Notice of Meeting and Agenda

Midlothian Health & Social Care Partnership

Midlothian Integration Joint Board

Venue: **Virtual Meeting,**

Date: **Thursday, 11 February 2021**

Time: **14:00**

Morag Barrow
Chief Officer

Contact:

Further Information:

This is a meeting which is open to members of the public.

1 Welcome, Introductions and Apologies

2 Order of Business

Including notice of new business submitted as urgent for consideration at the end of the meeting.

3 Declaration of Interest

Members should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

4 Minute of Previous Meeting

5 Public Reports

5.8	Falls and Fracture Prevention - Strategic Plan Summary 2021-2022 - Report by Alison White, Head of Adult Services.	199 - 202

6 Private Reports

6.1 Care at Home Recommissioning - Report by Alison White, Head of Adult Services.

- 6. Information relating to the financial or business affairs of any particular person (other than the authority).
- 8. The amount of any expenditure proposed to be incurred by the authority under any particular contract for the acquisition of property or the supply of goods or services.
- 9. Any terms proposed or to be proposed by or to the authority in the course of negotiations for a contract for the acquisition or disposal of property or the supply of goods or services.
- 10. The identity of the authority (as well as of any other person, by virtue of paragraph 6 above) as the person offering any particular tender for a contract for the supply of goods or services.

7 Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be held on:

- 11 March 2021 at 2 pm – **Special Board Meeting/Development Workshop**
- 8 April 2021 at 2 pm - **Midlothian Integration Joint Board**

Clerk Name:	Mike Broadway
Clerk Telephone:	0131 271 3160
Clerk Email:	mike.broadway@midlothian.gov.uk

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 10 December 2020	2.00pm	Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Cllr Catherine Johnstone (Chair)	Carolyn Hirst (Vice Chair)	Cllr Stephen Curran
Cllr Russell Imrie	Angus McCann	Cllr Pauline Winchester

Present (non-voting members):		
Morag Barrow (Chief Officer)	Alison White (Chief Social Work Officer)	Claire Flanagan (Chief Finance Officer)
Fiona Huffer (Head of Dietetics)	Hamish Reid (GP/Clinical Director)	Wanda Fairgrieve (Staff side representative)
James Hill (Staff side representative)	Keith Chapman (User/Carer)	

In attendance:		
Jill Stacey (Chief Internal Auditor)	Mairi Simpson (Integration Manager)	Jamie Megaw
Roxanne KIng	Gordon Fender	Mike Broadway (Clerk)

Apologies:		
Mike Ash	Tricia Donald	Cllr Derek Milligan
Cllr Jim Muirhead	Caroline Myles (Chief Nurse)	Johanne Simpson (Medical Practitioner)

Midlothian Integration Joint Board

Thursday 10 December 2020

1. Welcome and Introductions

The Vice Chair, Carolyn Hirst, welcomed everyone to this virtual Meeting of the Midlothian Integration Joint Board, explaining that she had been invited by the Chair, Councillor Catherine Johnstone to chair today's meeting. She extended a particularly warm welcome to Councillors Russell Imrie and Stephen Curran, who were substituting for Derek Milligan and Jim Muirhead respectively, and to local democracy reporter, Marie Sharp, who was also in attendance.

2. Order of Business

The order of business was confirmed as outlined in the agenda that had been previously circulated.

3. Declarations of Interest

No declarations of interest were received.

4. Minute of Previous Meetings

4.1 The Minutes of Meeting of the Midlothian Integration Joint Board held on 8 October 2020 were submitted and approved as a correct record.

4.2 The Minutes of Meeting of the MIJB Audit and Risk Committee held on 13 September 2020 were submitted and noted.

4.3 The Minutes of Meetings of the MIJB Strategic Planning Group held on 18 August and 28 October 2020 were submitted and noted.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.1 Midlothian Response to Delayed Discharges – Presentation Alison White, Chief Social Work Officer and Head of Adult and Social Care provided a presentation on Midlothian's Response to Delayed Discharges in which she highlighted that the need to ensure that no	To thank Alison for her extremely helpful and informative presentation.		

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
one was unnecessarily admitted to an acute hospital bed or stayed in an acute hospital setting longer than necessary had been amplified by Covid-19, winter and Brexit. However, the solution to reducing delays was a complex one and in order to be able to put in place measures that truly address the problem, reduced delays and improved flow through the system, we must first understand the system and its processes, identify sticking points, reduce waste, streamline and reduce duplication. Alison then went on to outline some of the steps being taken to address these issues and highlighted possible ways in which MIJB might assist in supporting this work. There then followed a general discussion during which the need for a more holistic approach and better joint working across and between services was acknowledged. Whilst all the steps being taken were considered important, the introduction and development of a single point of access was particularly welcomed as an important step forward.			
Sederunt: Cllr Stephen Curran left the meeting, and Claire Flanagan (Chief Finance Officer) joined the meeting, at the conclusion of the foregoing item of business (14:50).			
5.2 Chief Officers Report This report provided a summary of the key service pressures and service developments which had occurred during the previous months across health and social care, highlighting in particular a number of the key activities, as well as looking ahead at future developments.	To note the content of the Chief Officer's Report.		

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
The Board, having heard from Morag Barrow, welcomed the good performance of Covid testing processes for staff and residents in local Care Homes, which were working well and the continuing push for expanded testing to cover the Care at Home team. With regards the availability of vaccine supplies, particularly post Brexit, Jamie Megaw sought to reassure Members that contingency plans were being put in place nationally to address this.			
5.3 Vision and Values The purpose of this report was to update the Board on the proposed final vision and values for the new Strategic Plan 2022-2025. The report explained that in order to meet the legal requirements of the Public Bodies (Joint Working) (Scotland) Act 2014, Midlothian Health & Social Care Partnership required to publish a new Strategic Plan in 2022. An agreed vision was a key requirement of the Strategic Plan, as outlined in the 3-Step Improvement Framework for Scotland's Public Services 2013. Mairi Simpson was heard in amplification of the report advising that the final proposed vision and values were: **New Vision**: People in Midlothian are enabled to lead longer and healthier lives. **New Values**: Right support, right time, right place.	To approve the proposed new vision and values for the Strategic Plan 2022 - 2025.	Integration Manager	

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
5.4 Midlothian IJB Directions 2020 Update With reference to paragraph 5.3 of the Minutes of 8 October 2020, there was submitted a report the purpose of which was to provide the Board with an interim review of progress on all Directions which, following a review in October 2020 had been reissued to the Chief Executives of Midlothian Council and NHS Lothian. Mairi Simpson was heard in amplification of the report after which there was a general discussion during which it was noted that work was in hand to improve output and outcome measures for a small number of Directions, which would complement work to improve performance measures. Additionally, a reduction in the use of acronyms and greater clarity of where progress has been impacted by the coronavirus pandemic would be welcomed.	(a) To note the update of progress on Midlothian Integration Joint Board Directions to Midlothian Council and NHS Lothian; and (b) To note the proposed change to Direction 1 Action (iv), which was to be removed as there was no aim to increase the proportion of patients admitted to the RIE.	Chief Officer/ Integration Manager	
5.5 Independent Review of Adult Social Care The purpose of this report was to provide the Board with information regarding the scope of the Independent Review of Adult Social Care (IRASC) in Scotland, which had been announced by the First Minister, as part of the Programme for Government on 1 September. The report highlighted the scope of the review; the term of reference for which were appended to the report.	(a) To note the report; and (b) To agree to receive a further update in the New Year once the outcome of the review is known.	Chief Social Work Officer/ Clerk	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Alison White was heard in amplification of the report making particular reference to having been involved in a meeting with the Chair of the Review and also in contributing to Social Work Scotland response.			
5.6 Clinical and Care Governance Report The purpose of this report was to provide assurance to the Board as to the clinical and care governance arrangements within Midlothian, along with highlight good practice and identify any emerging issues or risks. Additional reports would be submitted as appropriate throughout the year to provide updated information from specific service areas. Alison White and Fiona Huffer were heard in amplification of the report after which there was a general discussion on how the Quality Improvement Teams (QIT) would support the work of the Clinical and Care Governance Group (CCGG).	To note and approve the content of the report. .	All to note	
5.7 MIJB Improvement Goal Progress With reference to paragraph 5.4 of the Minutes of 14 February 2019, there was submitted a report updating the Board on performance and improvement towards achieving the Local Improvement Goals set by the MIJB based on the indicators recommended by the Ministerial Strategic Group (MSG) for Health and Community Care. The improvement goals focused on reducing unscheduled hospital and institutional care using	(a) To note the performance across the indicators; and (b) To note the inclusion of further information about performance in Midlothian against the Core Suite of Indicators.	All to note.	

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
data provided by the Health and Social Care team at ISD Scotland. Jamie Megaw was heard in amplification of the report drawing particular attention to the summary of Midlothian MSG Indicator Performance (detailed in para 3.5 of the report) after which there was a general discussion on this and the work to improve the local performance measures.			
5.8 Covid Vaccination Jamie Megaw provided the Board with an update on the Covid Vaccination programme rollout in Midlothian. He explained that the clinic set up in Midlothian Community Hospital was operating close to its capacity of 500 patients daily focusing initially on those in the nationally set phase 1 priority group, which included those administering the vaccine, residents and workers in care homes, and other frontline health workers. They would be followed by the over 80s and those who were housebound in the New Year. There then followed a general discussion during which Jamie responded to Members questions and comments. Morag Barrow expressed her thanks to all those involved in getting the programme operational, at what was an especially busy time of year with the normal flu vaccination programme, take up for which had been very good.	(a) To note the update; and (b) To note that further updates would follow as the programme progressed.		

Midlothian Integration Joint Board

Thursday 10 December 2020

Report Title/Summary	Decision	Action Owner	Date to be Completed/Comments
Sederunt: James Hill left the meeting towards the conclusion of the foregoing item of business (15:54).			
5.9 Finance Update for 2020/21 and 5 Year Financial Plan This report set out the results of the MIJB's partner's (Midlothian Council and NHS Lothian) month 6 financial reviews and considered how this impacted on the projected financial position for the IJB for 2020/21. The report advised that since these forecasts had been prepared both IJB's partners had received confirmation on the COVID additional funding, this had not been included in these forecasts as this had not been confirmed at that point, and therefore an illustrative adjustment has been made to the pre COVID funding positions. The report also presented the Board with a medium term rolling 5 year financial plan (2020/21 to 2024/25) for noting which was prepared in a Business as Usual, pre COVID scenario and would be refined when clarity on future service provision was known. Claire Flanagan was heard in amplification of the report following which there was a general discussion.	(a) Noted the month 6 financial reviews undertaken by partners; (b) Noted the impact COVID has had on the IJB financial position; (c) Noted the COVID funding that has been confirmed since this review; and (d) Noted the pre-pandemic medium term rolling 5 year Financial Plan.	Chief Finance Officer	

6. Private Reports

No private business to be discussed at this meeting.

7. Any other business

No additional business had been notified to the Chair in advance.

8. Date of next meeting

The next meetings of the Midlothian Integration Joint Board would be held on:

- Thursday 14 January 2021 2pm Development Workshop
- Thursday 11 February 2021 2pm Midlothian Integration Joint Board

(**Action: All Members to Note**)

The meeting terminated at 4.03 pm.

MIDLOTHIAN IJB STRATEGIC PLANNING GROUP

MS Teams

NOTES OF OUTCOMES AND ACTIONS
Wednesday 25th November 2020

PRESENT: Carolyn Hirst (Chair), Mairi Simpson, Jane Crawford, Jim Sherval, Debbie Crerar, Matthew Curl, Lois Marshall, Alison White, Sheena Wight, Fiona Huffer, Caroline Myles, Rebecca Miller, Aileen Murray, James Hill, Anthea Fraser, Morag Barrow, Anthea Fraser, Graham Kilpatrick, Jane Crawford, Jamie Megaw, Andrew Coull

APOLOGIES: Giovanna Di Tano

			ACTION
1	**Welcome and Introductions**	Carolyn Hirst welcomed members to the meeting. Apologies noted.	
2	**Minutes of Last Meeting**	Minutes of meeting on 28 October 2020 approved.	
3	**Action Log**	Actions from 28 October 2020: (i) *JC is looking at how the Third Sector Reference Group can be better supported to influence IJB strategic planning.* JC met with Lesley Kelly and will feedback following the next meeting with Third Sector Reference Group on 9th Dec 2020. (ii) *Representation from the Independent Sector.* MS looking to invite independent sector representative from both Independent Care at Home and Independent Care Home Services groups. Carry forward. *Representation from Housing sector:* MB and MS are meeting Lynne Douglas , CEO of Bield Housing week commencing 30th Nov 2020. Lynne would bring housing and NHS Lothian expertise to the SPG. In progress. (iii) *CH to progress requirement for a vice chair from Council*. Carry forward. (iv) *Equality Outcomes.* LM reported on public consultation meetings regarding equality outcomes. JC encouraging involvement of third sector. Further feedback to Strategic Planning	**JC** **MS** **MB** **CH**

		Group in January 2021. (v) *Development of Home First Model*. Work ongoing. Single Point of Access to start early Dec 2020. The following related actions to be carried forward. a. GC to include feedback on Glasgow and Fife models when progressing the Home First model locally. b. GC to report back on third sector contribution to the pathway.	**LM** **GC** **GC**
4.	**Report on Progress** **(i)**	**Direction Tracker - Lois Marshall** Lois Marshall discussed progress on Directions. Proposed to present update at IJB meeting on 10th Dec 2020. **Actions as follows:** i. Feedback to Lois on what could be included in the tracker in future. Comments on content and format to LM by 2nd Dec 2020. ii. Consider a Direction on the following and propose to the IJB Board. a. delayed discharges b. falls prevention and injury prevention. iii. Direction leads to add clear performance measures, both qualitative and quantitative where this is appropriate. iv. Direction leads to add clear timescales for review if progress not on track or targets unlikely to be met. v. Direction leads to consider capacity to deliver all aspects of a Direction - is there a need for the prioritising of tasks/objectives?	**ALL** **GC** **SW** **Direction Leads** **Direction Leads** **Direction Leads**
	(ii)	**Winter Plan Update – Leah Friedman** Leah Friedman delivered a presentation on updated Winter Plan. Plan was presented to IJB in October and update will be discussed at IJB on 10th Dec 2020. Weekly tactical groups are up and running. Original Winter Plan has been checked against Scottish Government Winter Preparedness guidance. **Actions as follows:** Comments on plan to LF by 27th Nov 2020.	
	(iii)	**Care Homes and Care at Home – (verbal update) Anthea Fraser)**	**All**

		Care at Home: In process of re-commissioning contract with the aim to be up and running by Sep 2021. Key areas being worked on include terms and conditions for staff with aim of improving staff retention. Also considering use of block contracts so that staff are paid for a full shift rather than just during visits. Aiming for in-house staff consultation in the new year. Keen to promote a care career pathway. Discussions underway with schools and links made with Pan-Lothian Care Academy. **Care Homes:** Midlothian has 11 homes for older people with 550 beds approx. 85% of places are occupied by Midlothian residents. Care Home Support Team has recently been expanded. There are regular meetings to support care homes alongside other support. Care Home Support Team undertook assurance visits to each care home and these are currently being repeated. Several initiatives are in place to support staff at this challenging time and throughout the winter. Expecting COVID vaccination programme for all care home residents and staff in Dec 2020 and Jan 2021. Care Staff have been asked to highlight if a resident is deteriorating to allow prompt response and reduce risk of hospital admission.	
5.	**Developments For Discussion** **(i)** **(ii)**	**Measuring our Performance Update – Jamie Megaw** JM reported on the challenges with developing a framework to report performance and the need for better intelligence. Currently improving the use of Tableau software to analyse data across health and care services. Aiming to have performance framework signed off by IJB by end of the financial year. JM requested feedback on what people feel the framework should include. This work supports plans to develop outcome maps for the HSCP. Workshops underway, supported by Matter of Focus. **Social Care Review – Alison White** AW discussed the Social Care Review paper. The paper reported on key changes that are proposed, areas in need of investment and areas of challenge. AW asked everyone to review the paper and feedback.	**All** **All**

	(iii)	**Astley Ainsley Redesign – Graham Kirkpatrick** GK delivered a presented on the redesign of services at the Astley Ainsley Hospital. Proposal is to shift the balance of care from the hospital to the community. The redesign links to the review of the stroke pathway, plans to provide Speech and Language Therapy locally, plans to increase extra care housing in Midlothian and the review of community nursing. Report highlighted the need for transfer of resources to provide care locally in the community. Progress in some areas has been limited in 2020 due to COVID.	
6.	**Strategic Planning Group Report Schedule 2020/21**	Suggested reports on 20th January or 17th March 2021: Technology Pathway Programme – Matthew Curl Climate Emergency & Green Health Prescribing – Jim Sherval Redesign of urgent care – Midlothian response Primary Care Improvement Plan – Jamie Megaw Equality Outcomes – update – Lois Marshall MS and CH to confirm schedule.	**MS**
7.	**AOCB**	i. MS to update and share the Strategic Planning Group members list. ii. SB asked members to respond to the Midlothian Local Housing Strategy 2021-2026 consultation – https://www.midlothian.gov.uk/news/article/3090/virtual_public_meetings_being_held_for_local_housing_strategy_consultation Some individuals/teams/services have responded. iii. MS to set up a Teams Channel for future meetings	**MS** **ALL** **MS**
9.	**Future Meetings**	**All future meetings below are via MS Teams (meantime)** **Wed 20th January 2021 2-4pm** **Wed 17th March 2021 2-4pm** **Wed 19th May 2021 2-4pm** **Wed 11th August 2021 2-4pm** **Wed 29th September 2021 2-4pm** **Wed 17th November 2021 2-4pm**	

Midlothian Integration Joint Board

Midlothian Health & Social Care Partnership

Thursday 11th February 2021, 2.00 pm

Chief Officer Report

Item number:	**5.1**

Executive summary

The paper sets out the key service pressures and service developments happening across Midlothian IJB over the previous month and looks ahead to the following 8 weeks.

Board members are asked to:

- *Note the issues and updates raised in the report*

Report

Chief Officer Report

1 Purpose

1.1 The paper sets out the key service pressures and service developments happening across Midlothian IJB over the previous month and looks ahead to the following 8 weeks.

2 Recommendations

2.1 As a result of this report Members are asked to:

- Note the issues and updates raised in the report.

3 Background and main report

3.1 Vaccination programme and plan

The Lothian COVID Vaccination programme is progressing well. We are implementing guidance from the Joint Committee on Vaccinations and Immunisations (JCVI) based on direction from Scottish Government.

Staff vaccinations have been underway since 8th December and Care Home vaccinations started on 23rd December. By Friday 15th January all care home residents who consented have received their first-dose vaccine.

General Practices have started to receive vaccine supply and all Midlothian practices are vaccinating their patients over the age of 80. The HSCP is vaccinating people over the age of 80 who are housebound for some practice-populations. Over 3,500 people have been vaccinated in Midlothian.

The HSCP has been running a staff vaccination clinic from Midlothian Community Hospital.

From the 1st February General Practices in Midlothian will lead on vaccinating people aged 75+ and people who were Shielding. The HSCP and the Mass Vaccine Sites will focus on vaccinating people aged between 70 and 74. This collective effort will ensure that all people aged over 70 and those who are Shielding will have received the first dose of the vaccine by mid-February.

3.2 Testing

Lateral Flow Testing (LFT) testing continues to be rolled out across Midlothian HSCP teams. This augments a robust current PCR testing model and offers additional assurance of Covid positivity for staff. A weekly local Midlothian LFT huddle has been established where all Service Managers/team leaders included in the LFT roll out are invited to attend to share best practice. This meeting is the HSCP assurance route to ensure all services are reporting results on the Scot Gov online portal correctly, recording distribution of kits and results departmentally and to monitor any potential clusters of positive cases within Midlothian. All services are reporting that the system and process is working well.

LFT outbreak management has been used within 3 Midlothian Care Homes after confirmation of a positive COVID result from routine weekly surveillance staff PCR testing and/or the confirmation of a positive resident. This has allowed rapid confirmation of whole staff testing over 7 days to mitigate the risk of any further transmission within the home.

3.3 Inspections

Highbank Intermediate care facility, Newbyres Village Care Home and Midlothian HSCP Care at Home service were all recently inspected by the Care Inspectorate. All three services were inspected on standard 7 which focuses on infection control and how services have managed Covid. All three services received grade 4's which is classed as "Good" and were described as having good processes and communication in place to care for residents and support staff in their role. These grades have improved from previous inspections.

Care at Home were also inspected on additional areas for leadership and management, care and support, as there had been outstanding requirements and recommendations made from legacy inspections. These requirements were all met, as were the recommendations and improved grades of 4s. No services received any requirements.

Newbyres Care Home, Gorebridge underwent an unannounced inspection between 11 and 21 January. The Care Inspectorate is quoted in a Parliamentary Report (3/2/2021) as stating that staff were compassionate and respectful towards people experiencing care. People were supported to maintain contact with friends and family. People were supported to socially distance when moving around the home. The care home was clean and tidy. Staff changing areas were being improved to ensure appropriate space for social distancing. There was sufficient PPE and staff had appropriate training in COVID-19 procedures and infection prevention and control. Staff used PPE appropriately. Staffing levels had increased to meet people's health and wellbeing needs. There was a staffing contingency plan to help manage staff shortages. Staff were knowledgeable about the signs and symptoms of COVID-19 and could identify when a person's health was deteriorating. The Care Inspectorate highlighted improvements around personal planning to better reflect people's choices and wishes. As stated above, in the four areas of evaluation Newbyres was assessed as 'good'.

3.4 Chief Nurse

Following the upcoming retirement of Caroline Myles in March, Fiona Stratton has been appointed to take up the role of Chief Nurse for Midlothian HSCP. Fiona has a wealth of experience across health and social care and will commence in post on 22nd March 2021.

I would also like to thank Caroline Myles for all her work within Midlothian over the last few years and wish her a very happy retirement.

3.5 Midlothian Community Hospital

As part of the HSCP plan to open additional beds at Midlothian Community Hospital (MCH), the bed model has been reviewed. A recently vacated ward was made available, providing an opportunity to open more beds and thereby support Midlothian residents to be cared for closer to home.

The hospital ward mode/configuration has been reviewed and reconfigured to meet current need. Recruitment of Medical, Nursing, Pharmacy and AHP staff was agreed and is being progressed. The new model for MCH will provide additional rehabilitation capacity whilst still providing vital care for continuing care patients, End of Life care, and those clinically stable patients awaiting care home placement.

3.6 Care Homes

A privately owned Care home within Midlothian was subject to suspension of registration. This followed concern about standards of care raised by Midlothian company's Lothian nursing staff working within the care home 24/7 to ensure safe care for all residents.

The Care Inspectorate lodged an application to the Sheriff Court in Edinburgh in December 2020 seeking suspension of the registration under Section 65 of the Public Services Reform (Scotland) Act 2010. This was not contested by the company. Midlothian HSCP worked with residents, their families and others to find alternative suitable accommodation. All residents have now been safely placed in another care home of their choice.

3.7 Scheme of Integration

There is a legislative requirement for each Local Authority and Health Board to carry out a review of the IJB Scheme of Integration every 5 years. The current Midlothian Scheme of Integration was approved by Midlothian Council and NHS Lothian on 14 May 2015.

The plan to review of the Scheme in 2020 was delayed as a result of the pandemic. It is the intention of NHS Lothian to resume the review in summer 2021. Discussion with the IJB will also be arranged prior to the review. The draft updated Scheme will be returned to the IJB for approval late autumn 2021. Members will recall that our Scheme of Integration was updated in 2019 specifically to incorporate amendments arising from the Carers (Scotland) Act.

3.8 Strategic Commissioning Plan 2022-25

Work to develop the Strategic Plan 2022-2025 is progressing. Building on from IJB agreement of the vision and values for the new plan in December 2020, work is underway with planning groups, including plans for consultation and engagement are in development. The intention is for the March IJB Development Session to focus on Strategic Plan priorities.

3.9 Palliative Care Project

This project, funded by the Scottish Government and Marie Curie, is part of a two-site project to explore ways to hear and learn from people's experiences of palliative and end of life care. In Midlothian, the project will follow Experience Based Co-design methodology and will focus on care provided by either the District Nursing service or at Midlothian Community Hospital. This involves gathering experiences from patients, carers and staff through in-depth interviewing, observations and group discussions. The approach focuses on helping people tell the story of their own experience and using these experiences to understand not just the care journey, but the emotional journey people experience when they come into contact with the service.

