probably little the then Care Commission could have done about this.

After the collapse of Southern Cross, however, the impact and dangers of financialisation became abundantly clear, yet nothing changed and the regulator still does almost nothing to determine whether a provider is fit to provide care (with the three large sales of services in Scotland over the last six months providing recent evidence of this). Rather than trying to regulate the way financial markets impact on the

care sector, it would simpler to require all care provision to be not for profit.

Since 2002 the Care Commission has been amalgamated with the Social Work Inspection Agency to form the Care Inspectorate, the number of services required to register with it has increased dramatically, the care standards have been revised. All this has created understandable challenges, made more difficult by changes in government funding and expectations. However, until forced to act by the Scottish Parliament in the Corona crisis[16], the Care Inspectorate has acted more like an improvement service than a regulator, with enforcement powers being very rarely used despite evidence of serious ongoing problems in services. Inspections have focussed on checking paperwork – which has served to reduce the time that staff spend actually caring for people – rather than using professional skills and engagement with staff and service users to assess whether a service was good enough and whether to take action.

A bottom up review of how adult services are regulated, similar to that accepted by the ICR for children, is now needed.

Failures in leadership

Proposed principle: The leadership of the National Care Service should embody the principles of that service

Currently Scottish Government responsibilities for social care are fragmented. At Cabinet level in theory there is a clear lead, the Cabinet Secretary for Health and Sport (Health care and social integration, allied Healthcare services, carers, adult care and support) but her remit is huge and the size and complexity of the NHS means social care is inevitably neglected.

However, there is also the Cabinet Secretary for Social Security and Older People (Welfare Policy and Benefits – who has nothing in their remit about care for older people), the Cabinet Secretary for Finance (public finances, local government finance, public sector pay, procurement), the Cabinet Secretary for Education (non-advanced vocational skills), the Cabinet Secretary for Communities and Local Government (third sector) all of whom have responsibilities touching the on care sector.

At Ministerial level, the fragmentation of responsibilities is even greater:

— The Minister for Public Health, Sport and Well-being (Addiction, Self Directed Support, Carers, Care Inspectorate)

— Minister for Mental Health (Children to Dementia, Autism, Learning Disability)

— Minister for Local Government, Housing and Planning (homelessness),

— Minister for Children and Young People (besides children services, social services workforce, vulnerable groups, British Sign Language)

— Minister Older People and Equalities (equalities all age groups, violence against women, social isolation and loneliness),

— Minister for Business, Fair Work and Skills (Labour market, living wage, fair work)

With the Cabinet Secretary for Health overburdened, the case for a Cabinet Secretary for Care who brings all these responsibilities together and would be able to take an overview of a National Care Service in all its aspects appears very strong.

Effective political leadership, however, depends not just on having a clear government lead but in leadership throughout the care system being open and honest about the longstanding crisis in care, being prepared to advocate for care and being prepared to re-consider some long-standing political shibboleths. The current bullying scandals in HSCPs in Argyll and Bute and East Dunbartonshire Council are not a coincidence but stem from the political expectation that it is still possible to do more with less. Every service closure and cut is presented as an improvement and anyone who think differently and is prepared to say so is bullied into submission. Whistleblowing policies are a joke, it is almost impossible for anyone working in the system to speak the truth.

One of the leadership shibboleths is the focus on delayed hospital discharge, which has been a priority for all governments since the Scottish Parliament was created and related to this the integration of health and social care, which has been seen as the way to address the issue. After 20 years the problem appears no closer to solution. If, however, instead of coming at the problem from a health perspective, it was approached from a care perspective, very different solutions would be possible. If care was free and no longer rationed, finance would no longer be an impediment to getting out of hospital. If people could phone a National Care Service like an ambulance, many unnecessary hospital admissions could be prevented. Instead of a National Care Service designed to cover emergencies and free at the point of use, at present it can take weeks to get an assessment and then people have to jump through all sorts of eligibility hoops. While it is essential that health and care interface effectively, that cannot happen unless care is properly resourced and currently no one working in the care system is allowed to say this.

CONCLUSION – TOWARDS A NATIONAL CARE SERVICE

There is a strong argument that a National Care Service should an independent service separate from the NHS. That might appear contrary to the cross-party policy drive of the last ten years to try and integrate health and social care which, so far, has had little obvious success. The chasm between primary and secondary care in the NHS remains and, with HSCPs close to financial collapse, the evidence suggests that neither the NHS nor Councils have the resources to invest the money necessary to make them work. So why not use the HSCPs to form the building blocks of the new NCS, with some health staff whose roles are as much about care as treatment transferring over, and then fund it independently? That is probably the only way to ensure that care is properly resourced. The NCS could then be designed to interface with the NHS on the one hand and, even more importantly, the informal carers who provide the majority of care in Scotland, local communities and community services on the other.

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