This approach includes:

- Offering video as a method to capture patient and family member feedback and using the video to create an impactful resource for workshops
- Holding workshops for staff and family members to come together, review the feedback, and identify opportunities for change and improvement that will offer patients a better experience of treatment and care.

The timescales for the project have been adjusted due to ongoing service pressures, however it is anticipated that the project will begin to collect data in March/April 2021 and will conclude in September 2022.

4 Policy Implications

4.1 The issues outlined in this report relate to the integration of health and social care services and the delivery of policy objectives within the IJBs Strategic Plan.

5 Directions

5.1 The report reflects the ongoing work in support of the delivery of the current Directions issued by Midlothian IJB.

6 Equalities Implications

6.1 There are no specific equalities issues arising from this update report.

7 Resource Implications

7.1 There are no direct resource implications arising from this report.

8 Risk

8.1 The key risks associated with the delivery of services and programmes of work are articulated and monitored by managers and, where appropriate, reflected in the risk register.

9 Involving people

9.1 There continues to be ongoing engagement and involvement with key stakeholders across the Partnership to support development and delivery of services.

10 Background Papers

AUTHOR'S NAME	Morag Barrow
DESIGNATION	Chief Officer
CONTACT INFO	0131 271 3402
DATE	29/01/2021

Appendices:

Midlothian Integration Joint Board

Thursday 11th February 2021, 2.00 pm

Outcomes Approach to Performance Management

Item number:	**5.2**

Executive summary

This report outlines a new approach to evaluating outcomes for users and carers. The approach is based upon the premise that many health and social care services, whilst undoubtedly making a difference to people's lives, do not on their own, lead to an improvement in outcomes. Rather, they make a contribution, working together with other services and informal support systems.

Measuring the contribution made by each service is complex and requires a combination of hard data and more qualitative information. The approach now being introduced, involves the development of Outcome Maps at each level of the organisation. A new software programme, *OutNav*, makes it possible to capture and link a wide range of evidence for evaluating progress with each of the stepping-stones in these maps.

An enhanced capacity to measure outcomes is consistent with the approach now being adopted by the inspection agencies. The implementation of this new approach will enable the Partnership to provide, more effectively, the evidence which the Care Inspectorate and Health Care Improvement Scotland will seek during any future inspection.

Board members are asked to:

1. Agree the high priority of this work- allowing for continuing pressures from the pandemic

2. Consider how IJB members can contribute to the development of the high level Outcome Map

3. Comment on the proposed service areas for initial implementation

Report

Outcomes Approach to Performance Management

1 Purpose

1.1 The purpose of this report is to inform the IJB of the main features of a new approach to performance management. The report recognises that it will take some time to roll the approach out across the Partnership. However, the long-term gains in quality assurance will enable the Partnership to be more confident that all its resources are making a positive difference to the health and wellbeing of the people of Midlothian.

2 Recommendations

2.1 As a result of this report Members are asked to:-

a. Reaffirm the high priority of this work- allowing for pressures of the pandemic

b. Consider IJB participation in the development of the high level Outcome Map

c. Comment on the proposed service areas for early implementation

3 Background and main report

3.1 **Outcome-Focussed Services**: For the past 10-12 years, there has been a gradual shift in Health and Social Care towards the delivery of more person-centred and outcome-focussed services. This has been reflected in policies such as *Self-Directed Support* in social care and in *Realistic Medicine* in health care.

3.2 **Contribution Not Attribution**: This shift to outcomes is reflected in areas such as staff training, supervision, service procurement and individual assessment processes. Measuring performance has proven problematic. There has been a growing reliance upon user and carer questionnaires such as the Health and Wellbeing Survey. However, measurement systems that gather evidence of user outcomes at a population level, whilst very important, do not enable individual services to evaluate the impact they are having. This is because outcomes are the result of a wide range of influences. This new approach, outlined in more detail in appendix 1, recognises that for the most part services **contribute** to improved outcomes rather than being the sole factor in bringing about change.

3.3 **New Software**: Identifying and measuring contributions is much more complex than being able to rely on one or two key performance indicators. Matter of Focus have developed software - **OutNav** - that enables a wide range of relevant information to be captured and linked including service user and staff feedback, individual patient stories and performance data such as numbers of people delayed in hospital. A major benefit of this system is that it provides real-time reports across all the

organisation's activities and sources of evidence. Currently this is only the case for quantitative outputs e.g. number of intensive care packages.

3.4 **Work to Date:** Three workshops have been held involving 25-30 staff from the Extended Management Team and the IJB. This has served both to introduce the methodology and to begin the process of outcome mapping. The proposal was then considered and debated at the Strategic Planning Group on 20th January,

There is broad agreement that the starting point has to be a high-level outcome map that outlines what the IJB and the HSCP are seeking to achieve on behalf of the people of Midlothian. The first iteration of this high-level outcome map is available through this **link.** Alongside this, the contract with 'Matter of Focus' allows the introduction of the approach in 2 or 3 service areas. Options identified so far include Frailty, Number 11, Substance Misuse, Intermediate Care and service developments in Learning Disability.

Consistency with Inspection Evaluation Frameworks: The inspection agencies, the Care Inspectorate and Healthcare Improvement Scotland, work together in evaluating the effectiveness of Health and Social Care Partnerships. While the EFQM (European Framework for Quality Management) has continued to provide the structure for such inspections, the impact on Outcomes is increasingly an underpinning critical consideration. Improving Health and Wellbeing Outcomes is the central criterion for judging the effectiveness of HSCPs along with the demonstration that all services are planned and delivered in keeping with:-

Integration Principles https://www.gov.scot/publications/guidance-principles-planning-delivering-integrated-health-social-care/pages/2/

and

Health and Social Care Standards,https://www.gov.scot/publications/health-social-care-standards-support-life/

3.5 **Workforce Implications:** The programme of work will be an ongoing one with an initial focus on the HSCP at a strategic level and in two or three specified service areas. Staff will require training in the methodology and in the use of the OutNav tool. 'Matter of Focus' will provide this training over the coming two years. During this time, we will seek to build internal capacity to continue the rollout of the approach.

4 Policy Implications

4.1 The importance of making a difference to people's lives through integration is a central objective of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act"). It aims to achieve tangible improvements to outcomes for people and to the quality of services across health and social care. By focusing on outcomes, integration aims to maximise the impact of this opportunity to shift the focus of performance improvement onto the achievement of individual personal outcomes for those receiving support and care, and their carers.

4.2 Legislating for national health and wellbeing outcomes (appendix 2) that apply equally across health and social care services in Scotland, under the Act, enables

service users and carers to have a clear understanding of what they can expect in terms of improvements in their health and wellbeing.

5 Directions

5.1 The proposed approach to a stronger focus on outcomes and the application of a more comprehensive performance management system is applicable to all services covered by the Directions.

More specifically, **Direction 23** considers the Health and Social Care Partnership's maturity and includes the commitment to the Outcomes approach:

Work should progress to better capture the impact of the Partnership's integration arrangements on outcomes for local people and on the wider health and social care system by March 2021.

6 Equalities Implications

6.1 There are no direct implication for equalities arising from this report. However, as all our services have the potential to impact positively on health inequalities, there will be considerable benefits to the enhanced capacity of this new approach to evaluate the contributions of individual services to the equality agenda.

7 Resource Implications

7.1 In addition to the cost of the contract with 'Matter of Focus', the system will require the allocation of staff resources on an ongoing basis. However, we would argue that this investment of staff resources will, in time, be offset by a much stronger approach to quality assurance of our health and care services. The process of developing outcome maps and then measuring progress with each step in the pathway will inevitably identify issues which require redesign enabling the pursuit of Best Value

8 Risk

8.1 The risk of continuing with the current arrangements are that our services remain focussed on the achievement of performance that is clearly measurable with hard data e.g. the number of delayed discharges. While such measures remain vital, they do not enable us to evaluate, in a comprehensive way, the outcomes for users and carers.

8.2 The complexity of the health and social care system makes it difficult to assess the contribution of individual services. The approach outlined in this report and described in appendix 1 will enable this assessment to be made in a much more focussed way.

9 Involving people

9.1 The Outcomes approach was fully considered by the Strategic Planning Group on 29th January. Members endorsed the approach as one which will enhance the capacity of the Partnership to continuously monitor and evaluate its effectiveness across all its services.

9.2 The development of outcome maps for each service area will require the inclusion of service-user engagement and feedback

10 Background Papers

10.1 None other than the links to Integration Principles and Health and Social Care Standards referenced in section 3.4.

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DATE	2nd February 2021

Appendix 1:

Outcomes Approach to Performance Management

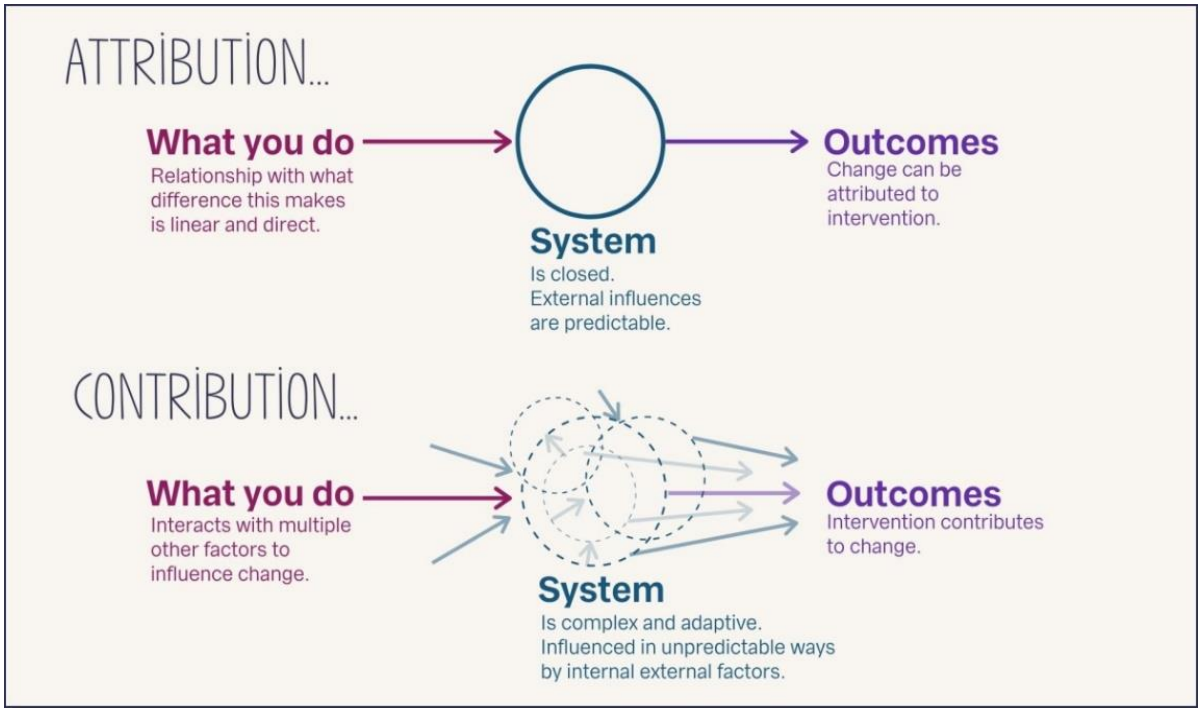
Matter of Focus is delighted to be working with Midlothian HSCP to help strengthen its commitment to outcomes focused working at strategic and service level. The Strategic Planning Group meeting is an important opportunity to outline key features of our approach, and to report on and sense check progress to date and proposed next steps. This paper provides background information and context for the accompanying draft Strategic Outcome Map developed with the HSCP.

Who We Are

Matter of Focus is a mission led company that supports organisations to understand and improve outcomes for the people and communities they care about. We have developed tools and a practical and robust approach to help organisations make better use of their data and evidence and to work meaningfully with the outcomes that matter to them.

The Matter of Focus Approach

The Matter of Focus approach is based on contribution analysis, a theory of change approach that works well for organisations working to deliver complex, people-based change. That is because it acknowledges that that key outcomes are often defined by outside influences and that people-based change is not driven by direct cause and effect.



Our approach, supported by our software OutNav, takes you through a series of processes to understand and 'map' how your activities link to outcomes. The 'Outcome Map' becomes the framework for thinking about the data and evidence you need, tracking and understanding change, and reporting on the difference you make. Our OutNav software supports reporting and enables you to visualise progress and the strength of your evidence using a colour coding system.

Our Work with Midlothian HSCP

Matter of Focus is working with the HSCP to help strengthen outcomes focused working.

At the strategic level

- Develop an Outcome Map to show the contribution of the HSCP to improving outcomes
- Use OutNav software to bring together existing data to track build a robust contribution story and add to this over time
- Identify opportunities to strengthen this data, feeding in evidence from services

At a service level

- Develop Outcome Maps and implement OutNav in two further service areas to test the approach and inform wider roll out
- Support evaluation of the TEC Pathfinder programme

Progress to Date

To date we have conducted a series of workshops with key staff and stakeholders, augmented by a core group meetings and discussions.

Through these workshops, using the Scottish Government's ISM Framework, we first developed a shared understanding of the unique context in which you work and how factors around Midlothian HSCP help and hinder the partnership to improve outcomes for people. This included thinking through assumptions about what will need to be in place for outcomes to be achieved and the potential risks faced, and how to include them in the way you monitor and evaluate progress.

Building on the sharing of success stories from three distinct service areas, we then worked together to understand the outcomes that matter at a strategic level and built consensus about how activities lead to outcomes. This has been brought together in the draft Strategic Outcome Map that shows how the partnership contributes to improving outcomes.

The Outcome Map can be accessed from this link.

Proposed Next Steps

- Share the Outcome Map widely for comment [beginning with this sense checking with the Strategic Planning Group]
- Refine and further develop the Outcome Map in discussion with core staff
- Start reviewing data and evidence against the strategic map (refining as we go)
- Work with 2-3 service areas to develop service level outcome maps (using strategic map as a basis)
- Use OutNav to review data and evidence and draft reports

Appendix 2

National Health and Wellbeing Outcomes

There are nine national health and wellbeing outcomes which apply to integrated health and social care. Health Boards, Local Authorities and the new Integration Authorities will work together to ensure that these outcomes are meaningful to people in their area.

People are able to look after and improve their own health and wellbeing and live in good health for longer.
People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

People who use health and social care services have positive experiences of those services, and have their dignity respected.

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

Health and social care services contribute to reducing health inequalities.

People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.

People who use health and social care services are safe from harm.

People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Resources are used effectively and efficiently in the provision of health and social care services.

Midlothian Health & Social Care Partnership

Thursday 11th February 2021, 2.00 pm

IJB Improvement Goal Progress

Item number:	**5.3**

Executive summary

This report's purpose is to provide a summary of the progress towards achieving the IJB's Improvement Goals.

Board members are asked to:

- Review performance across the indicators
- Note further information is included about current performance in Midlothian using a NHS Lothian data source (appendix 1)

Report

IJB Improvement Goal Progress

1 Purpose

1.1 To share information with the IJB on progress towards achieving the IJB's improvement goals

2 Recommendations

2.1 As a result of this report what are Members being asked to:-

- Review performance across the indicators
- Note further information is included about current performance in Midlothian using a NHS Lothian data source (appendix 1)

3 Background and main report

3.1 The IJB has identified improvement goals to monitor progress implementing the Strategic Plan. The improvement goals focus on reducing unscheduled hospital and institutional care. They are based on goals recommended by the Scottish Government Ministerial Strategic Group for Health and Community Care.

3.2 The IJB has reviewed its improvement goals and endorsed the recommendations from the HSCP to amend the goals. The Improvement Goals reported in this report were agreed by the IJB in February 2019.

3.3 The data used in the main report is provided by the Health and Social Care team at Public Health Scotland. The benefit to using this data source is that the data is validated by ISD and is the primary data source used by most IJBs in Scotland. The data used for in this report was extracted from Version 1.37 of the MSG Integration Indicators provided by ISD Scotland. This was circulated to HSCPs in January 2021. This data source has a lagtime of several months with October 2020 being the most recent data period for some indicators.

3.4 Further information is provided in Appendix One to show weekly performance up to 18th January for ED activity, unscheduled hospital admissions and delayed discharges.

3.6 Summary of Midlothian Performance

- The societal and system response to COVID19 impacted on all the IJB Performance Indicators.
- Unscheduled admissions have returned to a pre-COVID response level (pre-March 2020)
- Unscheduled OBD (Occupied Bed Days) are remaining below the IJB's April 2020 Improvement Goal.
- Mental Health OBD remain below the IJB's April 2020 Improvement Goal
- Emergency Department Attendances remain below the IJB's goal for activity to be below the 2017/18 baseline. The last month when activity was higher than the baseline was January 2020.
- Delayed Discharge OBD remains below the April 2020 Improvement Goal.
- Use of Geriatric Long Stay Services remains above the IJB's improvement goal.

3.7 Unscheduled Admissions into Hospital

3.7.1 The IJB improvement goal is to reduce unscheduled admissions into hospital from Midlothian by 5% by April 2020 compared to the average admissions during 2017/18. Chart 1 provides a summary of the monthly unscheduled admissions. Data from September 2020 is provisional and may be subject to change.

From May 2019 an increase in admission numbers at RIE has been identified following the introduction of ambulatory care facilities at the site, advice has been sought from ISD to ensure that this activity is being appropriately recorded.

Admission data for several months in 2019 included people who have been transferred to an Emergency and Observation Unit in the Royal Infirmary. This unit is intended to reduce emergency admissions into hospital for people but was coded on Hospital TRAK (the hospital's patient record system) as an 'admission' into hospital.

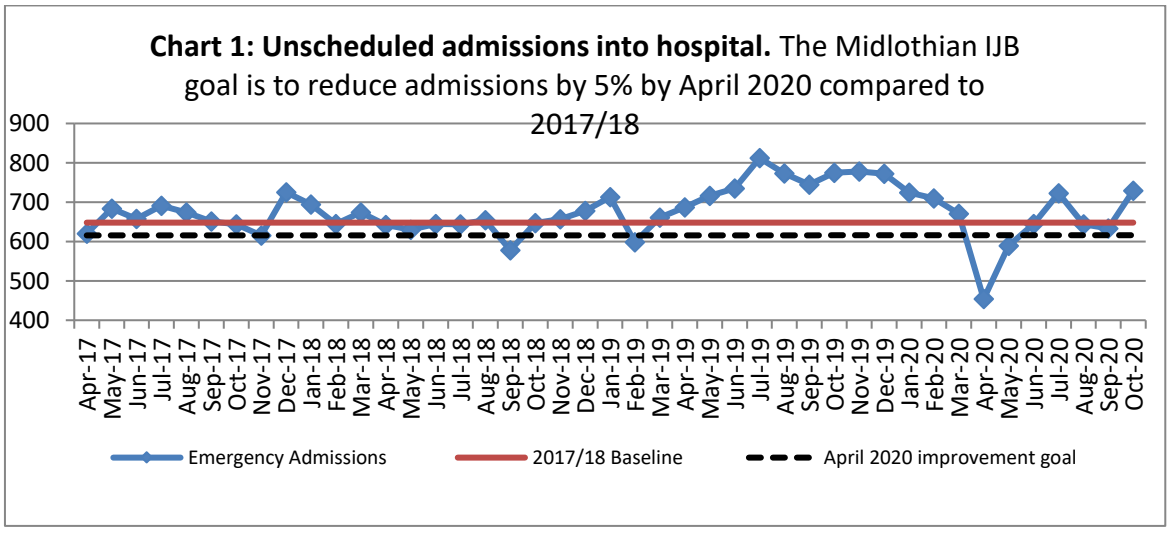
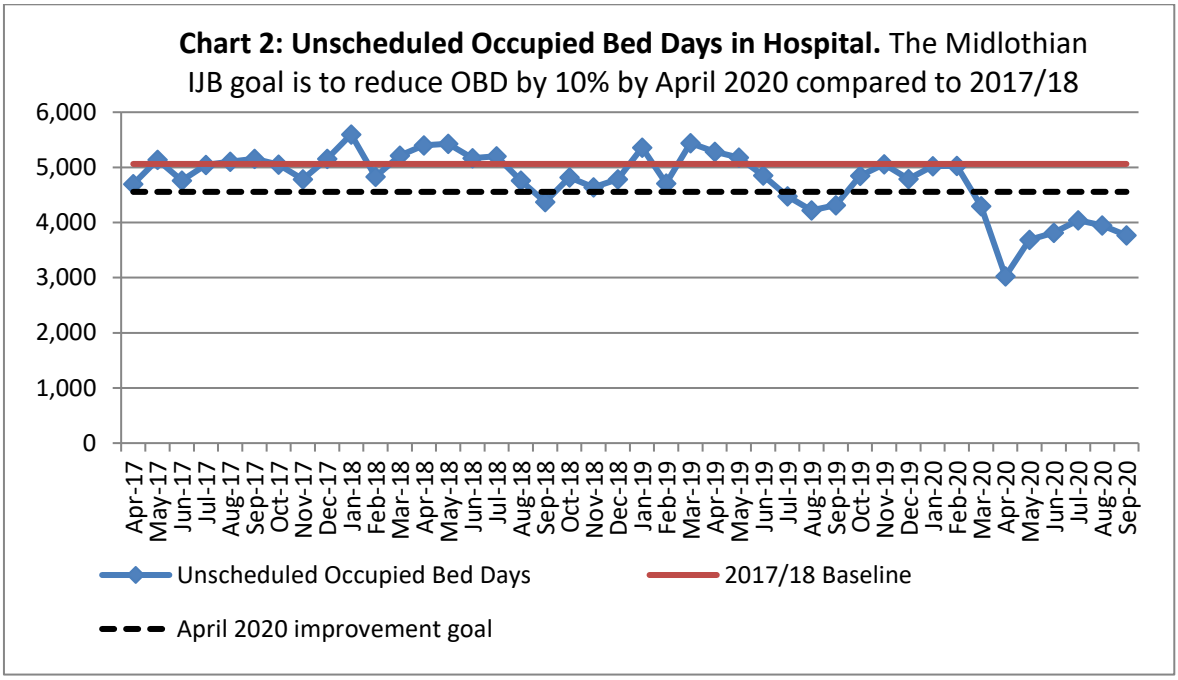


Chart 1: Unscheduled admissions into hospital. The Midlothian IJB goal is to reduce admissions by 5% by April 2020 compared to 2017/18

3.8 Unscheduled Hospital Occupied Bed Days

3.8.1 The IJB expects a reduction of 10% in unscheduled occupied bed days by April 2020 compared to the average OBD during 2017/18. Chart 2 provides a summary of the monthly unscheduled OBD. It is important to note that previous reports to the IJB excluded OBD in Midlothian Community Hospital because during that reporting period it was a strategic intention to increase the use of MCH by people from Midlothian and reduce the use of hospitals outwith Midlothian. That strategic goal has been realised with inpatient services in Liberton Hospital no longer used by people from Midlothian.

3.8.2 The Data from September 2020 is provisional and may be subject to change. The main reason for this is that people may be in hospital who have not been discharged and will not have their OBD included.



Geriatric Long-Stay Occupied Bed Days

3.8.3 To support the goal to reduce OBD by 10% there will be an expected decrease in the use of geriatric long-stay beds by people from Midlothian. Chart 3 provides a summary of use of these types of beds by quarter.

Data from June 2020 has not been formally published by ISD Scotland and may be affected by completeness issues.

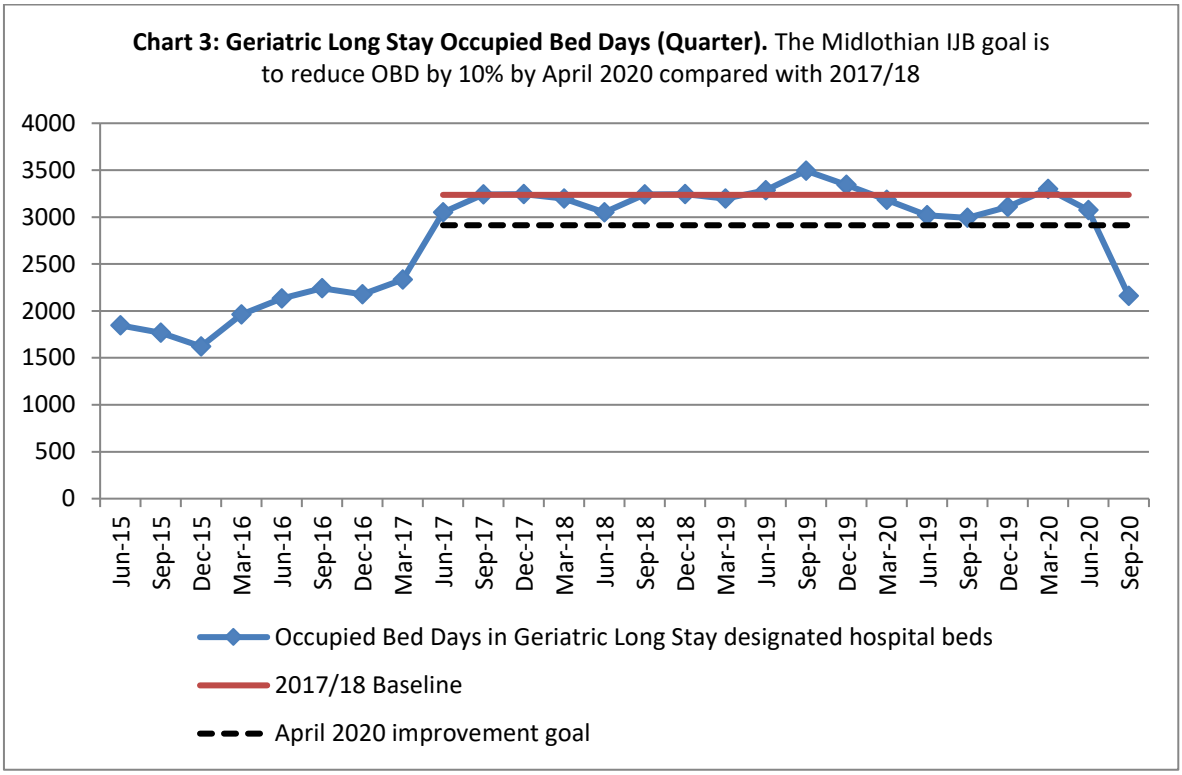


Chart 3: Geriatric Long Stay Occupied Bed Days (Quarter). The Midlothian IJB goal is to reduce OBD by 10% by April 2020 compared with 2017/18

3.9 Mental Health Occupied Bed Days

3.9.1 To support the goal to reduce OBD by 10% there will be an expected decrease in the use of mental health beds by people from Midlothian. Chart 4 provides a summary of use of these types of beds by quarter.

Data from June 2020 has not been formally published by ISD Scotland and may be affected by completeness issues.

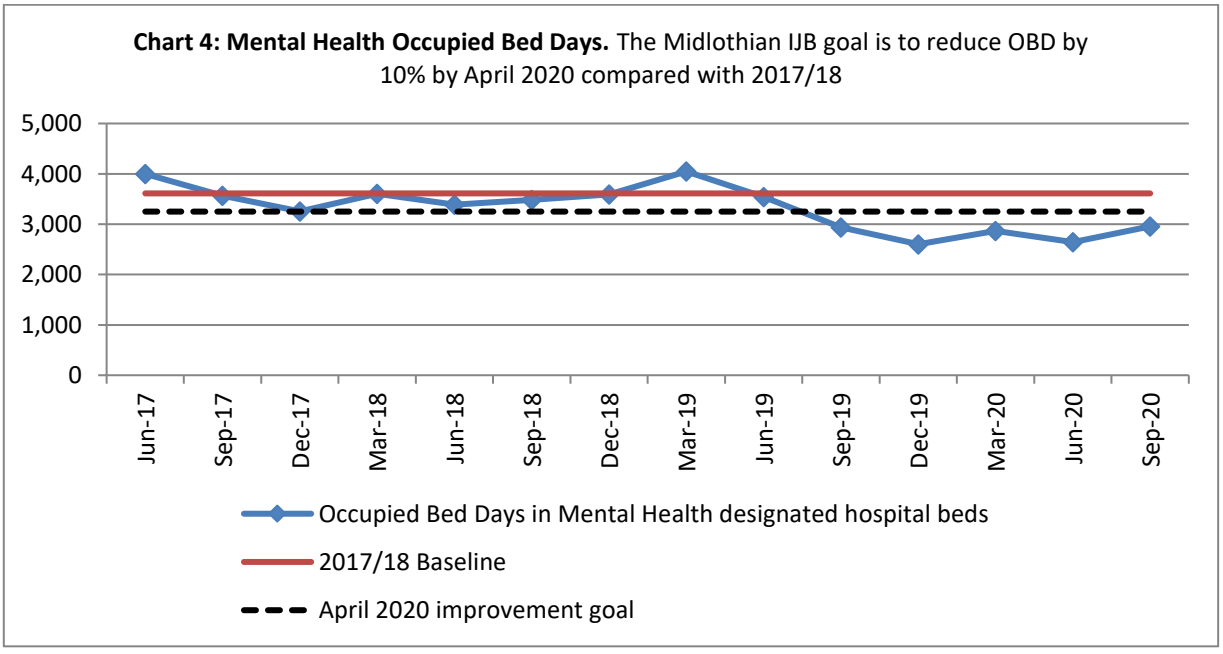
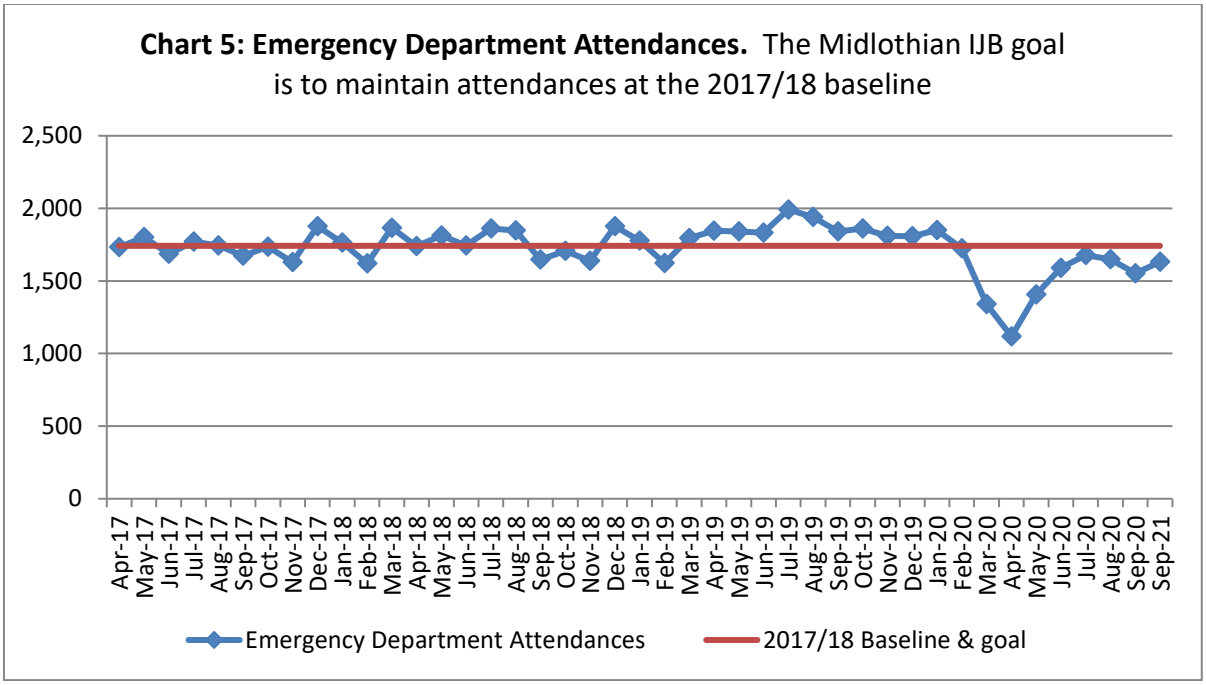


Chart 4: Mental Health Occupied Bed Days. The Midlothian IJB goal is to reduce OBD by 10% by April 2020 compared with 2017/18

3.10 Emergency Department Attendances

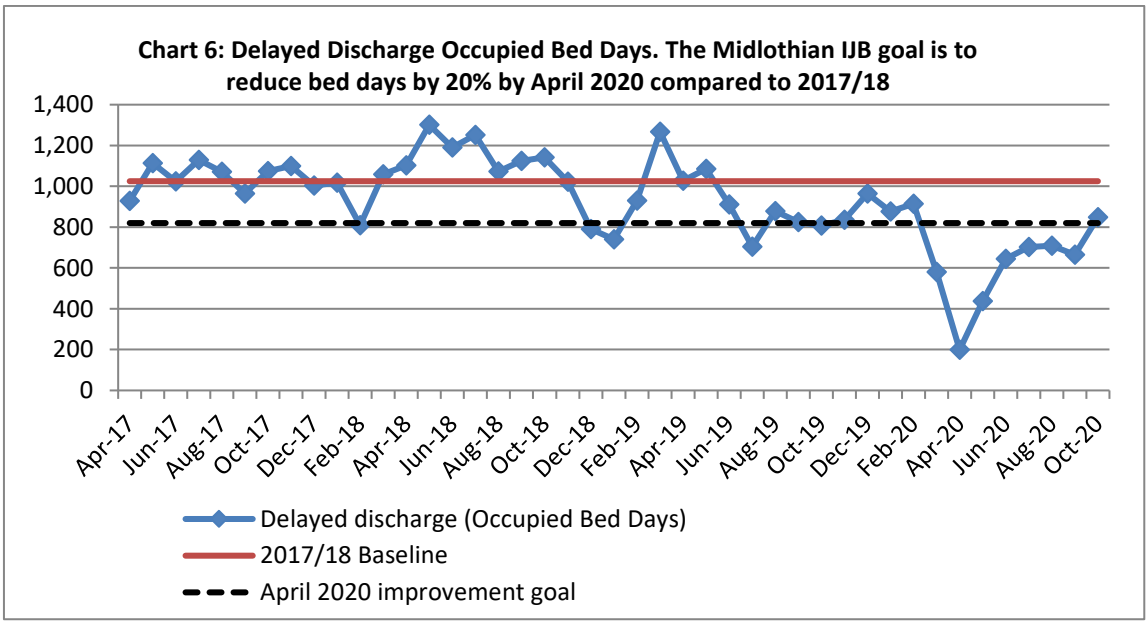
3.10.1 The goal in Midlothian is to maintain ED attendance numbers at the level experienced in 2017/18 because currently the use of ED is increasing year-on-year.

3.10.2 Chart 5 provides a summary of ED activity by people living in Midlothian.



3.11 Occupied Bed Days resulting from a Delayed Discharge from hospital

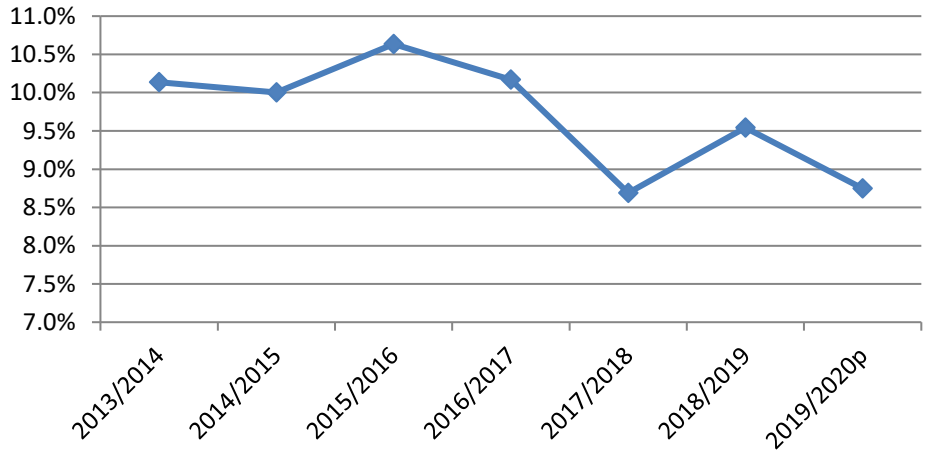
3.11.1 The goal in Midlothian is to reduce OBD as a result of a delayed discharge by 20% compared to performance in 2017/18. Chart 6 shows progress towards this goal.



3.12 End of Life Care

3.12.1 The IJB's ambition is to increase the proportion of time that is spent in their community during a person's last six months of life. To monitor progress the IJB has agreed the improvement goals in Chart 7.

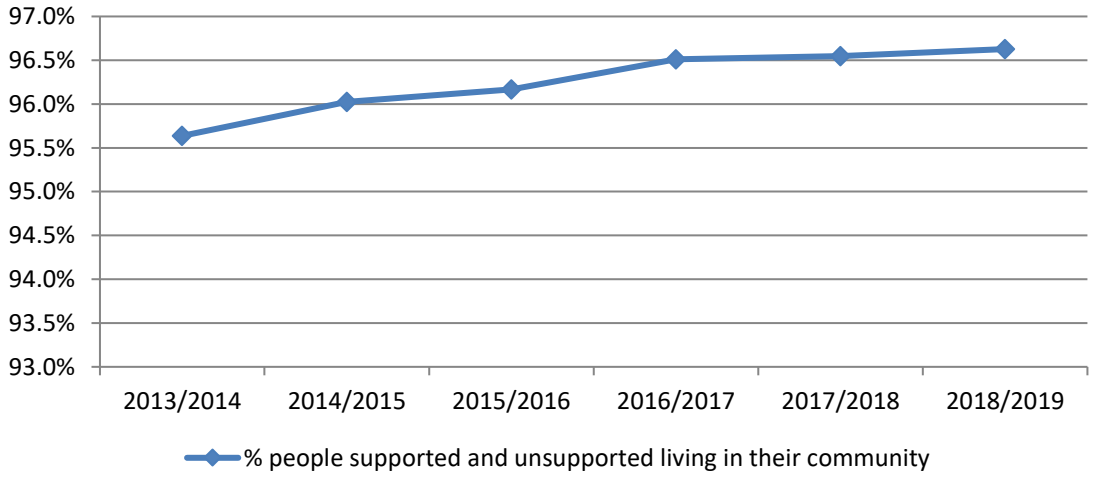
Chart 7: The Midlothian IJB goal is to reduce the pecentage of time people spend in a large hospital in their last six months of life



3.13 Proportion of people over 65 who are living at home (supported and unsupported)

3.13.1 The IJB's ambition is to increase the proportion of people over 65 who are living at home. To monitor progress the IJB has agreed the improvement goals in Chart 8.

Chart 8: The Midlothian IJB goal is to increase the proportion of people over the age of 65 who are living in the community



4 Policy Implications

4.1 Using these improvement goals to monitor change across the system of health and social care will support the implementation of the IJB Strategic Plan.

5 Directions

5.1 There are no implications on the Directions.

6 Equalities Implications

6.1 There are no equality implications from focussing on these goals but there may be implications in the actions that result from work to achieve them.

The focus of most of the goals is on reducing hospital activity and hospitals are not used equally by the population. There are population groups that make more use of hospitals than other groups – for example older people or people living in areas of deprivation.

7 Resource Implications

7.1 There will be resource implications resulting from further action to achieve these improvement goals

8 Risk

8.1 The main risk is that the IJB fails to set a suitable ambitious pace of change across the health and care system to reduce hospital utilisation and respond to the changing demographics

9 Involving people

9.1 The Strategic Planning Group was consulted in 2017 to agree the first set of Local Improvement Goals. The revised improvement goals in this paper were discussed at the April 2019 SPG meeting.

10 Background Papers

10.1 None

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DATE	03/02/2021

Appendices:

Appendix One, Overview of HSPC Hospital Metrics

Appendix One contains data from NHS Lothian Tableau. It's included to provide a more current position on system performance compared to the main body of this report which uses data provided from Public Health Scotland.

The data is presented in Statistical Process Control charts to indicate if variation between months is significant (special cause variation) or not significant (normal cause variation). The colour codes on the chart mean the following:

Green: significant shift in activity or the data is outside the range of expected variation (usually explainable)
Blue: Inside the range of expected variation and not significant.

HOSPITAL FLOW: Overview

This dashboard shows a run chart for each metric. Choose your H&SC partnership from the filter below to see how the run charts look for patients from your area. The run charts are colour coded to show outliers, shifts and trends as defined by run chart protocol. See the Help and definitions tabs for more information on the metrics and how to interpret run charts.

H&SC Partnership
Midlothian

RUN CHART NOTES

A&E ATTENDANCE

PATIENT COUNT BY WEEK OF ATTENDANCE

Week:18 January 2021
Attendances: 388
Shift

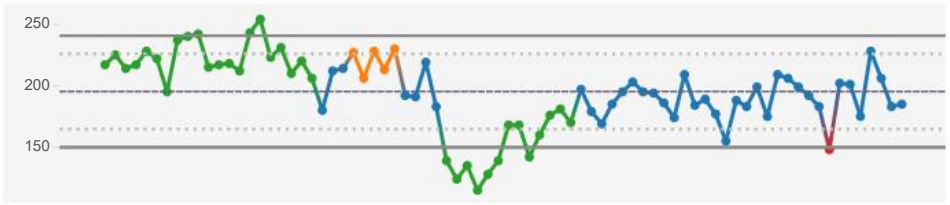
% OF A&E ATTENDANCES MEETING 4HR TARGET

% BY WEEK OF ATTENDANCE

Week: 18 January 2021
4Hour Target: 83.51%
Shift

UNPLANNED ADMISSIONS

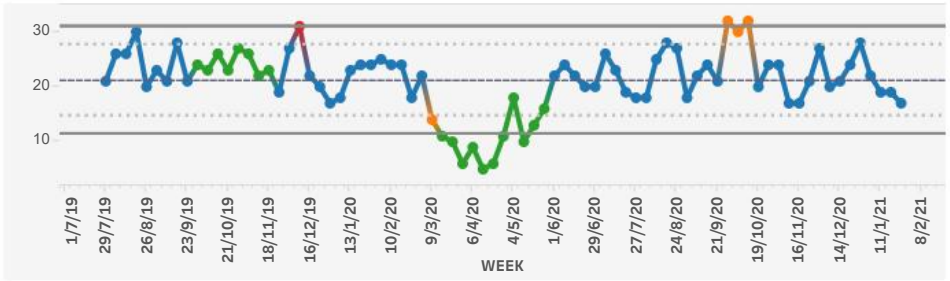
HOSPITAL ADMISSIONS BY WEEK OF ADMISSION



Week: 18 January 2021
Admissions:186
In Range

DELAYED DISCHARGES

DELAYED DISCHARGES BY WEEK OF DELAY



Week: 25 January 2021
Delays: 17
In Range

Thursday 11th February 2021, 2.00 pm

Independent Review of Adult Social Care in Scotland

Item number:	**5.4**

Executive summary

This paper is to share the newly published Review of Adult Social Care in Scotland Review to ensure that board members are aware of the impact of the report and have the opportunity to plan for the impact of the recommendations.

Board members are asked to:

Note the content of the review

Decide how best to plan for the impact of the review

Report

Independent Review of Adult Social Care in Scotland

1 Purpose

1.1 The purpose of this report is to provide an over-view of the Independent Review of Adult Social Care of Scotland.

1.2 To clarify how the IJB would like to consider the implications of the report.

2 Recommendations

2.1 As a result of this report what are Members being asked to:-

2.2 Note the content of the review.

2.3 Decide how best to plan for the impact of the review.

3 Background and main report

3.1 The Review of Adult Social Care in Scotland was announced by the First Minister as part of the Programme for Government on 1 September.

The Review's chair is Derek Feeley, former President of the Institute for Healthcare Improvement and ex-Director General of the NHS in Scotland. An advisory panel has supported him in this role.

Phase one of the review sought the views of people using social care services, staff working in them and social care provider organisations, as well as local authorities, Integration Joint Boards and NHS Boards.

The review is now published and has made recommendations for improvements in outcomes for people using adult social care services, their carers and families and improvements in the experience of people working in adult social care. The review has taken a 'human rights' based approach.

The report contains 53 recommendations over a number of key areas, namely, human rights based approach, unpaid carers, the case for a National Care Service (NCS), NCS – how it should work, a new approach to improving outcomes, models of care, commissioning for common good, Fair Work and Finance.

The report has been submitted to the Scottish Government for consideration.

4 Policy Implications

4.1 There are significant policy implications should all of the recommendations be taken on board and implemented.

5 Directions

This report is not linked to any particular direction however should the recommendations be progressed by the Government then there would be an impact across all of the directions.

6 Equalities Implications

- The review has taken an equalities and human rights based approach. There is no requirement at this point for a local Equalities impact assessment.

7 Resource Implications

There are no direct resource implications as a result of this report however the report recommends changes to the way in which funding for adult social care and Health and Social Care Partnerships is distributed and accounted for.

8 Risk

There are no risks directly associated with this paper, other than failure to plan for the impact should the recommendations of the report be fully implemented.

9 Involving people

The review process has involved large numbers of individuals and the review has links to the consultation evidence that was collected throughout the consultation period.

10 Background Papers

10.1 No papers submitted

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Appendices: Independent Review of Adult Social Care in Scotland

Independent Review of Adult Social Care in Scotland

Foreword

I am grateful to the Cabinet Secretary for Health and Sport for the opportunity to chair this independent review of adult social care support in Scotland. I also want to thank the panel of advisers who guided this work so expertly, our excellent team in the Scottish Government, and most of all the many people, carers and staff who have contributed their experience and insight so generously in the most difficult of times.

A good deal of public attention to social care support has been recently focused on care homes. We make a number of recommendations specific to the care home sector and, at the same time, it is important to recognise that most social care support is delivered in local communities and in people's homes. We want that pattern to continue, and wherever possible, to intensify. The Covid-19 pandemic has tended to focus attention still further on a small part of the system. Of course, there is learning to be had from people's experience during the last year. However, the vast majority of the challenges we are addressing in this review pre-dated Covid-19 and will outlive the pandemic unless we tackle them now. And we know that social care support touches upon the lives of a very wide range of people and settings, so we have taken as inclusive an approach as we can to understanding both the diversity and similarity of their experiences.

The core remit of the review was to "recommend improvements to adult social care in Scotland". The more work we did, the more it seemed like that was the right framing for the review. While we have not undertaken a review of social work, we have considered the key role of social workers, particularly in relation to assessment. I want to be absolutely clear from the outset that there is much about adult social care support in Scotland that is ground-breaking and worthy of celebration. The introduction of self-directed support, the integration of health and social care, and the promise of the Carers Act form the scaffolding upon which to build. When we add to those foundations the commitment and compassion we saw in the workforce, the immense contribution of unpaid carers and the will to improve that we saw across the sector, many of the ingredients for improvement are in place. And of course adult social care support does not stand alone: it has deep, historical and important links to social work, with children's services and the wider public sector.

And yet, the story of adult social care support in Scotland is one of unrealised potential. There is a gap, sometimes a chasm, between the intent of that ground-breaking legislation and the lived experience of people who need support. In the improvement world, there is a maxim which reads something like "every system is perfectly designed to get the results it gets". That is the basic challenge for us. We have inherited a system that gets unwarranted local variation, crisis intervention, a focus on inputs, a reliance on the market, and an undervalued workforce. If we want a different set of results, we need a different system.

"I want to be absolutely clear from the outset that there is much about adult social care support in Scotland that is ground-breaking and worthy of celebration. The introduction of self-directed support, the integration of health and social care, and the promise of the Carers Act form the scaffolding upon which to build."

Foreword

We also need to have an eye to the future. For example, the projected increase in the number of people living with dementia means that we need to start planning now for a future in which people can live well, in their homes wherever possible. The answer to tomorrow's challenges in social care support is not more of the same.

In the chapters that follow, we set out our vision for that new system. We describe how a National Care Service can drive consistent, high quality social care support in partnership with people who have a right to receive that support, unpaid carers and the workforce. We also look carefully at funding and make some recommendations about investing in social care support and ending all non-residential charging for services. To achieve that new system, we need the structural change and the new accountabilities that a National Care Service will bring and we need more. We need a new narrative for adult social care support that replaces crisis with prevention and wellbeing, burden with investment, competition with collaboration and variation with fairness and equity. We need a culture shift that values human rights, lived experience, co-production, mutuality and the common good.

In her Programme for Government speech that launched this review, the First Minister said "this is a time to be bold". The good news is that everyone we spoke to agrees with her. What follows is a plan for how. It will take time. It has taken over 50 years for our current system to form. It will take investment. It will take partnership. But we have an opportunity to create a system of social care support where everyone in Scotland has the opportunity to flourish. If not now, when?

Derek Feeley
February 2021

Contents

Executive summary

At the centre of the remit for this review was a request to recommend improvements to adult social care support in Scotland, primarily in terms of the outcomes achieved by and with people who use services. Having listened carefully, over the last several months, to the voices and the stories of many people with lived experience of social care support, unpaid carers and staff working in the sector we believe that there are three things we must change in order to secure better outcomes. These can be summarised as follows:

1. Shift the paradigm
2. Strengthen the foundations
3. Redesign the system

Shifting the paradigm

We need to start by challenging some of the prevailing narrative about social care support. It has its fair share of challenges, as this report will recognise and tackle, but it need not be unsustainable, or in crisis, or confined to the margins of society. Strong and effective social care support is foundational to the flourishing of everyone in Scotland. It is a good investment in our economy and in our citizens. In order to maximise the potential of social care support we have to change our perspective of what is social care support. We need to shift the paradigm of social care support to one underpinned by a human rights based approach. The table below summarises the changes required which are explored in greater detail throughout our report:

Old Thinking	New Thinking
Social care support is a burden on society	Social care support is an investment
Managing need	Enabling rights and capabilities
Available in a crisis	Preventative and anticipatory
Competition and markets	Collaboration
Transactions	Relationships
A place for services (e.g. a care home)	A vehicle for supporting independent living
Variable	Consistent and fair

Executive summary

Strengthening the Foundations

As we will rehearse in various sections of this report, there are many strengths in the Scottish system of social care support. We need to build on those foundations. We need self-directed support and the Independent Living Fund, and we need integration of health and social care. The challenge here is implementation. How do we bridge the gap between promise and reality? That will require a step change in the capability of the system across the whole country, in the adoption of science based improvement methods, and in the ability of the National Care Service to learn from success and failure – to solve problems when they are identified and to scale-up and spread promising practice much more effectively.

A second foundation that needs nurturing and strengthening is the social care workforce. For us to achieve the improvements we seek, they need to feel engaged, valued and rewarded for the vitally important work that they do. We have not made recommendations about the social work workforce in proposed new arrangements as we believe these will require careful consideration alongside implementation of The Promise the review of children's services, and any changes planned for criminal justice social work.

Third, we need to support and enable unpaid carers to continue to be a cornerstone of social care support. The contribution they make is invaluable. Their commitment and compassion is humbling. We need to provide them with a stronger voice and with the networks, support and respite they need to continue in their vital role.

Redesigning the System

We won't achieve the potential of social care support in Scotland without a new delivery system. We need a National Care Service to achieve the consistency that people deserve, to drive national improvements where they are required, to ensure strategic integration with the National Health Service, to set national standards, terms and conditions, and to bring national oversight and accountability to a vital part of Scotland's social fabric. The National Care Service will bring together everyone with a role to play in planning and providing social care support to achieve a common purpose.

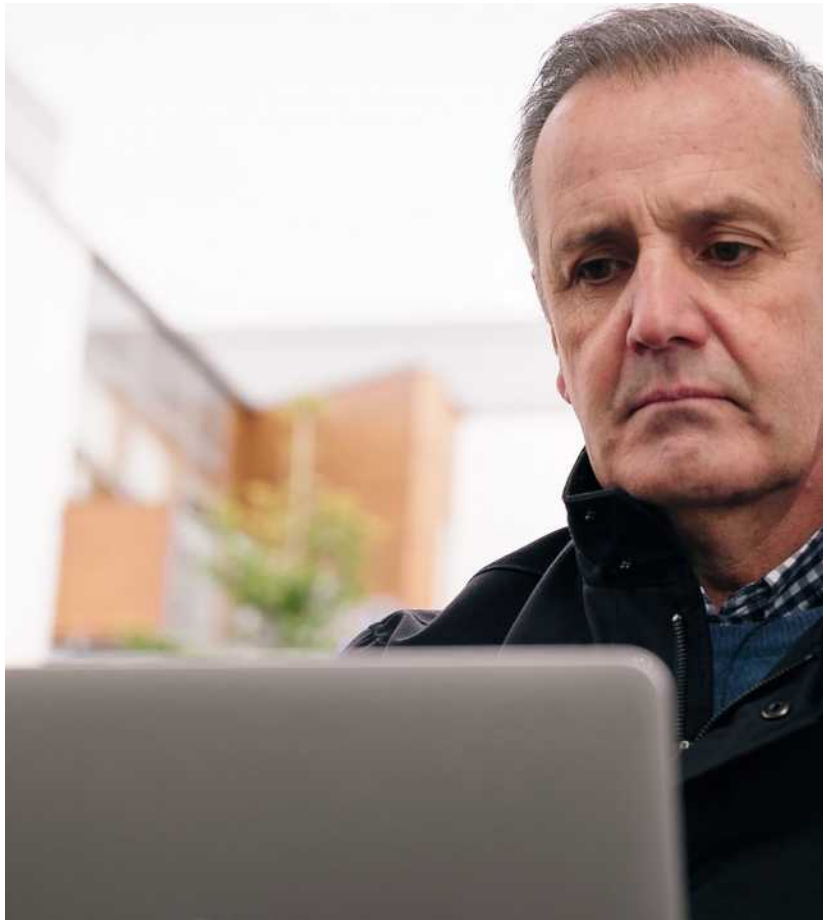
We also need a transformation of the way in which we plan, commission and procure social care support. We need an approach that builds trusting relationships rather than competition. We need to build partnerships not market-places.

Finally, it is vital that we amplify the voice of lived experience at every level in our redesign. We have a duty to co-produce our new system with the people who it is designed to support, both individually and collectively.

Chapter 1
What we heard

What we heard

> "... it should feel nurturing and supportive, rather than a battlefield."



This review is about people's experiences of social care support, whether you use social care services and supports, care for someone who uses them, or work in them. It has been our priority to hear from as many people as possible, to listen to your experiences and to learn from your ideas. To make that happen, we have carried out an engagement programme focused on three kinds of activity:

- **Open enquiry – From September to November 2020, individuals and organisations could submit views, papers and evidence to the review.**
- **Stakeholder engagement events – From September to November 2020, stakeholder engagement events were held with the support of the Health and Social Care Alliance Scotland (The ALLIANCE[1]). Each event had a particular focus such as learning disabilities, physical disabilities, mental health and dementia, addictions and the experience of carers.**
- **Meetings with key stakeholder groups and organisations – From September 2020 to January 2021, the Chair of the review, members of the advisory panel and members of the review Secretariat attended meetings to hear from key stakeholder groups and organisations, and from people who work in social care support services.**

The quotes you will find at the start of each chapter in this report are from individuals and organisations who participated in our programme of engagement, and who have lived experience of either using social care supports, or working in social care services.

Our programme of engagement, most of which took place online, resulted in:

228
Written submissions

13
Engagement events

128
Meetings with stakeholders

1 Home Page – Health and Social Care Alliance Scotland (alliance-scotland.org.uk)

What we heard

In total, we met over a thousand people in just a few months, and we are grateful to you all for your time, insights and wisdom.

This review was commissioned by Scottish Ministers in response to the experience so far of Covid-19, and we of course heard about people's experience of care during the pandemic.

We heard some positive experiences of the sector's response to Covid-19, including how quickly providers adapted to new and very difficult circumstances and a heightened public awareness, in time, of the vital work of the sector. Some people who work in social care support mentioned to us that during the pandemic they have been able to make decisions more quickly, to good effect. Inevitably, we heard of many negative experiences too: people who had been affected by the impact of the pandemic on care home residents and staff, people whose community-based supports had been reduced or entirely stopped, pressures on carers and providers and the impact on people's physical and mental wellbeing.

However, this is not "just" a review of social care during Covid-19 and all that we have learned from it. It takes into account all the different types of support and care that are provided in a range of settings, including residential settings such as care homes and in people's own homes, and it covers care and support for a broad range of people with long-term conditions, older people, people with physical disabilities, people with learning disabilities, people with mental health problems, people with addictions, and people with experience of the criminal justice system. This review covers all of these life circumstances, and takes account of people's experiences over many years.

Because our remit is so broad, it was vitally important that we listened to people's experience of the full spectrum of adult social care services and supports. We have summarised the key themes we heard below. You can read a full report on the engagement events here: Independent Review of Adult Social Care – Engagement report.

> "Service design and delivery can only improve if people with lived experience are involved in the process. It is impossible to address inequality if the people who experience it are not in the room."

What we heard

Key Themes

Access, eligibility and assessment

People told us about the transformative impact that "good" social care services and supports can have – and in many cases have had – on their lives and the lives of people they love. We heard about the dedication and responsiveness of people in the workforce; about self-directed support enabling people to "live a real life"; about integrated health and social care support services that work together well, jointly focusing on the wellbeing of the person using care; and about carers being supported to carry on caring for loved ones.

But we also heard a lot of frustration about the existing structure and design of social care. People feel that the term itself – social care – is too often used negatively, to mean services that are for people only when in crisis, that just prevent or delay a deteriorating situation, or are a buffer to absorb pressure that would otherwise fall upon the NHS. People told us that social care support should instead be understood as an asset that provides constructive, optimistic support to help people achieve their goals and desired outcomes: to live their best lives and maximise their wellbeing, as equal citizens.

We heard that our current system too often does not feel like a system at all: it feels like a guddle, and that causes people worry and anxiety. For people with care and support needs and their families the challenges of accessing support, only to find they are unavailable or unaffordable, or those seeking support are ineligible, causes unnecessary suffering and hardship. This is not a humane response to people living with disability or ill health, or who are simply getting older and are no longer able to live their lives without some support. For family members it means having to take on heavy responsibilities for caring. Some try to juggle this alongside work, but many give up, putting themselves into a precarious financial position. For staff it can lead to burnout, with the constant stress of having to respond to crises, and the feeling that whatever you do it is not enough.

People described the process of accessing social care as 'notoriously difficult', 'over-complicated' and 'bureaucratic'. When experiences had been negative, people told us that they had to 'fight for' and 'justify' their right for support. We heard that accessing social care is sometimes too difficult right from the start, with an inadequate referral process and not enough information available about supports, including peer support.

What we heard

Eligibility criteria were described as one of the main barriers to accessing social care.

People also told us that the threshold for accessing support is too high, and too often meaningful support is only available when people are acutely unwell or in crisis[2] [3]. We heard about the negative impact this has on the mental and physical wellbeing of people using social care support, their carers and the workforce.

We heard that the assessment process is too often based on a medical model focused on deficits – the things people cannot do – with little or no account taken of holistic and social needs; that it is too complex and takes too long; and once it is completed it takes too long before support is available. Some people with complex needs, including neurological conditions and sensory impairments, told us that their experience of assessment was that not all social workers had enough training in their functional difficulties.

In order to improve, people told us that social care needs to focus on holistic wellbeing and personal outcomes, rather than outputs and money. It should be flexible so that it can adapt to changing needs and wishes. It should take account of wider supports in a person's life, such as the support of carers and local services offered by community organisations to enable people to fulfil their potential, goals and outcomes, without reducing appropriate formal supports and shifting a burden of care onto families and informal networks. Assessment should be simplified and based upon collaborative engagement with the person's needs, rights and preferences at the centre.

Structure and design of services

We heard that recent changes across health and social care have produced improvements, especially in some parts of the country, but there is much more to be done. People told us that Integration Joint Boards have had benefits in terms of health and social care support services working together better locally, but in many instances people need to be much more directly involved in planning their own care, and in decisions about local priorities.

We heard that national and local services need to work together better, that transitions between children's and adult's services must improve, and so should joint working with other services such as transport, housing, education and employment.

People told us how frustrating they found it to be asked to repeat the same information to several different professionals when better data sharing arrangements would remove the need.

We were told consistently that Scotland needs to shift its attitude towards technology and data sharing to improve people's experience of social care. Technological solutions should of course never be "forced" on people as a substitute for other kinds of care, but experience during the pandemic has highlighted that, for some people, technology can really help people to live independently in their own communities and to feel less lonely.

2 https://www.centreforwelfarereform.org/uploads/attachment/655/an-emancipatory-welfare-state.pdf
3 https://discovery.dundee.ac.uk/ws/portalfiles/portal/34825382/insights_49.pdf

What we heard

Technology is not a replacement for support provided by another person but it can play a much bigger role in improving the lives of people who use social care services and supports. It can also help with people's ownership of their care and support, particularly when people "own" their own data or information that is about them and share it with the people who support them.

Planning, commissioning and procurement

Many people told us that Scotland has 'good strategies but poor implementation'. This 'implementation gap' was often referred to in terms of the differences between what is set out in legislation and guidance and what actually happens on the ground. We were also told about places and local teams that are good at follow-through from intention to service delivery, but with a sense that where that was people's experience it was partly because they were 'lucky'. More generally, people described current planning, commissioning and procurement processes as 'discredited', with poor outcomes for people who use services and for the workforce. Some people felt that Integration Joint Boards had made some improvements on this but a significant number of people we spoke to had serious concerns. Currently, Integration Joint Boards do not have responsibility for procurement or contracts.

We heard that the market approach to commissioning and procurement produces 'competition, not collaboration', which, in turn, leads to too much focus on costs rather than high quality, person-centred care and support. We were repeatedly told that this focus on costs causes poor terms and conditions, including pay, for the workforce.

People spoke to us about 'short-termism' resulting in providers spending significant time and resources applying and reapplying for contracts. This results in uncertainty for providers and the workforce, which makes it difficult to attract and retain staff. Providers cannot afford to have staff 'waiting in the wings for contracts to come along'. We also heard that commissioning using generic frameworks based on hourly rates does not work well for people with fluctuating needs for support, particularly where those relate to mental health.

Just as with individual care planning, people told us that local communities and third sector organisations should be more involved in collaborative approaches to planning, commissioning and procuring social care support services. Where people felt that they had had a good experience of using self-directed support they often also described good collaboration between organisations, communities and individuals in the design and delivery of care and support.

And we heard repeatedly that simpler and more accessible arrangements to challenge decisions – without recourse to the Courts – need to be established.

We refer to commissioning and procurement practices throughout this report, and Chapter 9 is dedicated to the subject. These are fairly technical terms and it may be helpful to explain what we are referring to at the start. Commissioning is the process by which public bodies strategically plan ahead for the services they will provide, either directly or by procurement, to meet their populations' needs, using the budgets at their disposal. Procurement is the process of contracting for (purchasing) specific services on the basis of that commissioning activity. It is important to note that not all commissioning activity results in procurement and that commissioning decisions and priorities should form the basis of any procurement process – never the other way around.

What we heard

Most models of commissioning emphasise its cyclical nature, with strategic commissioning providing the context for procurement and contracting. The cycle is sequential and each part is of equal importance. A key principle of the commissioning process is that it should be equitable and transparent, and therefore open to influence from all stakeholders via an on-going dialogue with people who use services, unpaid carers and providers. Outcomes for people are at the centre of the model, which is commonly illustrated in the diagram shown here (originally developed by the Institute of Public Care at Oxford Brookes University).

This diagram of course does not take account of our proposals for ethical and collaborative commissioning. It could usefully be updated to reflect those as work progresses.

What we heard

Workforce

Despite challenging circumstances, we heard repeatedly that the social care workforce are 'motivated', 'resilient', 'adaptable' and 'proud of their work'. However, a range of serious concerns were raised.

People told us they are worried about 'casualisation' of the largely female social care support workforce, which is both undervalued and underpaid as a result, despite their essential work to improve people's lives and wellbeing, and support their independence, every day.

We frequently heard that people 'could earn more working in a supermarket', and people also spoke to us about a lack of support and training opportunities with sometimes serious consequences for people who use services. This need to improve the skillset of the workforce was reported to us in various ways. People with complex needs or sensory impairments told us they could not get appropriate support. We heard about assessments being inadequate because assessors do not have sufficient training to understand people's circumstances. People told us that sometimes the full range of options available under self-directed support are not adequately explained. And employers told us that the lack of training and career development opportunities makes it difficult to attract and retain staff, which makes it difficult to establish rapport and trust between people who use social care support and their carers. At the same time, it was brought home to us many times that social care support is highly skilled and that many people in the workforce are very experienced. The fact that people who work in social care are undervalued and underpaid in no way correlates either with their skillset or importance to society.

Some people had specific ideas for how to improve the experience of the workforce, such as a national campaign to promote the value of social care support and help make it a more attractive career choice; a minimum wage for social care workers, with some suggesting £15 per hour; implementation of the Fair Work principles to improve workers' working conditions; peer support and supervision; and a more consistent approach to providing high quality training for staff.

Unpaid Carers

Unpaid carers were very clear with us that they want to care, and care well. But like the workforce, they told us that they are simultaneously undervalued by society and given 'all the responsibility without the support, resources or recognition'. We heard that carers are often unaware of their rights and the support available to them. Accessing support, whether for respite services or advice, was often described as 'complex', 'time consuming' and 'frustrating'.

Carers told us that respite is not always recognised as essential support. Without respite, some carers are 'on the job' 24 hours a day, which is unsustainable, unfair and limits their own life opportunities. Sometimes, we were told, inappropriate respite is offered, such as taking cared-for people into unsuitable care homes.

We also heard many carers reflect on the gender issue that also applies to the paid workforce. Many unpaid carers are women, and they told us they are often overlooked and disregarded.

What we heard

Registration, regulation and inspection

We heard mixed views on current arrangements for regulation and inspection of social care support services. Some good examples were described to us of meaningful dialogue and engagement with the Care Inspectorate, illustrated with observations like inspections being based on dialogue and improvement. On the other hand, we heard that too much attention is paid to procedural and process issues and not enough to individuals' experience of care and how social care connects people with their communities.

People told us that there is a clear accountability gap between national and local levels, and that there is not meaningful joint inspection of health and social care support services. We also heard that there is significant duplication in the information requested from services by the Care Inspectorate and local commissioners, which wastes time that could be better used to improve quality. Many people emphasised the need for much more support for locally driven improvement work to raise standards of care. Where members of the workforce had taken part in local improvement work, they expressed pride and satisfaction in the progress made, and they wanted to do more of it.

On registration, regulation and support for the workforce, we heard that the Scottish Social Services Council is not equipped or resourced to support effective training and development of staff. We listened to general observations that the workforce too often feel policed rather than supported as a consequence of current registration arrangements. We also heard particular concerns about the absence of support for, and regulation of, personal assistants, and failure to extend training opportunities for the paid workforce to unpaid carers.

Equality

Equality – and inequality – were raised with us again and again.

Some people who use social care services and supports told us that they are expected to pay to access their human rights: to carry out normal day-to-day activities such as washing and getting dressed, and going to work.

We heard about gender unfairness, as before; that the needs, rights and preferences of people from minority ethnic communities are often overlooked; that communication support for people with sensory impairments and learning disabilities is often inadequate; and that the stigma sometimes attached to accessing supports for mental health problems, addictions and criminal justice issues should be addressed.

We also heard that advocacy arrangements need to be improved, so that people with incapacity and others who are accessing supports and services have their needs, rights and preferences properly represented.

What we heard

National Care Service

Many people asked what would be meant by a National Care Service, which the First Minister mentioned when she announced this review in the Programme for Government[4]. In response we asked the people we were talking to what they thought such an idea should and should not mean.

There was a wide variety of views about what a National Care Service should represent. Points mentioned frequently included: social care services should not be run for profit as a matter of principle – different rules should not apply to social care support compared with the NHS; charges, if any, should be fairer and the same in different Local Authority areas; assessments and care packages should be portable between Local Authority areas; and the workforce should be better supported with effective planning, training and support arrangements consistently managed at national level. We asked what would worry people about a National Care Service, and the most frequently mentioned concern was that it would bring loss of local knowledge and expertise. Many people said they thought a better mix of national and local responsibilities and activities was needed.

Having listened carefully to the experiences, views and ideas so generously shared with us, we have set out our proposals for reforming adult social care in Scotland in the remainder of this report.

4 Programme for Government – gov.scot (www.gov.scot)

What we heard

> “Those who need support to live fully and to navigate the real-world barriers they face should be able to ask for that support without guilt or the endless need to justify themselves.”

Susan McKinstery

I think the public don’t realise, that when you depend on care services for your most fundamental rights and needs, that can put you in a very precarious position. The fact that services can be taken away by someone who often doesn’t know you or understand the complexity of your situation is such a violation.

You are made to feel guilty for asking for help and you have it driven home to you that resources are limited and there are people with greater needs than yours. The result of this is that you are given the sense that by accepting support, you are taking resources away from someone more deserving. Nobody should be made to feel like that. We need a system based on rights and aspirations of individuals and one which is adequately funded and structured in a way which allows these to be upheld. Those who need support to live fully and to navigate the real-world barriers they face should be able to ask for that support without guilt or the endless need to justify themselves. Care itself shouldn’t be yet another barrier.

Ultimately, I believe we need more people with lived experience of social care in positions of power and influence. Those of us who have experience of the system from this perspective know the importance of not only involving people in decisions which affect their lives but, importantly, believing them as experts in their own needs. As the saying goes, nothing about us without us.

Chapter 2
The purpose of social care

The purpose of social care

> Social Care should be a springboard not a safety net."

Looking back at the history of failed adult social care reforms, the debate has all too often started and ended with funding. We have tried not to make the same mistakes. We will talk about funding in this report but only once we have described our statement of purpose for social care support in Scotland, our design of a system to deliver on that vision, and the values and relationships that will be required to make improvement happen.

There have been multiple helpful attempts to articulate a shared vision or ambition for social care.[5][6][7][8]

We suggest the following as a definition:

Everyone in Scotland will get the social care support they need to live their lives as they choose and to be active citizens. We will all work together to promote and ensure human rights, wellbeing, independent living and equity.

We have been absolutely determined to describe the purpose from the point of view of people who receive or may benefit from social care support. That is why we have drawn heavily from previous articulations of vision and ambition. And, of course, the incredible input that we received as we conducted our engagement meetings has also been vital here. We have also used the term social care support throughout the report to reinforce that the person directs the system to support them – not the other way around.

Why start with purpose? To improve social care support, we must change systems and processes, but first we must change hearts and minds. A common purpose unites and helps to ensure that the right things are done well. It is the basis of continuous improvement in any system. It is difficult to conceive of a successful national scale improvement effort that did not have a unifying purpose.

5 Social care – gov.scot (www.gov.scot)
6 Social care: Reforming adult social care support – gov.scot (www.gov.scot)
7 Health and Social Care Standards: my support, my life – gov.scot (www.gov.scot)
8 Health and Social Care Standards: my support, my life – gov.scot (www.gov.scot)

The purpose of social care

In addition, the purpose needs to drive a set of changes that will lead to people being able to live their lives to their full potential. We might see those changes as follows:

- **A new narrative for social care support;**
- **A redesign of the system of social care support (including the creation of a National Care Service);**
- **Redefining quality and closing the gap between intent and lived experience (the implementation gap);**
- **Protecting, promoting and ensuring human rights and equality;**
- **Greater empowerment of people who need support and unpaid carers at the level of the individual and the collective; and**
- **Valuing of the social care support workforce.**

Giving effect to any stated purpose of social care support requires us to create the right conditions for change. When we examine successful improvement efforts at large scale, the purpose is 'hard-wired' into the design of the delivery system. The purpose needs to provide a direction for the securing of long-term results. It needs to guide our shared understanding of rights and needs. It needs to inform the planning and stewardship of resources in the system, and it needs to influence culture, behaviours and values.

A new narrative for social care support

Frederick Seebohm, in his landmark 1968 report[9], said that social care should enable 'the greatest possible number of individuals to act reciprocally, giving and receiving service for the well-being of the whole community'. Social care support is the means to an end, not an end in itself. The end is human rights, wellbeing, independent living and equity, as well as people in communities and society who care for each other. However, more recently the default narrative about social care support is too often one of crisis, unsustainability, providing for the vulnerable, staff shortages and underfunding and occasionally even harm. It's time to change that.

In our engagement sessions, there was a debate about independent living as an outcome. Independent living means people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means having rights to practical assistance and support to participate in society and live a full life. This is the definition of independent living adopted over many years in the strategic approach to independent living, by the Scottish Government, COSLA, the NHS and the Disabled People's Independent Living Movement.

9 Report of the Committee on Local Authority and Allied Personal Social Services The Seebohm Report HMSO(1968)

The purpose of social care

Giving effect to the narrative requires some shifts in mindset. First, we need to shift from seeing the funding of social care support as a burden to be borne to seeing it as an investment in society and the economy. Second, we need a shift away from crisis being the entry point to the system of social care support to a system that values prevention and early intervention. Third, we need to see people who need some support for their assets, their experience, and their potential rather than as passive recipients of a service.

We will set out elsewhere in this report the strong economic case for investing in social care support. It is a good investment of public funds. It is also the right thing to do. In setting out Scotland's purpose in the National Performance Framework[10], the Scottish Government sets out five tests, to:

- **Create a more successful country;**
- **Give opportunities to all people living in Scotland;**
- **Increase the wellbeing of people living in Scotland;**
- **Create sustainable and inclusive growth; and**
- **Reduce inequalities and give equal importance to economic, environmental and social progress.**

Investing in social care support helps us to achieve every one of these.

Redesigning the system

There is a maxim in improvement science that 'every system is perfectly designed to get the results it gets'. The real point being made is that if you want different results, you need a different system. There are some good things upon which to build the new system. For example, if we did not have self-directed support, we would need to introduce it. If we did not have integration of health and social care, we would need to create it. However, to fully meet the needs, rights and preferences of people, we need some re-design too.

Further details about the proposed new system are in Chapter 6. In summary, the key design principles that have guided our thinking are not dissimilar to those first set out in the work of the Christie Commission back in 2011[11]. The Commission set out four pillars of public service reform that should be kept in mind when developing plans for public services:

- **A decisive shift towards prevention;**
- **Greater integration of public services at a local level driven by better partnerships, collaboration and effective local delivery;**
- **Greater investment in the people who deliver services through enhanced workforce development and effective leadership; and**
- **A sharp focus on improving performance through greater transparency, innovation and use of digital technology.**

10 National Performance Framework | National Performance Framework
11 Christie Commission on the future delivery of public services – gov.scot (www.gov.scot)

The purpose of social care

To the Christie principles, we would add:

- **A stronger voice for the person requiring support and their advocates;**
- **A means to learn and improve across the country;**
- **A sharp focus on equity, equalities and human rights;**
- **Fairness and consistency in relation to access, eligibility and outcomes; and**
- **Transparency and accountability.**

In order to ensure that prevention, investment in people, learning, fairness and accountability are driven by national strategy and national partnership, we need a National Care Service. To get different results, we need a different system.

Quality and the Implementation Gap

This is one of the immediate priorities for any National Care Service. At present we have no national infrastructure and no national approach for delivering on the good intent of world leading policies such as those relating to self-directed support. In this report, we have identified three areas where we can begin to create the capacity and capability required for social care support in Scotland to make breakthroughs in performance.

In order to make progress, we will need to be clear about our improvement aims, we will need to build the collective will to improve, and we will need to engage people with lived experience in generating ideas for change.

Empowering people

Throughout the report, we stress the importance of partnership and collaboration, and of amplifying the voice of staff and of people who need social care support. That is true at every level and in every part of the system.

At the individual level, self-directed support must be scaled-up to achieve its full potential across social care support, including at transition points from children's services.

At the population level, Integration Joint Boards and locality planners need to do a better job of building the user voice into their considerations. People with lived experience must be partners in the commissioning process and integral to decision-making and prioritisation, monitoring progress and making improvements; nothing about me, without me, as the saying goes.

And at the system level, we strongly recommend the involvement of people with lived experience in the governance of the National Care Service, including positions on the Board (see Chapter 6). We also recommend that unpaid carers should be similarly recognised. They already have a non-voting seat around the Integration Joint Board table, but they should be full partners and also involved at the Board level of the National Care Service.

> Understanding of the role of social care starts from its visibility within an integrated health and social care landscape, including ensuring the social care voice is present and heard within IJBs."

Valuing the workforce

A welcome thread throughout our work has been unanimous support for the idea that a top priority for investment is the social care workforce. People who access social care support, advocacy groups, disabled persons organisations, and trade unions have all put forward compelling arguments for a national approach to workforce issues and for social care staff to be fully (and more generously) recognised and rewarded for the vital work they do. We make some recommendations in Chapter 10 about how this might be done, building on the strong foundations of the Fair Work Convention[12].

A Human Rights based approach

We believe we cannot improve social care support and people's health and wellbeing if we do not ensure their human rights are upheld. A human rights based approach has been central to the creation of the report and we believe that it needs to be central to its implementation. We set out proposals for strengthening the ability of individuals to vocalise and secure their rights in Chapter 3. We outline areas where duty bearers – organisations and professionals – need to enhance their capability to recognise and enable the fulfilment of human rights.

Human rights are described extensively in international law. Important examples for this review include freedom from torture and inhumane or degrading treatment, the right to liberty and security, and respect for your private and family life. We recognise that not all rights are absolute, that they can be overruled in certain circumstances, and that practitioners are frequently required to balance competing rights.

We are aware of work underway to consider the incorporation of human rights conventions within Scots law. Whilst we do not wish to anticipate the outcome of that expert analysis, everything we have heard during our discussions suggests that there would be a warm welcome for any approach that brought clarity and certainty to the importance of human rights, not just for social care support but across civic life. We have no doubt that the incorporation of human rights conventions would aid the direction of travel set out in this report.

12 The Fair Work Convention

The purpose of social care

We also recognise that the Taskforce for Human Rights Leadership is considering options for resolution and redress where required. Without anticipating the specific recommendations of the Taskforce on this, we welcome the attention being paid to this critical topic and agree that progress is a key priority.

A new social covenant

One key factor in the realisation of the above is the need for mutual commitment by citizens, representative bodies, providers, civic Scotland, and national government to set aside self-interest and each work together for the common good. Trust is not currently in plentiful supply in social care support and so we believe that there is a need for an explicit social covenant to which all parties would sign up. This will be particularly important if we want to achieve our aspiration for everyone in Scotland to get the social care support they need to live their lives as they choose and to be active citizens.

In their 2014 report, the World Economic Forum describes a social covenant as a vehicle for giving effect to a common set of values and beliefs:

- **The dignity of the human person, whatever their race, gender, background or beliefs;**
- **The importance of a common good that transcends individual interests; and**
- **The need for stewardship – a concern not just for ourselves but for posterity.**

Together, these offer a powerful, unifying ideal: valued individuals, committed to one another, and respectful of future generations. Fostering these values, which we believe would serve Scotland well as guiding principles for improving social care support, is both a personal and a collective challenge. We must do more than just talk about them; we must bring them into public life and use them to guide decision-making.

Chapter 3
A human rights based approach

A human rights based approach

> It shouldn't be a fight to get the support I need, nor a fight to keep the support I have."

Respect for the fundamental dignity of each and every person lies at the heart of human rights, as do the principles of equality and individual autonomy. The Covid-19 pandemic has intensified pre-existing inequalities and a lack of focus on rights, especially for older people, disabled people, people from minority ethnic communities and people from disadvantaged communities. This underlines our belief that more attention must to be paid not only to recognising but to realising human rights, equality and participation for people using social care support.

In summer 2020, the Scottish Human Rights Commission (SHRC) carried out monitoring research into the impact of the Covid-19 pandemic, and how it has been managed, on people's rights in the context of care at home and support in the community. SHRC published its report in October 2020[13]. It details how legislative, policy and practice decisions taken by public authorities have affected the rights of people who access, or wish to access social care support, unpaid carers, and people who work in social care support. The report makes 24 recommendations, some of which call for urgent action to resolve immediate human rights concerns.

Similarly, the Equality and Human Rights Commission (EHRC) published a report in December 2020[14] about its findings on the impact of the pandemic on equality and highlighted the diminution that many people using social care support have experienced. In addition, the Glasgow Disability Alliance[15] and Inclusion Scotland[16] undertook surveys of disabled people to understand and put on record their experiences of the pandemic.

13 COVID-19, Social Care and Human Rights Monitoring Report (scottishhumanrights.com)
14 Equality in residential care in Scotland during coronavirus (COVID-19) | Equality and Human Rights Commission (equalityhumanrights.com)
15 https://gda.scot/what-we-do-at-gda/resources/publications/supercharged-a-human-catastrophe-inequalities-participation-and-human-rights-before-during-and-beyond-covid19
16 https://inclusionscotland.org/covid-19-evidence-survey/

A human rights based approach

Strengthening the rights of citizens

We asked people about respect for their rights when using social care services and supports in recent years as well as during the pandemic. People told us about their experiences over a much longer timeframe, and in many cases over very many years.

We heard a few examples of where human rights had been put at the core of services and supports and where staff and supported people alike felt valued and their rights upheld. We also listened to positive experiences where people were managing their own budget and had put in place the support they wanted, and that was helping them to lead fulfilling lives in their local communities. However, we heard from many people that their human rights were not being upheld and that equality was not at all obvious, nor was there a focus on supporting and ensuring individual autonomy and participation in decision making.

Access to social care services and supports presented particular challenges for many people and there was not clear understanding about what their rights to social care and support were. These rights must be made more transparent by "duty bearers". Where rights are not upheld people must understand the means by which they can complain or seek redress and this must not be so cumbersome as to make that an impossible process for people to embark upon. They must also be provided with appropriate support in this process.

The assessment process was difficult for many and was variously described as intrusive, not focused on rights or equality, not focused on assets or potential but on deficits, reduced to identifying care tasks, and always overly focused on eligibility, which was frequently set at "critical needs", and costs. Most damningly, one person summed up her experience of the assessment process as "brutal".

Charging for services and supports that had been assessed as needed also presented major issues for many people, as this reduced their income and had a real impact on their choices, limiting their options and control about what they wanted to do with support in place. Charging is considered in more detail in Chapter 11 on finances.

Decision making, participation and self-directed support

Many people did not feel they had the opportunity to be a partner in the decision making process about their care and support, and nor did their unpaid carers or families. Some people felt totally unprepared for the assessment process and had not had all of the options for self-directed support set out, explained or offered. A network of support and brokerage services is in place in parts of Scotland that can help people prepare for assessment, including identifying what goals or outcomes people want to achieve with support. This has been crucial in highlighting the choices and possibilities people have across the self-directed support options but it is not available to everyone and not everyone who would benefit from this support knows about it.

There is also not enough local independent advocacy (either individual or collective) available to people to support them in this process, nor to ensure that support plans are a co-produced effort involving other people whom the supported person wishes to involve, including families and carers. A recent ALLIANCE and Self-Directed Support Scotland report[17] identified that around 50% of people had not had access to all of the self-directed support options. Independent advocacy should also be available assist people when things do not go well and they wish to complain or to seek redress.

17 My Support My Choice: People's Experiences of Self-directed Support and Social Care in Scotland- National Report, October 2020 (alliance-scotland.org.uk)

The purpose of social care

> Start listening to disabled people. We are the solution, we're not the problem."

Kiana Kalantar-Hormozi

I've had a traumatic experience trying to get the support hours I need to live independently, stay healthy and have a full life like everyone else.

I can't live fully independently because of the piecemeal support package I have. My arm movement is limited, I'm at risk of choking and need support to shower, turn in my bed at night and do all my breathing and other exercises that I have to do to keep healthy. So, the support I don't have impacts directly on my health, social, work and family life.

To move my arms and legs, go to the bathroom, take a shower and exercise when I choose; those things are fundamental rights for me to be able to live independently.

I want everything in the system to change. The funding allocated to facilitate someone's human rights and independence is an extension of healthcare.

Start listening to disabled people. We are the solution, we're not the problem. If you give people what they need to have a full and healthy life, that in turn has benefits to society as a whole. I think we need to stop thinking that disabled people are supposed to be patronised or locked up in their homes.

A human rights based approach

Some supported people had taken part in "good conversations" about their assets and strengths, together with the assets of their local communities, and what would help them to lead a fulfilling life, rather than being assessed for all that was wrong, and had been part of joint decision making about their support plan. However, this could then be hampered by having to go through a bureaucratic process of approval, that they were not part of, leading to changes in the plan because it could not be delivered within costs or provided in the way planned.

People told us how important it was to them to be involved in decisions about their life and to be supported to do so, when required. We were pleased to hear about the work underway on developing supported decision making for people who lack capacity, who beyond most have experienced all decision making being made by others on their behalf, based on their past wishes and preferences but ultimately with a proxy making those decisions for them. People want to be regarded and treated as experts on their own needs and preferences, and the extent to which they wish to be active citizens, participating in life and in their local communities in the way they want.

Many people told us that they do not want to be treated as passive recipients of services that are provided. They want social work professionals to work with them to help plan how support will assist them in achieving their own goals, aspirations and personal outcomes, not to limit possibilities from the outset because of budgets or to plan without them the services and support that can be made available. An effective relationship, based on trust and mutual regard between the social worker and the supported person, and whoever they wish to involve in the assessment, is absolutely key to planning support.

The lack of portability of support packages and plans between different local authority areas is a further issue that serves to diminish people's rights and self-determinism. The whole process of assessment and decision making has to be repeated if a supported person moves home or residence from one local authority area to another. While everyone understands that the range of services and supports available in the larger conurbations in the central belt cannot be replicated in full in more rural or remote communities, it is unnecessary and unfair for previous assessment and support plans to be stopped and entirely new ones developed, often after much delay and at great distress to individuals. The result is wasteful with much unnecessary duplication of effort by professional staff.

Prevention and extending eligibility

As a result of access to social care support being based on eligibility, where the starting point means that you have to be in critical need and at crisis point in your life, it is little wonder that there is a lack of focus on prevention and early intervention, and few resources targeted at providing a little support to prevent the crises from occurring in the first place. This needs urgent attention and priority, and is picked up later in the report.

Social workers and their representative organisations told us about their frustrations with this process, which put social workers in the position of gatekeeping budgets on behalf of cash-strapped Local Authorities, and prioritising cost and eligibility considerations above working with people to plan their support and to ensure access to high quality support. As one social worker put it to us: It's the equivalent of NHS staff having to make a case for funding every time someone needs a blood test.

> "It's the equivalent of NHS staff having to make a case for funding every time someone needs a blood test."

A human rights based approach

Taskforce for Human Rights Leadership

Taking a human rights approach is about using the comprehensive set of international human rights established and adopted worldwide. The Scottish Government has established a Taskforce for Human Rights Leadership[18], jointly chaired by the Cabinet Secretary for Social Security and Older People, and Professor Alan Miller. Professor Miller was previously the Chair of the First Minister's Advisory Group on Human Rights Leadership and we have ensured that close links have been forged between these key pieces of work.

The Taskforce, which is due to report in March 2021, is considering the incorporation of international treaties and conventions on human rights into Scots law, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW), Convention on the Rights of Persons with Disabilities (CRPD), and the International Convention on the Elimination of All Forms of Racial Discrimination (CERD). As well as this, the Taskforce is considering how to better support delivery of these rights and is looking at a range of additional support that would be required to underpin incorporation of these rights into Scots law, with which we have a great deal of agreement:

- **Practical steps to build the capacity of those delivering public services, including workforce development and training.**
- **Accountability, including regulations, standards, audit measuring and ensuring capacity to take a human rights based approach towards their work.**
- **Rapid access to justice and redress and in the instance of systemic failure with potential for particular bodies to undertake this on behalf of individuals.**
- **Strengthening the role of rights holders through public education and the provision of support through independent advocacy, more status to third sector agencies who can articulate the rights of rights holders, allocation of resources, equality impact assessments etc., and based on international law and remedies.**

> We no longer have a life outside full time work and our family home resembles a care home. Our bills have trebled and quality of life decreased – disappeared in fact."

18 National Taskforce for Human Rights Leadership – gov.scot (www.gov.scot)

A human rights based approach

Recommendations

Our recommendations for establishing a human rights and equality approach to social care services and support are rooted in the work to consider incorporation of international treaties into domestic legislation, and the recent experiences during the pandemic that exposed structural inequalities and pre-existing inadequacies in the current social care support system:

1. Human rights, equity and equality must be placed at the very heart of social care and be mainstreamed and embedded. This could be further enabled by the incorporation of human rights conventions.
2. Delivering a rights based system in practice must become consistent, intentional and evident in the everyday experience of everyone using social care support, unpaid carers and families, and people working in the social care support and social work sector.
3. People must be able to access support at the point they feel they need it, including for advice and signposting to local community-based resources and help, and for barriers to this, such as the current eligibility criteria and charging regime, to be fundamentally reformed and removed, to allow a greater emphasis on prevention and early intervention.
4. People should understand better what their rights are to social care and supports, and "duty bearers", primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.
5. Where not all needs can be met that have been identified as part of a co-production process of developing a support plan, these must be recorded as unmet needs and fed into the strategic commissioning process.
6. Informal, community based services and supports must be encouraged, supported and funded to respond appropriately to the needs of local citizens, including for preventative and low level support.
7. A co-production and supportive process involving good conversations with people needing support should replace assessment processes that make decisions over people's heads and must enable a full exploration of all self-directed support options that does not start from the basis of available funding. Giving people as much choice and control over their support and care is critical.
8. More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.
9. When things do not work well for people and their rights have not been upheld, they must have rapid recourse to an effective complaints system and to redress.
10. Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.

Chapter 4
Unpaid Carers

Unpaid Carers

> We are preventing a tsunami of need from overwhelming public services. That comes with costs to us, to our families."

Caring is normal. 60% of us will be carers at some point in our lives, supporting family members, friends or neighbours who are affected by disability, physical or mental ill-health or who may just need some support. A carer does not need to be living with the person they care for and can be any age: very young, very old and anything in between. Around 4% of the population aged 4-18, i.e. 29,000 children and young people, are carers. Around 15% of the adult population, i.e. 661,000 people aged over 18, are carers.

The Scotland's Carers research report[19] estimates that the number of carers in Scotland fluctuates, with about 700,000 people currently providing unpaid care[20]. The value of unpaid care in Scotland is estimated at over £36 billion a year. For comparison, in 2019 the NHS Scotland budget was £13.4 billion.

Unpaid carers in Scotland represent a larger workforce than the paid health and social care support workforces combined. The people we spoke to acknowledged that Scotland recognises the contribution of unpaid carers in a number of ways[21].

Nevertheless, a survey carried out by the Coalition of Carers in Scotland in 2019 reported that only 16% of carers knew what the Carers (Scotland) Act 2016 was and the rights it provides; 33% had heard of it but didn't know what it was about; 51% had never heard of it. We heard from many carers during the review that much needs to be done to better support and sustain carers in their caring roles.

We heard that unpaid carers are often best placed to understand the needs, rights and preferences of the person they support. It is also important that we record what we heard about the toll unpaid care, however willingly given, can have on its giver. Deciding to provide care should be a positive decision on the part of the giver. When someone is being assessed for social care support, the role of the carer should be determined by them and not assumed by the assessor. Carers and carers organisations told us about personal sacrifices made by thousands of carers, and the impact caring without decent breaks can have on their physical, psychological and mental wellbeing.

19 Scotland's Carers – gov.scot (www.gov.scot)
20 https://www2.gov.scot/Resource/0054/00548776.pdf
21 https://www.gov.scot/policies/social-care/unpaid-carers/

Unpaid Carers

Unpaid carers are integral to good care, so it is important that we recognise the value they bring and ensure they are included as equal partners in the team of people who together plan and provide support and care. The phrase 'nothing about me without me' should apply equally to people who use services and their unpaid carers.

Over half of the respondents to the Coalition of Carers survey were not aware of any of their rights, including their right to a carer's assessment[22], and advised that pre March 2020 they had still not had an assessment. The subsequent introduction of Covid-19 emergency legislation has meant that many Local Authorities have suspended carer's assessments. In the same timeframe, a recent survey by Carers Scotland showed that most respondents have taken on more care since March, and that 77% are exhausted and worn out.

Carers need more support. Many asked for the same things that people who use social care services and supports asked for as discussed in Chapter 3: greater consistency between Local Authority areas in terms of provision; clarity on the application of eligibility criteria; better involvement in, and transparency about, decisions regarding support; better data on support provided to carers and unmet need.

Many carers give up work to care, and it was also suggested that consideration of the carer's access to employment should be a routine part of assessment for support. Carers should not be prevented from working, or indeed studying or having social connections of their own, because of their caring role. Yet we heard that many people are prevented from working because of their caring responsibilities, and about the impact this can have on household income that is not addressed by the Carer's Allowance. We reflect further on this in Chapter 11 on finance. Some carers told us about their need for support to get back into employment and education – and indeed into social activities – after a period of caring, which can be difficult and daunting.

> "Carers feel invisible, that they are just left to "get on with it" and that no one cares or appreciates them.... now is the time to act and make carers count, treated as equal partners in care with professionals."

> "Loneliness is such an integral part of caring. I no longer have a husband. I care for him."

22 https://www.carersnet.org/wp-content/uploads/2019/01/Awareness-of-the-Carers-Act-January-2019.pdf

Unpaid Carers

Access to respite came up repeatedly as a priority. Carers need to be able to take a break and respite should be viewed as integral to carer support. However, a greater range and more imaginative options should be developed for both the supported person and unpaid carers to better meet needs and preferences.

When carers are unable to access their rights, including their right through the Carers Act to have their eligible needs met, they are unable to challenge effectively. We heard that the complaints system is inadequate and legal recourse is not a viable option for most people. As well as an improved complaints process, and greater transparency about decision making processes, we were frequently told that more, easily accessible information is needed for carers.

In appropriate circumstances, there is also a need for the carer's assessment to be undertaken alongside that of the supported person, to ensure that the support provided helps to support their relationship, is jointly agreed and helps to deliver choice and control, especially in family relationships.

Unpaid Carers

> There is also very little accountability in the current system and this inevitably results in unpaid carers and the people that they care for, feeling powerless."

Shubhanna Hussain-Ahmed

In Scotland we are fortunate to have some really great pieces of legislation such as the Carers Act and the Social Care (Self-Directed Support) Act. This has given unpaid carers in Scotland some key rights to access support, as well as greater choice and control over how care and support for themselves and the people that they are caring for should be met. However, many of these great policy intentions are very rarely implemented in the way that they were intended or in the 'spirit of the Act'. There is also very little accountability in the current system and this inevitably results in unpaid carers and the people that they care for, feeling powerless about decisions made about their lives, and less likely to seek support for themselves or their families. It feels pointless introducing new legislation or policies, if we are going to continually fail to implement them.

The current social care system also prides itself on being person-centred. However, once again, we see very little evidence of this in practice. A person-centred approach would acknowledge that unpaid carers are not a homogenous group; we come from all ages, from different cultural and ethnic backgrounds, and with very different caring experiences. Each of us have our own needs, desires, and aspirations, and these cannot be addressed by a one-size-fits-all service.

When we think about what the future of social care should look like, we need to begin by viewing social care as a right, and not as a service or industry. Social care shouldn't be limited to only those who can afford it or to those who are in crisis; it should be available to anyone who has support needs to be able to reach their full potential and to ultimately have the same life opportunities as anyone else.

Recommendations

Our recommendations for creating a National Care Service provide a mechanism for better representation of carers in local planning, commissioning and procurement of services. To ensure the contribution of carers is properly recognised and supported, we recommend:

11. Carers need better, more consistent support to carry out their caring role well and to take a break from caring with regular access to quality respite provision. Carers should be given a right to respite with an amendment to the Carers Act as required, and a range of options for respite and short breaks should be developed.
12. A new National Care Service should prioritise improved information and advice for carers, and an improved complaints process. It should take a human rights based approach to the support of carers.
13. Local assessment of carers' needs must, in common with assessment of the needs of people using social care support services and supports, better involve the person themselves in planning support.
14. Carers must be represented as full partners on the Integration Joint Boards and on the Board of the National Care Service.

Chapter 5
The case for a national care service (NCS)

The case for a National Care Service (NCS)

> We need a system that is controlled nationally, that delivers locally, has the person at the centre, that does not cost the earth"

The Terms of Reference for this review make no reference to a National Care Service, although the First Minister in her Programme for Government announcement set out her ambitions to build out of the Covid-19 pandemic a social care legacy equal in stature and impact to the creation of the National Health Service after World War 2:

> ". . . the pandemic has reminded us of the vital importance of social care services, and of the extraordinary professionalism, dedication and compassion of those who work in that sector. However, it has also underlined the need for improvement and reform. I can therefore announce today the immediate establishment of a comprehensive independent review of adult social care. The review will seek the views of those with direct experience of adult social care, and make recommendations for immediate improvements. However, more fundamentally, it will examine and set out options for the creation of a National Care Service. . . The quality of adult social care is something that matters deeply to us all. This is a moment to be bold and to build a service fit for the future. The National Health Service was born out of the tragedy of World War 2. Let us resolve that we will build out of this COVID crisis, the lasting and positive legacy of a high quality, National Care Service for all who need it."
>
> Nicola Sturgeon MSP, First Minister
>
> 1 September 2020[23]

During the engagement phase of our review many people asked what a National Care Service would consist of, how it would be organised and who would pay for it. When we asked people for their suggestions, many different ideas were shared. Some people were strongly in favour, others strongly opposed, and others were not sure without more details.

The pandemic has demonstrated clearly that the Scottish public *expect* national accountability for adult social care support and look to Scottish Ministers to provide that accountability. Statutory responsibility for care homes sits with Local Authorities and individual providers. However, it was clear during the pandemic there was an expectation that Scottish Ministers should be held to account, which makes sense from a public health perspective. We therefore recommend the establishment of a National Care Service – that brings together all adult social care support delivered in Scotland.

23 Programme for Government 2020-2021: First Minister's speech 1 September 2020 – gov.scot (www.gov.scot)

The case for a National Care Service (NCS)

We recognise that Ministers do not currently hold the levers that would enable them to manage the social care support services for which they are held to account. We nevertheless think the expectation of Ministerial accountability is reasonable, in light of adult social care support's impact on people's wellbeing, its deep links to and mutual dependency with the National Health Service, and the scale of public funding for it.

We also recognise that Local Authorities have a key statutory role to play in supporting public wellbeing that is wider than provision of social care support, extending to for instance housing, transport and, leisure and recreation. We believe that, by establishing national accountability for adult social care, the Scottish Government can work with local systems to address systemic problems evident in our current arrangements while at the same time developing, maintaining and enriching key links to other Local Authority services. We envisage an important and continuing role for Local Authorities as public providers of social work and social care services, and as partners in Integration Joint Boards, where they will continue to work with their NHS partners and others to meet local needs and steward health and social care resources.

A National Care Service must ensure that people have equity of access to social care supports, and experience a similarly high quality of care, wherever they live in Scotland. Where there is variation in the kinds of care provided in different parts of the country, that should be a positive response to differences in geography, local assets and local priorities. There should not be inexplicable or un-evidenced variation in care that diminishes or harms people's life experiences. There should be a consistent, national focus on preventative, early intervention and anticipatory forms of support that shift the emphasis, and experience of care, away from crisis intervention and towards better quality of life. Lower level needs should not be left unattended until they become a bigger problem, they should be addressed to avoid the bigger problem occurring.

As identified in Chapter 3, care and support should be portable. When someone has been assessed for care in one part of the country they should be able to move to another area and take their entitlement to social care support with them. The current situation, which requires people to be re-assessed for support in their new home, impinges directly on their rights to lead a socially engaged, full and active life, and is wasteful and bureaucratic.

> "The changes which are required are national, we should therefore deal with the social care service in a national way just like our NHS"

The case for a National Care Service (NCS)

Some aspects of adult social care support need new and modified arrangements at national level to support the progress required.

New provision should be made for learning and improvement programmes for social work and social care, to support quality, improvement, consistency, professionalism and to work directly with equivalent provision in the NHS. There is a pressing need for a national infrastructure to scale-up and spread promising local practice as well as to deal consistently with common challenges. These arrangements must focus on the skillsets specific to social work and social care support and links to equivalent developments of the health workforce. The Scottish Social Services Council (SSSC) and NHS National Education Services Scotland (NHS NES) linking effectively to Scottish Universities and Colleges, should be part of the new arrangements and must work much more closely together to build upon each other's strengths. Neither organisation is currently fully equipped to provide the scale and range of support required to improve the quality of social care support or deliver effective integration.

Provision should also be made at national level for support for people whose needs are very complex or highly specialist. This will provide people with greater levels of support and allow for the cost to be absorbed nationally. The Independent Living Fund Scotland should form part of the suite of services supported at national rather than local level and become part of the National Care Service. We consider in Chapter 11 whether the Independent Living Fund should be reopened with additional investment.

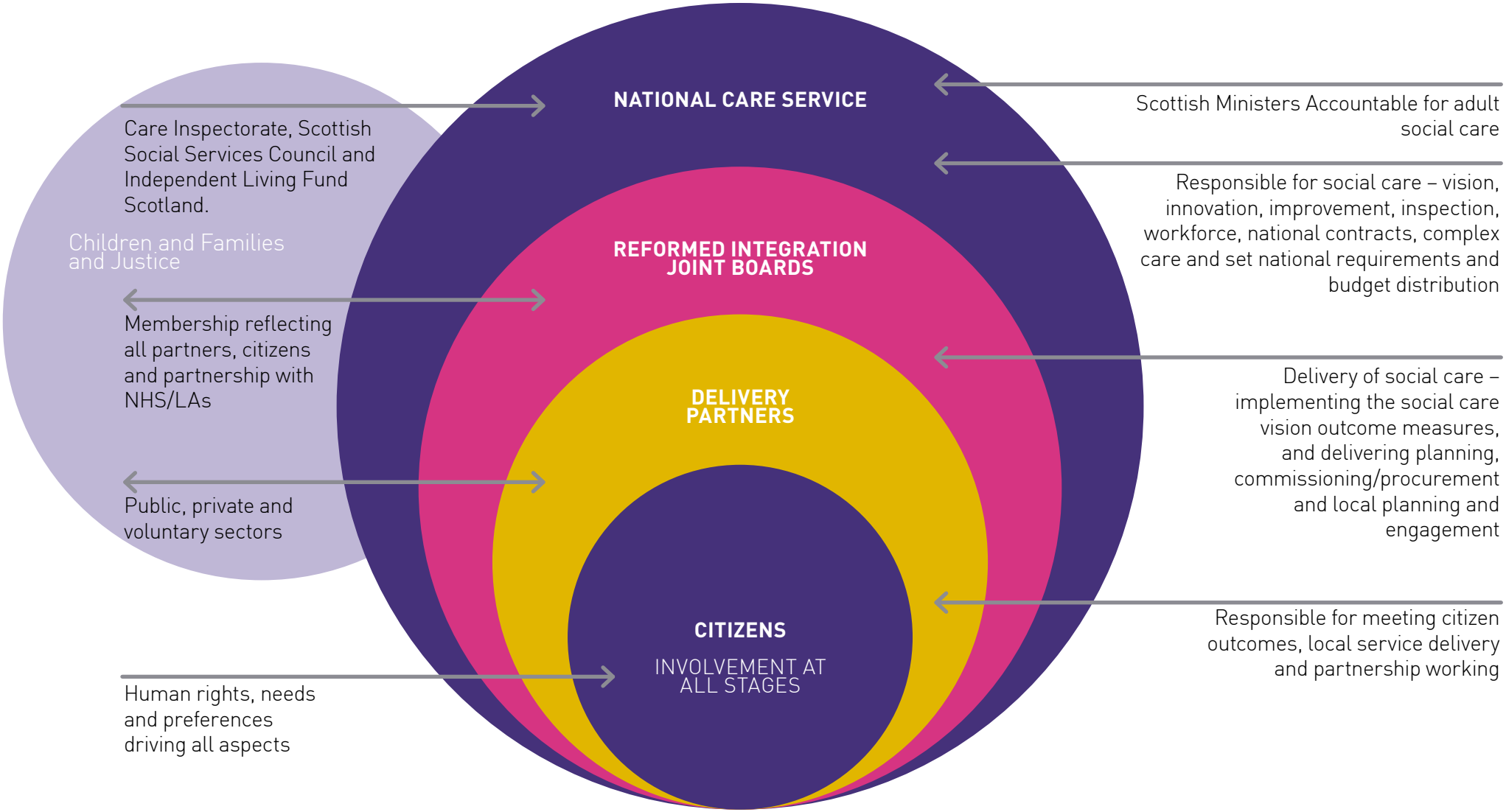
Consideration should also be given to supporting social care in prisons and other custodial settings as part of the national service rather than through local arrangements.

We believe that the problems outlined above can only be dealt with by a National Care Service that drives forward improvement and requires certain common standards and rights based approaches across Scotland. We therefore recommend that the accountability of Scottish Ministers for adult social care support should be legally established to put beyond doubt that overall responsibility sits with the Scottish Government. This will mean that Local Authorities are no longer legally accountable for adult social care support. Of course, as key partners in Integration Joint Boards, they will continue to influence and direct resources to meet identified local needs and they will provide social care support and professional social work services.

We also recommend that, recognising this shift in responsibility, a Minister for Social Care should be appointed.

Statutory responsibility for adult social care support should be set out in law along similar lines to those already established for health services, to establish parity of esteem and clarify mutual dependencies between health and social care support, and to establish equity in terms of reporting arrangements. We recommend the creation of a National Care Service via which Ministers are empowered to discharge their responsibilities for adult social care support, to oversee delivery in local areas as set out in further detail below. In simple terms, we envisage a National Care Service that operates along these lines:

The case for a National Care Service (NCS)



The case for a National Care Service (NCS)

To ensure parity and clarity with the NHS we recommend that the Scottish Government should at the same time establish NHS Scotland in law on an equal footing to a National Care Service, to oversee delivery by individual NHS Boards.

Why not nationalisation?

We have considered whether nationalisation – taking all of adult social care into public ownership and management – is desirable.

The evidence suggests that nationalisation would not in and of itself improve outcomes for people using care. Care Inspectorate data[24] indicates that, when it comes to community based services, quality is generally highest among third sector providers. In terms of residential care for older people, evidence from the pandemic[25] indicates a correlation between size of care home and quality of care, with smaller facilities faring better than larger ones, but no evident link between type of ownership (public, private or third sector) and quality. We therefore think that the evidence does not support nationalisation into public ownership on the basis of improving the quality of care.

Notwithstanding quality, if nationalisation is supported by some people they need to explain how it would be paid for. We have considered public value and how much it would cost to take the social care sector into public ownership. Examples such as the purchase of Home Farm care home in Skye at a cost to the public purse of £900K during the Covid-19 pandemic suggest that nationalising the sector would require an unaffordable level of public outlay, particularly in terms of investment in capital. It would also be hugely time-consuming: time that could be better spent working with providers and people who use services to improve care. We have also considered more fundamental financial questions, like responding to unmet need for social care supports, which in our view should be the priority for financial solutions; we provide further detail in Chapter 11.

Different arguments and different solutions apply to the social care workforce. Material inconsistencies in terms and conditions, low pay, high turnover, lack of training and development, low esteem and long-standing gender-based unfairness need to be tackled consistently and fairly without undermining the arrangements that underpin good quality existing provision as above. A national approach – without nationalisation itself – is needed to resolve these unacceptable features of current employment arrangements, without removing the unquestionable value added by the diversity and specialism of the third sector in particular, and without dismantling organisations that are already doing a good job. We set out our recommendations for achieving fair work in social care support in Chapter 10.

24 Datastore (careinspectorate.com)
25 Discharges from NHSScotland hospitals to care homes 28 October 2020 – Data & intelligence from PHS (isdscotland.org)

Local responsibilities

Local planning for, and delivery of, adult social care support should continue and should build upon the progress made to date with integrating health and social care support. That progress has not, the evidence is clear[26] [27], been sufficient so far to meet the Scottish Government's ambitions for integration, which are necessary and urgent to improve public wellbeing.

Currently, the onus to integrate health and social care support sits locally, with responsibility devolved to Health Boards, Local Authorities and Integration Authorities. Lack of integration at national level is contributing to unacceptable variation in local progress.

Integration Authorities are new organisations, created only a few years ago under the Public Bodies (Joint Working) (Scotland) Act 2014. They should be reformed to take full responsibility for the commissioning and procurement of adult social care support locally, accountable directly to the Scottish Government as part of the National Care Service. Local Authorities should no longer be responsible for commissioning and procuring adult social care support but can continue to provide social care services procured by reformed Integration Joint Boards. One model of integration, the Integration Joint Board, should be used throughout the country. There is no evidence that lead agency arrangements have delivered better results than Integration Joint Boards and consistency will be important in the new system to simplify governance arrangements and improve public understanding of who is responsible for what.

We heard evidence that those Integration Joint Boards, which have gone beyond the statutory delegation minimum of all adult social care, and that have all children's services and criminal justice social work also delegated, have performed well in relation to these services. It will be important in the implementation of this report to have regard to implementation plans for the review of children's services (The Promise) and of the work being done to consider the future of criminal justice social work. Social workers and their representative organisations expressed concerns about further fragmentation of the social work workforce, across different arrangements for those working in adult care, children's services and criminal justice. We fully recognise and value the role of social workers in respect of assessment and care management, and in changing the way self-directed support currently operates, as well as their critical role in adult support and protection.

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

As the local delivery agencies of a new National Care Service, Integration Joint Boards will need considerable support from the Scottish Government, Local Authorities, the NHS, and delivery partners, to make consistent progress. Contributing wholeheartedly to that support must be a priority for all partners in health and social care support in Scotland. There will be a continuing need for partners at a local level to work collegiately to share intelligence and understanding about local needs and to explore joint solutions. This will only be achieved by prioritising it and working together to achieve the best outcomes for local communities. The importance of clear, committed leadership at all levels and in every organisation to making a reformed system work cannot be overstated. We recommend the creation of a National Integration Joint Board where the senior leadership of the National Care Service and NHS meet regularly to agree strategy and priorities.

26 Health and social care integration: update on progress | Audit Scotland (audit-scotland.gov.uk)
27 Health and Social Care integration: progress review – gov.scot (www.gov.scot)

The case for a National Care Service (NCS)

> The amount of paperwork support staff now need to complete has got out of control and takes away precious support time."

Richard Toner

I was transitioned to adult care providers at the age of 16. The care provider I was initially given, wasn't able to work with people who have physical disabilities, therefore was totally unsuited to meet my needs.

The British Red Cross stepped in and gave me a new outlook on life and the opportunity to have the independence I desired and I stayed with them for almost a decade. I am now in the process dividing my care package between Quarriers and Ayrshire Independent Living Network to better suit my requirements.

Transitioning from children services to adult services is a daunting experience. The communication between social worker and care provider could be improved to allow a steady transition, and in my situation there could have been better research into care services to ensure they met my requirements. The amount of paperwork support staff now need to complete has got out of control and takes away precious support time. This bothers me as I have to allow staff time away from caring for me to write reports. Support from team leaders and management to the service user is much less forthcoming since I transitioned to adult services and this should be improved to allow issues to be dealt with more effectively and positive relationships to be formed between management and the service users.

Overall, I've found my experience of transitioning between children services to adult services and between care providers steady and carefully considered over the years.

The case for a National Care Service (NCS)

Budgets for integrated health and social care support services should be determined nationally and distributed directly by the Scottish Government to Integration Joint Boards, as they are to Local Authorities and NHS Boards. This will mean that budgets that are currently distributed to Integration Joint Boards via Local Authorities and Health Boards will now be allocated directly by the Scottish Government. Too much time and effort is currently spent agreeing budgets for integrated health and social care support services at local level. We heard that budgets are often not agreed until well into the financial year in question. A new distribution formula for Integration Joint Board budgets is needed to ensure equity and transparency, rather than relying on a blend of the existing NHS and Local Authority formulae as at present. Such a formula will need careful development with partners to ensure a fair outcome for Integration Joint Boards, Local Authorities and Health Boards. Consideration will need to be given to VAT in relation to the National Care Service.

We set out our recommendations for how a new National Care Service should work in Chapter 6.

Recommendations

We recommend that a National Care Service should be established:

15. Accountability for social care support should move from local government to Scottish Ministers, and a Minister should be appointed with specific responsibility for Social Care.
16. A National Care Service for Scotland should be established in statute along with, on an equal footing, NHS Scotland, with both bodies reporting to Scottish Ministers.
17. The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers. Integration Joint Boards should manage GPs' contractual arrangements, whether independent contractors or directly employed, to ensure integration of community care and support provision, to respect and support professional interdependencies, and to remove the current confusion about where responsibility for primary care sits.
18. The National Care Service should lead on the aspects of social care improvement and support that are best managed once for Scotland, such as workforce development and improvement programmes to raise standards of care and support.
19. The National Care Service should oversee social care provision at national level for people whose needs are very complex or highly specialist and for services such as prison social care that could be better managed on a once-for-Scotland basis.
20. The National Care Service's driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce.

Chapter 6
A National Care Service for Scotland – how it should work

> We must shift beyond the mindset of existing systems and services to embrace individual and community capacities, and collaborative opportunities to enable innovative support mechanisms."

The importance of integrating health and social care is as important today as it was in 2012 when the Scottish Government consulted on proposals that were given effect by the Scottish Parliament through the Public Bodies (Joint Working) (Scotland) Act 2014.

Progress has been patchy. In particular it is evident that the ambition quoted above – that whether money for support and services is from an "NHS budget" or a "Local Authority budget" should be of no importance to the person using services – has not been achieved. This is not merely an accounting problem. It is a significant impediment to the wellbeing of people who use health and social care support services, because it gets in the way of early intervention and preventative approaches, and it is a significant barrier to innovation for people working in health and social care support.

This chapter builds on the principles set out in Chapter 5. We have included quite a lot of detail about structures in this chapter, to help people who currently work in health and social care organisations understand the changes we are suggesting.

We are concerned that, by setting out this detail, we may give the unintended impression that we believe structural change is what matters most. We do not. In some ways we would prefer not to have to recommend any structural change at all. All structural change involves effort, and money, which some people will argue would be better used in supporting people. We do not disagree. But structural change is necessary if the structures themselves are impeding good care and support for people, which we believe is currently the case.

The changes we propose here would likely not be necessary if more progress had been made by the Scottish Government, Health Boards, Local Authorities and Integration Joint Boards with integrating health and social care. Wishing it were so does not make it true, however. We therefore encourage everyone involved to embrace these proposals as they are intended to be received: as a means through which to achieve consistent, Scotland-wide improvements in social care supports focused entirely on improving outcomes for people using and working in social care, and to the potentially enormous benefit of civic life and local communities. We have been asked for clarity on responsibilities; for obstacles to be removed to good, rapid decision making; for arrangements to be made to enable good ideas to be shared, spread and deployed easily; and for changes that will enable money to flow easily to where it can be used to best effect. We have framed the recommendations that follow around these basic, reasonable, requests. It should not be beyond our collective means in Scotland to achieve them.

Statutory basis for a National Care Service

To address the problems we have already outlined, and for the reasons we set out in Chapter 5, we recommend that new legislation should empower Scottish Ministers to:

- **Discharge responsibility for the local planning, commissioning and procurement of social care support via Integration Joint Boards; and**
- **Create national bodies to service and support social care support and social work at local and national level.**

Ministers should be able to change the number and configuration of Integration Joint Boards and national care bodies without changing primary legislation. This approach mirrors the existing powers of Ministers to establish NHS territorial and special boards.

Some existing agencies should become national care bodies under the National Care Service: the Care Inspectorate and Scottish Social Services Council. We recognise that the remit of each of these agencies extends beyond adult social care but believe their inclusion will be vital in establishing a coherent context for the National Care Service. We also consider that this will provide additional impetus for close working between adults, children's and criminal justice social work services, whatever the conclusion made about overall structures.

Within the National Care Service, provision will also be needed to oversee priorities that currently have no home in the national infrastructure, such as workforce planning and development, data and research, IT and, as appropriate, national and regional service planning, and to manage services that are better organised on a once-for-Scotland basis, such as support for people with complex and specialist needs, provision in custodial settings including prisons, and so on.

The remit of this review is only to consider adult social care. As part of our work we have engaged closely with colleagues leading on The Promise, which is responsible for driving the work of change demanded by the findings of the Independent Care Review for children's care[28]. The recommendation of our review is that social work and social care support should be made more cohesive across age and professional groupings, should enable transitions between children's services and adult services, and that further work should be done to ensure that implementation of the two reports is mutually reinforcing. This will need close attention during implementation.

28 Home – The Promise

A National Care Service for Scotland – how it should work

> "I am living a full life, but there are still too many other people who aren't getting the support I'm getting and are suffering as a result."

> "Sophie self-manages very well. She knows the strategies she needs to cope, and she knows physical health is good for her mental health."

Sophie Hogg

I am 74 years old and was diagnosed with vascular dementia a couple of years ago. I thought I'd been asked to go to the clinic to get help with my diabetes when I was given the news. The doctor told me I had dementia, handed me a DVD and a book and opened the door for me to leave. Within the space of a few minutes I had been told I wouldn't be able to drive again and I'd need to get a power of attorney. It was a dreadful way to be given a diagnosis. I thought my life was nearing an end, I even started to clear out my house and give my jewellery away to my family. However, since then I have been very lucky with the support I've had. I was referred to Alzheimer Scotland and given a great link worker. I am able to live a great life because I have support and have been put in touch with other people in the same position. My husband Robert and I regularly volunteer, helping people with special needs. I am living a full life, but there are still too many other people who aren't getting the support I'm getting and are suffering as a result.

Marian Garcia
Link Worker

Sophie is a fine example of someone who has learned how to live well with dementia. Her confidence has grown exponentially, having gone from not attending groups to now contributing, supporting her peers, campaigning and helping others with a recent diagnosis. Sophie self-manages very well. She knows the strategies she needs to cope, and she knows physical health is good for her mental health. Before COVID, Sophie had a regular gym and swimming routine. She lost a lot of weight and reported feeling empowered and confident. Without Post Diagnostic Support, I believe we'd be seeing a very different Sophie today. She is an inspiration.

Governance of a National Care Service

The National Care Service should have a board of governance with a Chair appointed by, and accountable to, Ministers. Its other members must include representation of the workforce, people experiencing social care support, unpaid carers and providers.

The National Care Service should have a Chief Executive who is the accountable officer to the National Care Service national board of governance and is also a member of the Scottish Government Health and Social Care Management Board, as the Chief Executive of NHS Scotland is now. The Chief Executive of NHS Scotland should be a member of the board of the National Care Service. If there is a similar board for NHS Scotland then the Chief Executive of the National Care Service should be a member of it.

Functions of a National Care Service

The National Care Service should:

- **Provide assurance to Ministers and to the public about the quality of social care support in Scotland and ensure that opportunities for continuous improvement are identified and implemented.**
- **Oversee the work of reformed Integration Joint Boards and national care bodies and ensure effective engagement is taking place at all levels.**
- **Establish, maintain and oversee national requirements for ethical and collaborative local commissioning and procurement of social care (see Chapter 9). These requirements will cover standards of care and outcomes to be achieved, and fair work.**
- **Develop and maintain the distribution formula for direct allocation of budgets by the Scottish Government to Integration Joint Boards and national care bodies.**
- **Be responsible for social care support functions that currently have no home in the national infrastructure, such as workforce planning and development, data and research, IT and, as appropriate, national and regional service planning, and to manage services that are better organised on a once-for-Scotland basis, such as support for people with complex and specialist needs, provision in custodial settings including prisons, and so on.**
- **Ensure effective working with NHS Scotland, establishing a joint approach where beneficial to people accessing care. This priority could be enabled by the creation of a similar board of governance for NHS Scotland and the creation of a National Integration Joint Board where the senior leadership of the National Care Service and NHS meet regularly to agree strategy and priorities.**
- **Ensure effective local and national working with other public services including transport, housing and education, all of which are key to public health and wellbeing. People's environments can be disabling if not properly planned for accessibility, and people's needs for care and support vary depending on their context. More broadly than social care and health, it is important that the public sector as a whole designs different environments – home, workplace, local services and infrastructure (e.g. transport, amenities), community networks – to support people's independence and enable everyone to participate as full citizens in society.**

Monitoring progress

As part of its oversight of local and national progress the National Care Service will need to develop and maintain outcome measures for the Integration Joint Boards and national care bodies, and monitor their performance.

Previous attempts to establish a single set of outcome measures across adult health and social care have been hampered by complexity and duplication. These obstacles need to be overcome to ensure clarity of purpose and transparency of the evidence base for progress. We recommend that a single, clear set of outcomes, process measures and balancing measures should be developed for the whole health and social care system. This should involve people using social care support, patients, unpaid carers, providers, clinicians and professionals, to ensure the right balance of measures is identified. This should be developed as a priority and should simplify, reduce in number and improve the current range of measures. It should acknowledge this report and ensure a focus on outcomes for people using social care supports and healthcare services and should reflect the ethical and collaborative approach to commissioning that we recommend here.

Reforming Integration Joint Boards

The law should be changed so that Integration Joint Boards are reconfigured to employ staff, hold assets and contracts, including the GMS contract and employment of directly employed independent contractors in health, as described in Chapter 5.

Integration Joint Boards should contract directly with public sector providers, and with the third and independent sectors. This means that the National Care Service, through Integration Joint Boards, will hold contracts with providers of social care support services, which is an arrangement not unlike the contractual arrangements between NHS Boards and primary care contractors such as GPs and pharmacists. Consideration should be given to whether any contractual arrangement is needed with Local Authorities for the provision of professional social work services and how this would work.

The post of Integration Joint Board Chief Officer should be retained though the skillset for the job should be updated, clarified and sharpened to reflect the new responsibilities of Integration Joint Boards. Currently Chief Officers perform a dual role as accountable officer for the strategic commissioning plan and use of the integrated budget to the Integration Joint Board, and as director of integrated delivery within the Health Board and the Local Authority. Under the new model Chief Officers, and the staff who plan, commission and procure care and support, as well consideration given to other key staff such as Chief Finance Officers, should be employed by the Integration Joint Board itself, rather than by the Local Authority or Health Board as is the case now. They will no longer be jointly accountable to Chief Executives of Local Authorities and Health Boards.

We heard and saw compelling evidence of where current integrated arrangements were working well under Integration Joint Boards and their delivery arm, Health and Social Care Partnerships. This was especially the case where all social care, social work and community based healthcare were delegated to its greatest extent. We strongly believe that there is scope to be more consistent in these arrangements and embed the effective working we saw throughout the country. We are also keen to ensure a further narrowing of the gap between purchaser and provider, an unwelcome split introduced to social care and social work some 30 years ago. We intend this as a means by which the best possible outcomes are planned for and achieved, and high quality integrated services are delivered across Scotland.

Integration Joint Boards should continue to develop strategic commissioning plans, and should be given direct responsibility for procurement, holding contracts and contract monitoring. Strategic commissioning plans must be better linked to planning for other types of service, including particularly housing plans and plans for acute hospital care.

The Integration Joint Board (equal numbers of elected members and NHS non executives) and Integration Joint Board Strategic Planning Group (a broad range of representative user and professional interests) should be combined to form the membership of the reformed Integration Joint Board.

Every member of the Integration Joint Board should have a vote. Membership should include but not be limited to representation of the workforce, people who use services, carers, providers, professionals, localities and local communities. Careful thought will need to be given to the workable size of Integration Joint Board and appropriate support will need to be provided to enable participants to fulfil their responsibilities. We know from experience with integration that very large Boards are unwieldy, but that at the same time narrow membership seems to inhibit innovation and a local sense of ownership, and the clear sense of involvement that gets things done. This combined with active community engagement and involvement will provide a powerful basis for planning and delivering change and improvements at a local level. Additional support and training for members and Chairs of reformed Integration Joint Boards would help them to fulfil their functions more effectively without resorting to simplistic solutions to these challenges.

The Integration Joint Board budget should continue to include a sum for unplanned adult hospital care to help incentivise preventative interventions. Integration Joint Boards should bear responsibility for unplanned and potentially avoidable hospital care.

Integration Joint Boards' budgets should be allocated directly by the Scottish Government, rather than via Health Boards and Local Authorities as at present, as set out in Chapter 5. See Chapter 11 for financial recommendations.

Recommendations

We recommend the following arrangements should underpin a National Care Service:

21. The National Care Service in close co-operation with the National Health Service should establish a simplified set of outcome measures to measure progress in health and social care support, through which to oversee delivery of social care in local systems via reformed Integration Joint Boards and national care bodies.
22. A Chief Executive should be appointed to the National Care Service, equivalent to the Chief Executive of the National Health Service and accountable to Ministers.
23. Integration Joint Boards should be reformed to take responsibility for planning, commissioning and procurement and should employ Chief Officers and relevant other staff. They should be funded directly by the Scottish Government.
24. The role of existing national care and support bodies – such as the Care Inspectorate and Scottish Social Services Council – should be revisited to ensure they are fit for purpose in a new system.
25. The National Care Service should address gaps in national provision for social care and social work in relation to workforce planning and development, data and research, IT and, as appropriate, national and regional service planning.
26. The National Care Service should manage provision of care for people whose care needs are particularly complex and specialist, and should be responsible for planning and delivery of care in custodial settings, including prisons.

Chapter 7
A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

> Self-directed support is absolutely the right policy but there has been a failure of implementation."

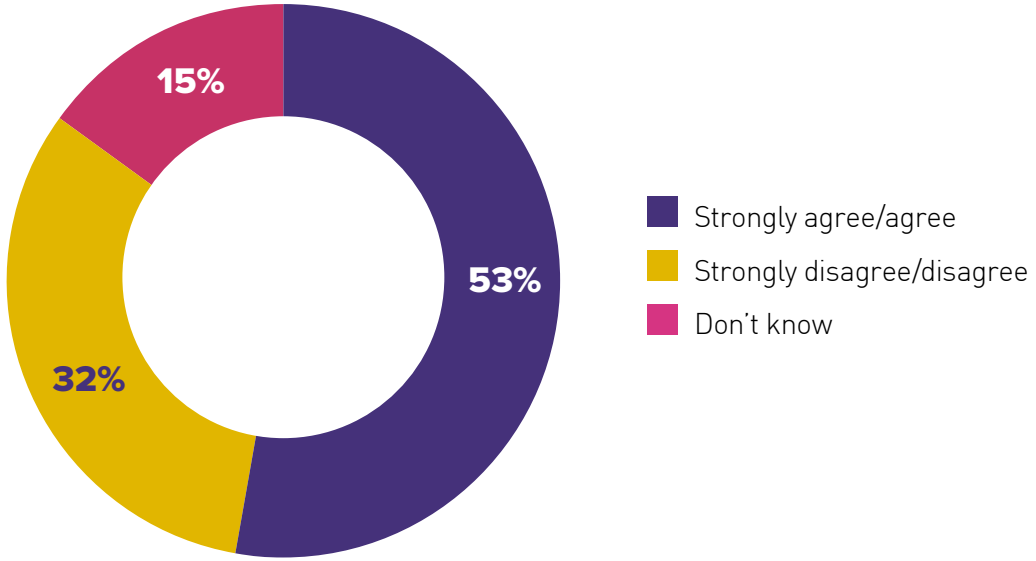
> Elements of an ideal model of social care would include suitable housing, investment in training, technology enabled care, capacity building in communities, funding for community rehabilitation, and a shift away from crisis intervention to a much earlier more enabling, person centred, model of care."

What is high quality social care support and where do we find it?

The quote about self-directed support from one of the participants became a recurring theme in our engagement process. People recognised the ground-breaking legislation to introduce initiatives like self-directed support but were frustrated by both the pace and the variability of implementation. The recent report by Self-Directed Support Scotland (SDSS) and the ALLIANCE[29] provides evidence to back up the assertion. As the charts below show, only 53% of people felt prepared for their needs assessment and only 42% felt that they had all self-directed support options discussed with them:

"I felt prepared for my needs assessment"

(My Support My Choice (Health and Social Care Alliance Scotland and Self-Directed Support Scotland, Chart 11)

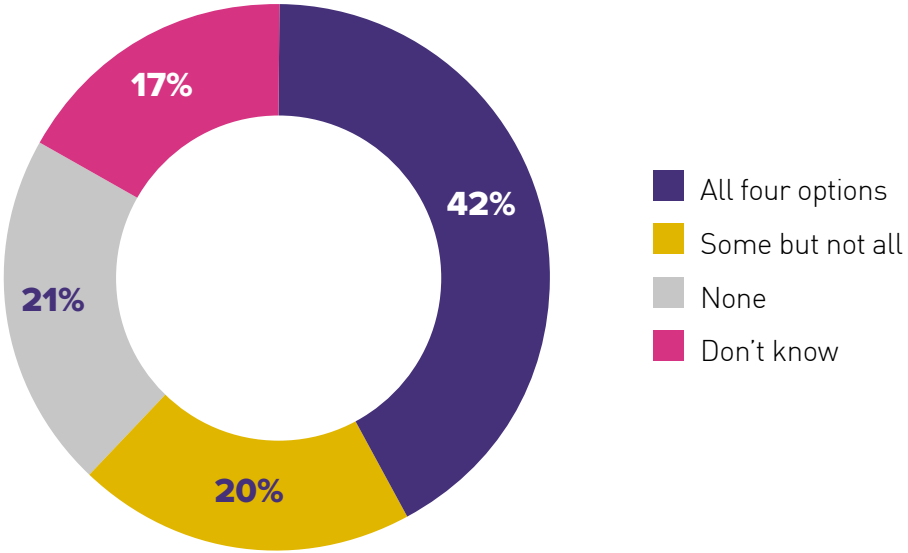


29 My Support My Choice: People's Experiences of Self-directed Support and Social Care in Scotland- National Report, October 2020 (alliance-scotland.org.uk)

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

"Discussing SDS Support with Professionals"

My Support My Choice (Health and Social Care Alliance Scotland, Chart 12)



We heard similar perspectives shared with us on the impact of the Carers Act. Furthermore, the Audit Scotland Report on progress with implementation of health and social care integration[30] explores a consistent set of themes, describing progress in some areas but a good deal of variability.

The underlying reason for these challenges lies in the fact that we have no systematic approach to implementation and improvement in social care support. One widely used system of improvement is built on five components, all of which we'll cover in the report (adapted from Langley et al, The Improvement Guide, 2009):

- **Establishing constancy of purpose;**
- **Gathering intelligence for improvement (establishing whether and how people's right and needs are being met);**
- **Taking a systems approach (seeing the interdependencies between the various parties);**
- **Planning for improvement (commissioning and investing in the right activities); and**
- **Learning from a portfolio of improvement programmes (a way to share learning across the country).**

30 Health and social care integration: update on progress | Audit Scotland (audit-scotland.gov.uk)

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

In chapter 2 of the report, we described what we believe to be the purpose of social care support in Scotland. Simply stating the purpose is not enough, however, to secure constancy in pursuit of the purpose. That needs an environment and culture that enable everyone in the system to contribute every day to the achievement of the purpose. We explored with people what might be the key elements of that supportive culture. Amongst the issues that were identified were: a focus on long term outcomes, an environment of co-operation and trust, valuing lived experience, replacing judgement with learning, and backing that up with a proper stewardship of our resources.

In the remainder of this chapter, we will set out recommendations for a system of improvement. We will propose how to close the implementation gap in a way that is rights based, systematic, planned, prioritised and continuous. But before we get to how we are going to improve, it is useful to spend some time on the question of what. Our remit specifies that we are to "recommend improvements to adult social care support in Scotland, primarily in terms of the outcomes achieved by and with people who use services . . ." In short, we are invited to improve quality. Don Berwick, former Administrator of the Centres for Medicare and Medicaid in the Obama Administration, describes quality as the degree to which the results of the work you do match the needs you intend to meet. What people have been describing to us as they talk about SDS etc., is a quality gap. This is how we go about closing the quality gap.

First, we need a workable definition of quality in social care support. A statement of its essential dimensions. There is already a lot to build from here. Principally (but not exclusively), we currently describe high quality social care support through 5 Health and Social Care Standards, 146 Standard Statements, 9 Health and Wellbeing Outcomes, and 23 Integration Indicators. Through a process of well-intentioned accretion, we have a situation now where we could not find a single shared definition of social care support. On the basis of our feedback from people receiving support and those providing it, we have created the following distillation of high quality social care which we recommend is deployed across the system to help understand people's experience of social care supports, alongside measures of the kind recommended in Chapter 6, whether the person is receiving support to live at home or is in a care home:

6 Quality Dimensions

- **Accessible** – I get the support I have a right to receive when and how I need it.
- **Personalised** – I am able to direct my support and I am a full partner in its planning.
- **Integrated** – if I need care, it is joined up. I get the help I need to navigate.
- **Preventative** – my needs are understood and addressed at lower levels, they are anticipated and I have a plan for the future.
- **Respectful** – I can live with dignity and my voice is heard.
- **Safe** – I feel safe in my environment and free from harm.

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

Creating the conditions for improvement – infrastructure and culture

There is an old Palestinian saying which goes something like "you can't fatten a cow by weighing it". It has shades of the recommendations made by W Edwards Deming[31]. As Deming points out, inspection is too late. The quality, good or bad, is already in the product or service. You cannot inspect quality into a product; instead you have to reduce the need for inspection on a mass basis by building quality into the product in the first place.

It is important to note Deming's use of the term "inspection on a mass basis." He doesn't call for the elimination of inspection altogether, but rather for its reduction to the optimal level. Some inspection is always necessary, and is an important tool for gathering intelligence about what and how you are doing, as well as what needs to be prioritised for improvement. We also recognise and value the regulation role at individual practitioner and service levels. But wholesale reliance on inspection is seldom appropriate, and is costly in both time and money. And most important, inspection cannot always catch problems that are inherent in the system itself.

And yet, that is pretty much all we have in social care support a total reliance on external verification as a vehicle for improvement. It won't work. It distorts our sense of who is the 'customer' away from the person in need of care and support towards the inspector and it inhibits the sharing of learning and innovation.

Our social care support system is crying out for the kind of step change that the Scottish Government made with the National Health Service back in 2007 when they introduced the Scottish Patient Safety Programme as a means to secure large scale national improvement in outcomes for patients. The programme has become a world leader, replicated across the world, and achieved a significant breakthrough in the quality and safety of the NHS in Scotland.

We recommend that creating a similar approach to national improvement in social care should be a key responsibility of the National Care Service. The National Care Service should utilize the intelligence generated from the Care Inspectorate's work to identify a number of areas where national performance is currently falling short of our expectations. It should set aims for the improvement required then commission the Care Inspectorate and Healthcare Improvement Scotland to design and develop a collaborative improvement effort to generate the level of performance required. Those two organisations should engage with providers, people with lived experience and unpaid carers to agree a set of changes and build the necessary local improvement capacity and capability.

We recommend that just as Healthcare Improvement Scotland sits within NHS Scotland, so too should the Care Inspectorate be part of the National Care Service. We further recommend that it should work in partnership with Healthcare Improvement Scotland and the two organisations should create complementary functionality rather than compete or duplicate. In social care national improvement programmes, the Care Inspectorate can bring subject matter expertise and the quality improvement input can be provided by Healthcare Improvement Scotland.

31 W. Edwards Deming, Out of the Crisis, 1982

Their role in the development of quality improvement activities will require a rebalancing of the Care Inspectorate's role, building on the current strategy, energy and direction of travel. It will be a key contributor to the quality planning that will be carried out in the National Care Service. Elsewhere in this report, we propose an important new role for the Care Inspectorate in relation to market oversight. In order to create space for these new functions, we recommend that the Care Inspectorate shifts some of its quality assurance activities to the Integration Joint Boards and to providers, involving people using services and carers in improvement and quality assurance work. The Care Inspectorate and Healthcare Improvement Scotland should be held jointly accountable for the planning and delivery of improvement programmes.

Building capacity and capability

These new approaches and quality improvement methods will require a significant building of improvement capability at the point of social care support. Staff in care homes, for example, will need basic improvement knowledge. In addition, we will have to create some kind of quality improvement infrastructure for this work.

In order to manage the impact of the Covid-19 pandemic, the Chief Nursing Officer for Scotland and her team have led work to develop what they call a 'safety huddle tool' in care homes. This has generated daily intelligence on the current situation in all care homes across Scotland and has potential as an important building block for the kind of quality improvement infrastructure we might require.

In the United States, The Agency for Healthcare Research and Quality (AHRQ) is partnering with the University of New Mexico's ECHO Institute and the Institute for Healthcare Improvement (IHI) to establish a National Nursing Home Action Network. The network aims to provide training and mentorship to 15,000 nursing homes across the country via over 100 geographic hubs to increase the implementation of evidence-based infection prevention and safety practices to protect residents and staff. A similar model could be used to build on the success of the 'daily huddle'.

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

> We're dying out there, my pals are dying out there and we are trying to get treatment but it's hard to get treatment."

Robert Faulds

I had addiction issues and was on methadone for 18 years and I was a heroin addict for a couple of decades. It stole a good part of my life. Now I volunteer at the treatment centre, which helped me get clean and I also work a 12 step programme with a sponsor which has changed my way of thinking.

Having to go to the chemist *for methadone*, is brutal. Going through the door at the chemist made me feel like less of a person, a second class citizen. I had a terrible self-hatred, there was no exit strategy. I thought I would die in addiction and although I would have accepted that, I couldn't accept it for my daughter, she never chose this situation.

We're dying out there, my pals are dying out there and we are trying to get treatment but it's hard to get treatment. I just needed some guidance, and the structure that Rainbow House, *a recovery service in Glasgow*, gave me.

I needed time to breathe and process the things that had gone on in my life. My life transformed in seven months. If I wasn't for that service, I would likely be dead.

I now volunteer at Rainbow House and I plan to work in addictions, in the future. I've got a beautiful daughter and a lovely family and I believe my life is going to be good. A big part of recovery is hope. Most people don't know what recovery is, we need to make it visible, we need to give it direction.

Recommendations

We make the following recommendations:

27. A National Improvement Programme for social care, along the lines of the NHS Patient Safety Programme, should be introduced by the National Care Service, and should address the three following key areas:
    - **The experience and implementation of self-directed support must be improved, placing people using services' needs, rights and preferences at the heart of the decision making process.**
    - **The safety and quality of care provided in care homes must be improved to guarantee consistent, appropriate standards of care.**
    - **Commissioning and procurement processes must be improved in order to provide a vehicle for raising the quality of social care support and for enhancing the conditions and experience of the social care workforce.**

Chapter 8
Models of care

Models of care

> A person-centred approach to social care support must be premised on ensuring citizens are able to fully exercise autonomy and choice in the supports available to them, which includes clear and defined resources directly available to citizens and a strong, healthy and diverse suite of support options tailored around the needs of local communities."

We heard about some excellent examples of innovative work that is improving people's experience of care and support while local systems maintain core supports and services. However, innovation seems usually to be the result of a combination of enthusiastic local leadership, availability of additional funding and willingness locally to change. We heard little to suggest consistent efforts to share learning, scale-up or spread approaches that work well. The current system seems to support local innovation rather than widespread improvement, which is why we have made specific recommendations about prioritising improvement programmes for self-directed support, and commissioning and procurement.

Examples of the kind of improvements that people are trying to make include:

- **Reducing use of institutional/residential care**
- **Making better use of adaptations and technology**
- **Involving people and their families more in decisions**
- **Including wider community supports in care**
- **Professionals working together better across traditional boundaries of health, social care support and other services such as housing.**

We have not called this chapter "new" models of care because Scotland has been committed to these approaches for the last 30 years. The problem is not that we do not have good ideas; it is that we have not acted on them at scale and with genuine commitment. We seem to rely too much on bottom-up developments that we expect to flourish without systemic support. We have summarised a few of the good ideas and good practice examples we have heard about over the last few months, below. This is by no means a comprehensive description of "what good looks like". It is just an illustration that Scotland does not seem to be short of inspiration, and can learn from other places – but we have not bridged the gap between these good ideas and consistent access to the best quality social care supports for everyone.

Reducing use of institutional/residential care

Given the demographic trends, including the projected growth in diagnoses of dementia, this needs urgent attention. We do not believe that the answer to those demographic challenges lies in building additional care homes. Most people say they would like to live in their own homes for as long as possible. Nonetheless, people told us that there is still an almost automatic default to care home care in some areas, particularly for frail older people. This observation is especially striking in light of our human-rights based approach: moving into a care home must always be the informed choice of the person requiring care and support. We are concerned that at times the emphasis on residential care for older people is counter to that fundamental right to choose and is sometimes suggested because care at home can be more expensive. Alternatives exist beyond the traditional choice of care home/care at home, a few of which we outline here.

We heard about extra care housing from Moray, Scottish Borders and South Lanarkshire. These combine private housing space with communal facilities, on-site care and dedicated nursing support. Fewer people with learning disabilities live in care homes, with most using Supported Living arrangements. Although designed for different needs, this model is not so different from extra care housing for older people: it enables the person with learning disabilities to live alone or with other people of their choosing, in their own home with an onsite team providing 24 hour support.

The Shared Lives model takes a different starting point, with approved carers welcoming adults who need day support or longer term care into their own home. This model is currently used, most extensively in Scotland in Fife, to support a range of people, particularly people with learning disabilities, but it could be extended to offer respite to unpaid carers of frail older people and utilised more extensively across Scotland.

For older people, there is also potential in a Home Share model, in which someone facing a housing challenge – for instance a younger adult or student – provides companionship and practical help with tasks like shopping and cleaning in exchange for low-cost accommodation. Arrangements like this are overseen by a management company for the protection and assurance of everyone involved.

As we find new ways of providing care at home for more people, there is likely to still be a need for facilities, where care at home is no longer suitable, that can provide extra care but are alternatives to hospital and residential nursing facilities. Innovative approaches are emerging for those adults and older people who have more complex needs, enabling them to remain in a more homely setting where extra care is provided. Close working between social care, health and housing services is needed to develop such services and there are good examples in Scottish Borders and Midlothian.

Early intervention

We heard from Alzheimer Scotland that a more preventative and early intervention approach to dementia can sustain people in their own homes and communities for a longer period of time and result in a high quality of life for people who might otherwise have been institutionalised. The success of the post diagnostic support service that is provided for one year by professional and highly trained staff is undisputed and helps people recently diagnosed with dementia, along with unpaid carers and families, understand the illness, access supports and services, and to plan for their future – yet this is not implemented across universally across Scotland. Dementia friendly communities have been developed in a number of towns and cities but this too needs to be the norm rather than exception. The efficacy of this strategic approach has been clearly demonstrated through detailed evaluations, including powerful testimony from people with dementia, and their carers and families.

Making better use of adaptations and technology

If our aim, as so often stated in Scotland, is to emphasise supporting people to stay in their own homes and communities for as long as possible, we must do more to improve and adapt those homes to support a better quality of life. Even minor adaptations can deliver significant improvements, particularly when combined with necessary repairs and home improvements, yet we heard that for some people the process of getting adaptations and improvements done is so complex that even professionals struggle to navigate it.

In this context, housing adaptations are often an investment rather than a cost, and we heard that it is helpful if clear arrangements are in place setting out where responsibility sits for paying for and arranging work. Similarly, Technology Enabled Care (TEC) in people's own homes can support greater freedom while also providing greater assurance. However, we know some people are concerned that the introduction of such technology may be used to reduce costs, particularly of overnight support and that reducing face to face support may increase loneliness. It is therefore suggested that the introduction of technology should be explored and discussed thoroughly as part of support planning, where the person's needs, rights and preferences should be paramount.

Involving people and families more in decisions

The need to involve people who use services, their families and carers better and earlier in discussions about social care supports is one of the most consistent themes of this review and we discuss this particularly in Chapter 3 in relation to human rights. In policy terms, much has been written in recent years about the benefits of co-production and some people report a really positive experience. We heard about a couple of approaches that help support an inclusive approach.

In Falkirk, community-based Living Well centres offer appointments or access to a web portal where people can come in and have a conversation about their wellbeing, and health and social care supports, and access holistic supports, community-based supports and advice to help manage their own health and wellbeing. In Edinburgh, a Three Conversations model is being tried, which focuses on: a) really listening to what matters, so that connections can be made to resources already available in the community; b) understanding what needs to change immediately so that arrangements and a plan are put in place; and c) establishes what support or connections are needed for the person to continue to live their chosen life. This is early work, which is showing positive results at this stage.[32]

The "Esther" approach from Jönköping County Council[33], in Sweden, is well known internationally, with its focus on delivering the best possible outcomes for a fictional older resident. Creating Esther helped professionals to map a range of care pathways and explore how these could be improved to best meet Esther's needs. A number of areas of Scotland have in recent years tried to take a similar approach, and a National Care Service should build on those examples to ensure a consistent focus in local systems on improvement through the eyes – and experiences – of people using services, their families and carers.

32 Case study: Assessment and care planning – 3 conversations – SCIE
33 Case study 1: Jönköping County Council | The King's Fund

Prevention and community support

The role communities play in supporting adults to remain active in their community simply cannot be overstated. There are many community-led initiatives across the country that provide vital advice and support to adults and unpaid carers, for example through practical peer support, activities and outings. These community supports are often not recognised as part of a care package, but we heard that they can make a tremendous difference to people's quality of life and provide a clear sense of choice and control, including deciding how they spend their time to follow their passions and interests.

Again, there is positive work already underway upon which a National Care Service can build, working in close partnership with Integration Joint Boards, Local Authorities, NHS Boards and other Community Planning partners at a local level. Community supports should not be regarded as an optional add on. Experience during the pandemic has demonstrated just how crucially important community and social connections are to people of all ages and across civic society, and we saw the heroic effort of communities to support people who needed essentials such as food, pharmacy deliveries and socially distanced company. To be sustained, community supports do however need some form of infrastructure and funding – often fairly modest to develop and flourish. There is a network of third sector interfaces that provide a good starting point for this. Community supports are discussed further in Chapter 9.

Social connections are intrinsic to everyone's wellbeing – people who access social care as much as people who do not – and befriending networks can play a significant role in reducing isolation, improving quality of life and providing a gateway to other types of activity. Transport is an important matter for many people as it can inhibit of enable accessibility to a range of support - it was suggested to us that transport should be integrated into the care pathway. Peer support can have a very positive impact, especially for people with mental health problems and people with addictions. The Links Worker Programme[34], which makes links between people and their communities through their GP practice aims particularly to mitigate the impact of the social determinants of health in people living in areas of high socioeconomic deprivation. There are opportunities, with leadership, investment and focus from a National Care Service, to develop approaches like these more and to support connections that make them more than the sum of their parts.

> "Digital advancements must be embedded in adult social care, however care must be taken to ensure that services remain person-centred."

34 Links Worker Programme – In the Community (alliance-scotland.org.uk)

Models of care

> What a buzz Laura gets when she realises that she has actually controlled a situation by vocalising what she wants!"

Marion McArdle and daughter

My eldest daughter Laura is 37 years old and she has profound and multiple learning disabilities and complex health needs which means she needs maximum support with every aspect of her life.

Having a personalised budget has made huge positive changes in Laura's life. She is happier and healthier and she's able to communicate with us much more than she ever did before.

Previously Laura could have up to 42 different people in her life in one week. There was no way these people could get to know her well and so often Laura's limited communication was lost.

Now with Self Directed Support (SDS) Laura employs a small staff team of six people who know her so well and have time to understand what she is trying to communicate.

What a buzz Laura gets when she realises that she has actually controlled a situation by vocalising what she wants!

Before SDS Laura's days were regimented and timetabled to fit in with staff shift times and transport availability. Each morning Laura was washed, dressed and strapped in her wheelchair by 8.30 am regardless of what kind of night she'd had. I could see little chance of her ever reaching her full potential with these limitations.

Now every day is about what suits Laura and she has choice and control over her life and the opportunity to reach her potential.

Despite Laura's significant health problems we hardly ever need to see a doctor or social worker. This must have a huge cost saving. It seems like a win /win situation!

The SDS care package has worked so well, because whilst Laura's needs were being assessed the cost wasn't mentioned. I didn't want to think of Laura's life in terms of money. We got it right for Laura because the focus was always kept on Laura- not the budget!

In some parts of Scotland, such as Glasgow and East Ayrshire, community connectors provide a free confidential service to help people access activities, advocacy services, community transport; buddy support and volunteering opportunities. Sometimes these arrangements are embedded within GP practices.

On a similar theme, community brokers across Ayrshire provide information and support to help identify personal outcomes, develop and set up a funded package of support, connecting people to community activities and services. This service is free to the person accessing support: brokers are self-employed, local people who have some personal experience of directing their own support or that of a relative or family member, and now use that experience to help other people. They receive specific training including a new SVQ qualification.

Professionals working together better across traditional boundaries of health, social care support and other services such as housing

We reflect elsewhere in this report on the need for better, faster, more consistent progress with integration of health and social care support. Again, there are areas where progress is really good. The Scottish House of Care Approach[35] has been widely used and adopted to encourage and promote GP input to care and support planning conversations routine for people with long-term conditions and support self-management – it provides a strong graphic and is easy to remember. In most GP practices across Aberdeenshire, GP-led Virtual Community Ward teams bring health and social care professionals together to identify, coordinate, organise and deliver services required to support people. The team provides short-term integrated solutions within the community as an alternative to more-resource-intensive community and acute hospital admissions. As well as reducing hospital admissions teams have felt a positive impact of the approach in building multi-disciplinary relationships, better use of resource with less duplication, quicker access to interventions and a move to more holistic and person centred care.

Developing the provider network

As well as professionals working together in new and innovative ways, we believe that social care providers should be supported to develop networks of mutual support. The development of alliance based commissioning, provider co-operatives, user-led and community-owned organisational models, and social enterprise models, should be encouraged to help improve quality, flexibility, resilience and responsiveness to people's needs.

All of the above are good examples, but they are not enough. Neither in terms of ambition nor scale are they sufficient to address the challenges adult social care support needs to meet in order to improve the experience of people using it. We believe that a stronger national approach, coupled with local ownership of innovations, is needed to deliver improvements and instil a real learning culture in social care support in Scotland.

35 The House of Care Model – Health and Social Care Integration (alliance-scotland.org.uk)

Models of care

Scale-up and spread of innovation is challenging. The idea that new ideas or promising practice can just be 'rolled out' is a fallacy. Large scale implementation of innovation needs leadership, design and contextualisation. Given the current variability in the system, we suggest it is necessary to establish additional national capacity for harvesting ideas and preparing the ground for implementation in a National Centre for Social Care Support Innovation. In this regard, the future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service should be considered.

Recommendations

We have identified key priorities to realise, consistently and at scale, Scotland's ambitions to deliver social care services and supports that maximise people's wellbeing and independence:

28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible.
29. A national approach to improvement and innovation in social care is needed, to maximise learning opportunities and create a culture of developing, testing, discussing and sharing methods that improve outcomes. The future role of the Institute for Research and Innovation in Social Services (IRISS) and its inclusion as part of the National Care Service must be considered.
30. There must be a relentless focus on involving people who use services, their families and carers in developing new approaches at both a national and local level.
31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies.

Chapter 9
Commissioning for public good

Commissioning for public good

> If the commissioning and procurement model is to be maintained, there is a need for the introduction of more ethical commissioning models that take into account factors beyond price, including fair work, terms and conditions and trade union recognition."

Over the course of the independent review there can be few things we heard more people speak about than commissioning, even if only in passing, and the need for it to be radically overhauled. Many people and organisations believed if it was done differently and altogether better that commissioning would provide the bedrock for a fairer, rights based, improved social care support system with a relentless focus on quality, outcomes, participation and collaboration. This would drive up standards and improve outcomes for people using services and supports, and the experience of social care support staff. This is one area where the proposal for a new social covenant rehearsed earlier in this report could bear fruit. The current approach to commissioning and procurement is characterised by mistrust, conflict and market forces. We need to radically redesign commissioning and procurement around the common good and stewardship of public money.

An improved approach to commissioning would change how procurement works. Care planning would be based to a lesser extent on costs and more on a range of factors. These could include, for instance, terms and conditions of the workforce, investment by providers in training and support for staff and in the fabric of buildings, flexibility and adaptiveness of services and people's experience of the quality of care. We were sympathetic to the view expressed by many people that procurement arrangements with providers should include requirements for the investment of a proportion of any profit made in improving the quality of care, and in staff terms and conditions.

Although spoken and written about often, not everyone has a shared understanding of what commissioning is. In Scotland, we used the term strategic commissioning to mean medium to long term planning that determines the choice of services and supports to meet individuals' needs, rights and preferences to live independently or as independently as possible. This must be underpinned by a robust strategic needs assessment of the whole population that is then segmented to understand the range of local needs, such as those of people from a particular geography or care group. This process is undertaken skilfully and expertly in some parts of Scotland but it is not yet consistent and is not always having the desired result on improving care and support because of the translation from strategy to delivery and the continuing dominance of a competitive social care market. Reformed Integration Joint Boards must give priority to making changes in how commissioning and procurement is undertaken supported appropriately by a national improvement programme.

Collaborative commissioning and procurement

As outlined in Chapter 1, commissioning is not synonymous with procurement but procurement can result from the commissioning process, i.e. identify the need to purchase a service from a provider or range of providers to meet identified needs. Over the last 10 years and more in adult social care support, procurement methodology and practices have increasingly driven and occasionally undermined commissioning decisions, where price and a competitive market environment, characterised by competitive tendering between providers, dominates.

We want to see an end to this emphasis on price and competition and to see the establishment of a more collaborative, participative and ethical commissioning framework for adult social care services and supports, squarely focused on achieving better outcomes for people using these services and improving the experience of the staff delivering them. By shifting emphasis in this way we believe Scotland can deliver social care supports more fairly and more sustainably.

We would like to see the split between commissioners and providers narrowed so that we can get the expertise of both, foster innovation, and engage people with lived experience more productively. In return for a seat at the commissioning table, we expect providers to be accountable for new standards of accountability, quality, staff wellbeing and transparency.

Professionals leading commissioning processes are often good at involving people with lived experience, carers, local communities, providers and other professionals to develop the large scale strategic commissioning plans that are statutorily required from Integration Joint Boards, for and with their local populations. We want to see this level of engagement and participation at all levels of commissioning from the strategic planning end of the spectrum through to any procurement of individual services and supports. And we want to see the decisions taken by social workers on people's care needs decoupled in the first instance from questions of affordability. We are not suggesting that it will be possible to meet every need nor that costs do not matter, but we believe assessment should be the product of a full understanding of the individual's needs, rights and preferences, and that when that assessment is translated into a package of supports any unmet needs should be recorded.

People with lived experience told us they want to be more involved, not just in the planning of their own care, but in the planning and design of services and they self-evidently have much to offer in this regard. In some instances peer groups, such as Disabled Persons' Organisations, Collective Advocacy Agencies and other representative groups, can play a very valuable role too.

There are alternative models of commissioning and procurement, including Public Social Partnerships and Alliancing, that are tentatively and selectively being adopted in various parts of Scotland. While these have not been wholly successful in changing prevailing practice, and we heard many have been too complicated and taken too long, we think they, along with other models, offer the opportunity to move away from competitive tendering. In some instances, the whole model of Alliance contracting has not been adopted but the principles have been fully embraced and applied but attention needs to be paid to the timescales for establishing such arrangements and must not take years to set up. New models of procurement need to be adopted more rapidly across services and alternative models put in place across different kinds of services and supports, and across Scotland.

Commissioning for public good

Focus on prevention and early intervention

National guidance is in place for effective commissioning and procurement processes[36], but as with so many other aspects of social care support, an implementation gap remains. We believe that national leadership can support increased pace and urgency to enable bold, long term whole system redesign commissioning decisions. Greater emphasis and focus are needed on prevention, early intervention and de-institutionalisation, which means decommissioning, disinvestment and redesign of current services must become a reality and not just an aspiration. This will help support a move to independent living for everyone or the development of smaller supported community living arrangements.

Alongside this is the vital importance of recognising, valuing and linking people to local community assets, which should be commissioned and appropriately funded by Integration Joint Boards, potentially through grant aid, and working jointly with Community Planning Partners. Even modest resources can make a huge difference and help establish highly effective community supports, planned by local people for local people, where these do not already exist, to ensure availability to local communities, in addition to what are more traditionally considered to be social care services and supports.

Commissioning, procurement and service delivery approaches must factor in how people using services and unpaid carers will be engaged and involved throughout the journey of their care plan, its delivery, review and feedback. Information about identified unmet need must be fed into the strategic commissioning process so that this can be addressed.

Commissioning should become increasingly transparent in relation to how people's rights have been taken into account and eligibility criteria applied, and local plans should include a method statement and commitment describing how organisations and individuals will be and have been involved and respected in the process.

Ethical commissioning and procurement

An ethical approach to commissioning, and as a consequence to any procurement of care and support, will reap benefits for staff and supported people alike. We know there have been some gains already made in the small number of Local Authorities that have adopted the Unison Ethical Charter on social care commissioning[37], but this approach must be extended and enhanced, and must ensure that Fair Work practices are fully supported by commissioning and procurement for all services and supports across the country.

Adopting an ethical, fair approach cannot be an optional extra: it must form the cornerstone of future contractual relationships, to help improve the experience of the workforce and help create sustainable, high quality provision. Along with the failure of many current commissioning and procurement arrangements, the most frequent observation made to us throughout this review has been that the workforce must be better regarded, rewarded and supported.

36 Strategic commissioning plans: guidance – gov.scot (www.gov.scot)
37 UNISON's Ethical Care Charter – UNISON Scotland (unison-scotland.org)

Commissioning for public good

We do not underestimate the immense culture change implied by what we have set out above. We firmly believe that without radical change and a more collaborative and ethical approach to commissioning adopted at all levels, we will see the disparity between what people require and what they actually get continue to grow, alongside levels of dissatisfaction and people not achieving their desired outcomes or reaching their potential. Costs will spiral, and services will become less sustainable and quality will decline further, which we can avoid by taking decisive action.

People want choice and control in self-directed support options to be a reality, not a slogan, so that they can be supported to live their lives in the way they determine not the way services or commissioners choose.

The Coalition of Care and Support Providers (CCPS) has been working on alternatives to the way that social care support is planned, purchased and funded in Scotland, in close partnership with supported people and support providers, and drawing on academic research. It has developed a number of "Big Ideas"[38] – one of which calls for a pause button to be pressed on the current procurement system to support the move from a competitive process and culture to a collaborative approach. We think this idea has considerable merit but that it needs close consideration for any unintended consequences and careful planning to ensure it does not impede anyone's care and support. In particular, its success will be entirely dependent on delivering the recommendations for a national improvement programme we set out in Chapter 7. It should be a priority for a new National Care Service.

> "Competitive tendering destroys the very relationships that are crucial to success in social care."

38 BIG Ideas (ccpscotland.org)

Care homes

During the Covid-19 pandemic, a great deal of attention has rightly been given to care homes. A previously creaking and fragile system has been exposed, particularly in regard to infection prevention and control (IPC). We know from research[39] that those care homes that have successfully minimised outbreaks of Covid-19 have been smaller, locally run and staffed services, that are part of the local social care ecosystem, operating in partnership with other local services and commissioning bodies. Arrangements have been put in place in each Local Authority area to directly and indirectly support and nurture improved standards of IPC, with increased clinical oversight provided by Directors of Public Health and Directors of Nursing, alongside professional support from Chief Social Work Officers and IJB Chief Officers to ensure a focus is simultaneously maintained on people's wider wellbeing as well as adult support and protection issues.

The safety huddle tool referred to in Chapter 7 has meant that for the first time ever a standard data set is available in real time about each and every care home in Scotland. This data is available to local systems and at a national level, and is helping to ensure support is provided at as early a stage as possible to care homes to ameliorate and better manage risks for residents, staff or the whole care home, identified through use of the tool. This approach has wider implications and opens possibilities to a more partnership-based approach to improvement in care homes, which is not reliant on the Care Inspectorate using its regulatory powers but instead focuses on the priority we heard expressed that local ownership of improvement work needs to be nurtured and supported.

Generally, care homes are not part of a managed market or commissioned set of services. The care home market is largely led by business decisions made by individual care homes or groups of care homes, some of which are large multinational companies. There is currently no oversight of this market and we believe there is an enhanced role for the Care Inspectorate as part of its regulatory activity to undertake this work, drawing on existing work and expertise. A more actively managed market should be shaped and facilitated to respond to a longer term strategic vision that takes into account the balance of providers in the market and local needs, for example, by requiring engagement with Integration Joint Boards before a service can be registered. In this role the Care Inspectorate would provide information and assurance to the National Care Service and to local systems about care home provision.

The extent to which some privately-run care homes yield profits for their shareholders was raised with us repeatedly as an issue of concern[40]. We have reflected on whether nationalisation is practical, desirable or affordable elsewhere in this report. We nonetheless want to record here that we share the unease expressed by many about whether it is right – in a country committed to health-care free at the point of need to all of its citizens, regardless of age or any other characteristic – that an important part of our care system is largely run on a profit-making basis.

39 Discharges from NHSScotland hospitals to care homes 28 October 2020 – Data & intelligence from PHS (isdscotland.org)
40 https://chpi.org.uk/papers/reports/plugging-the-leaks-in-the-uk-care-home-industry/

Commissioning for public good

Our principle concern is not with profit itself, which plays an important function in any market economy, but with what we have come to think of as "leakage" from the care system in Scotland. Significant sums leave the care economy, some of which could be better used to raise standards of care and terms and conditions for staff. We therefore recommend that the National Care Service should take these concerns into account as part of its development of a new approach to ethical and collaborative commissioning. National contracts, and other arrangements for commissioning and procurement of services must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.

Care home placements are currently purchased by Local Authorities on an individual basis at a price set through annual negotiations on the National Care Home Contract. This contract is in urgent need of reform so that the focus on the price payable per placement does not undermine the vital focus on achieving good outcomes for people and ensuring high quality care is delivered to care home residents, and staff enjoy the benefits of fair work requirements being fully delivered.

Finally, care homes should be supported fully by primary care and integrated health and social care support teams. Access to the NHS is a universal right in Scotland, provided free at the point of care for everyone. We heard that some care homes have excellent support from local primary care practitioners including GPs, and integrated health and social care support teams, but others do not: there can be no justification for denying healthcare to care home residents on the basis of their place of residence. Addressing inequities like this should be a priority for the new National Care Service.

Commissioning for public good

> Living in a good care home is so much better than sitting at home alone and struggling."

Helen Morrison
Care Home Resident

I have been living for several years in a wonderful care home, run by the council in South Lanarkshire. I couldn't be happier. The staff do everything for me, I don't need to worry about anything and even during the pandemic I feel so safe because we are so well looked after. We have a hairdressers, a cinema and a lovely café and I am surrounded by friends. The staff are really committed to making sure we have everything we need. I don't think the staff are paid enough for what they do. They have a really difficult job at times and they never complain, they just get on with it and work so hard, particularly dealing with the Covid situation. They are worth their weight in gold.

I know some people dread the idea of going into a care home but it's been a wonderful move for me. I would urge people to look into the care and help that is available. Living in a good care home is so much better than sitting at home alone and struggling. Nothing would persuade me to move from here. It really is my home and I love it.

Recommendations

We have identified a range of changes needed in commissioning and procurement practices:

32. Commissioners should focus on establishing a system where a range of people, including people with lived experience, unpaid carers, local communities, providers and other professionals are routinely involved in the co-design and redesign, as well as the monitoring of services and supports. This system should form the basis of a collaborative, rights based and participative approach.
33. A shift from competitive to collaborative commissioning must take place and alternatives to competitive tendering developed and implemented at pace across Scotland. Commissioning and procurement decisions must focus on the person's needs, not solely be driven by budget limitations.
34. The establishment of core requirements for ethical commissioning to support the standardisation and implementation of fair work requirements and practices must be agreed and set at a national level by the new National Care Service, and delivered locally across the country.
35. To help provide impetus and support to the adoption of a collaborative and ethical approach to commissioning, the idea from CCPS of pressing pause on all current procurement should be fully explored in the context of a National Care Service, with a view to rapid, carefully planned implementation.
36. The care home sector must become an actively managed market with a revised and reformed National Care Home Contract in place, and with the Care Inspectorate taking on a market oversight role. Consideration should be given by the National Care Service to developing national contracts for other aspects of care and support. A 'new deal' must form the basis for commissioning and procuring residential care, characterised by transparency, fair work, public good, and the re-investment of public money in the Scottish economy.
37. National contracts, and other arrangements for commissioning and procurement of services, must include requirements for financial transparency on the part of providers along with requirements for the level of return that should be re-invested in the service in order to promote quality of provision and good working conditions for staff.
38. A condition of funding for social care services and supports must be that commissioning and procurement decisions are driven by national minimum quality outcome standards for all publicly funded adult social care support.
39. A decisive and progressive move away from time and task and defined services must be made at pace to commissioning based on quality and purpose of care – focused upon supporting people to achieve their outcomes, to have a good life and reach their potential, including taking part in civic life as they themselves determine.
40. Commissioning decisions should encourage the development of mutually-supportive provider networks as described above, rather than inhibiting co-operation by encouraging fruitless competition.
41. Commissioning and planning community based informal supports, including peer supports, is required to be undertaken by Integration Joint Boards and consideration of grant funding to support these is needed.

Chapter 10
Fair Work

Fair Work

> The carers that came in were worth their weight in gold and should be rewarded or acknowledged for this."

While carrying out this review we heard from many people about their experiences of working in social care. We also met representatives of the workforce, including trade unions, and employers.

We heard much that is impressive, heart-warming and uplifting about the commitment of the workforce to supporting people who use social care support. But we also heard much about a workforce that is undervalued, badly paid for vital, skilled work, held in low esteem in comparison particularly to the health workforce, poorly supported in terms of learning and development, and generally under-represented.

The social care workforce in Scotland is so notably disadvantaged because it is highly gendered. The sector is about 83% female. Were it 83% male, it simply would not be marginalised and undervalued as it is. The consequences of this are obvious, and highlighted by the pandemic. Turnover is high at roughly 30% p.a.[41], recruitment is challenging and it is difficult to maintain and improve standards when investment in training and development is low.

We recognise that efforts are underway to improve the situation. We are not the first to listen to the challenges facing the social care workforce and as we have carried out our review we have been careful to understand progress made by the Scottish Government to realise its ambitions on fair work and gender equality at work [42], and as part of its programme to reform adult social care support, which was launched in June 2019 and includes a commitment to ensuring the workforce is valued and skilled[43].

41 Scottish Social Services Council Data | SSSC
42 Fair Work Action Plan – mygov.scot
43 Social care: Reforming adult social care support – gov.scot (www.gov.scot)

Fair Work

In February 2019, the Fair Work Convention published its report Fair Work in Scotland's Social Care Sector[44]. The report called for urgent reform to improve the quality of work and employment for the 200,000 people who work in social care support in Scotland. It made five recommendations, as follows:

- **A sector-level body should be established by the Scottish Government with responsibility for ensuring that social care workers have effective voice in the design, development and delivery of social care services.**
- **Key stakeholders should develop and agree appropriate minimum contract standards for the provision of publicly-funded social care services, consistent with the Fair Work Framework and the Scottish Government's Fair Work First initiative.**
- **Commissioning practices should be overhauled to ensure that fair work drives high quality service delivery through the adoption of both minimum contract standards and through engagement at a sector level between purchasers, providers and deliverers of social care services.**
- **Key stakeholders in the social care sector should apply the Fair Work Framework and commit to improving pay, conditions and opportunities for progression for directly employed care workers and for Personal Assistants.**
- **The Scottish Government should support delivery of these recommendations, and incorporate them into their Fair Work Action Plan and Gender Pay Action plan. A central location within Scottish Government's Health and Social Care Directorate should coordinate policy for the social care workforce, integrated with workforce strategies for the health workforce, and support delivery of these recommendations through its own Fair Work action plan.**

In August 2019 it was agreed that the Social Care Living Wage Implementation Group, whose membership comprises representatives from Scottish Government, COSLA, Integration Authorities, third and independent sector providers and the Scottish Trade Union Congress, would be renamed the Fair Work in Social Care Implementation Group and would focus on implementation of the report's recommendations. The Implementation Group is chaired by Andy Kerr of the Piper Group and is due to report to Scottish Ministers in February 2021.

We agree with all of the recommendations of the Fair Work Convention and support their rapid implementation when the work of the Implementation Group is complete. We recommend that the Scottish Government set an ambitious implementation timetable to ensure progress and momentum.

In setting that timetable, we recommend that priority is given to the establishing of the sector level body as a means to take forward the Fair Work recommendations in partnership. That body should also take the lead in creating national sector level collective bargaining of terms and conditions.

44 Fair Work in Scotland's Social Care Sector 2019 – The Fair Work Convention

Fair Work

Valuing the workforce

Throughout our review we have heard that the social care workforce feels undervalued and under-recognised. The inclusion of social care staff, alongside their health colleagues, in the recent announcement of bonuses in recognition of their work during the pandemic will help here but there is a deeper underlying sense that social care workers have not had parity of esteem with their NHS counterparts. The recommendations made below for training and development opportunities are designed to tackle this issue. However, it will also be necessary to consider some basic terms and conditions on issues like sick pay, time-off, and travel time. But at the root of the sense of value is pay. Social care staff do not feel valued in relation to the work they do. They pointed us to numerous comparisons in the retail sector where an entry level position paid more than an experienced care worker could secure. In order to establish the true value of the skills, competences and responsibilities of social care, we propose that a national job evaluation programme is undertaken.

Workforce Planning

There is currently no national oversight of workforce planning for social care in Scotland. With many different employers in Local Authorities and the third and independent sectors, and only very limited, recent, arrangements for mutual support, current arrangements make it too hard to ensure appropriately skilled staff are trained, supported, employed and available in the right place at the right time. Experience during Covid-19 has shown us how difficult it is to deploy appropriate staff quickly when there is an urgent priority to meet. Longer-term, problems result from failure to plan ahead for training, recruitment and retention, and failure to work with partners in health and housing in particular to model innovative new approaches that depend on the availability of a suitably trained workforce who understand each other's contributions.

Given both the size of the workforce and its importance to people's wellbeing, this lack of planning, and resulting lack of resilience and flexibility, needs to be addressed. Some workforce planning is undertaken centrally for the NHS in Scotland, but there is plenty of scope to take a holistic approach across health and social care support and improve for both.

> "Without tackling the chronic low pay and gendered undervaluation of social care work itself it will not be possible to attract and retain a quality workforce or to deliver substantive improvements in the quality and provision of care."

As noted in Chapter 6, workforce planning should be a priority for a National Care Service. An adaptive and nuanced approach will be important as it will not simply be seeking to meet the staffing requirements of local delivery agencies. It will need, for instance, to be supportive of, without taking over, employment arrangements between Personal Assistants and people who use a direct payment under self-directed support Option 1. As well as enabling training for Personal Assistants one suggestion is that a national workforce planning function could establish bank arrangements for Personal Assistants who are available to support people either on an ad-hoc or more permanent basis. Social care needs workforce planning support that is equal to, but not the same as, that provided to the NHS in Scotland, so that it addresses individual requirements like this as well as helping plan for the resilience of small, medium and large providers.

Commissioning and Procurement

We cover commissioning for the public good in Chapter 9. A key priority for a National Care System should be to establish mandatory parameters within which adult social care is commissioned and procured by Integration Joint Boards, including minimum fair work standards for social care.

As part of this, the Scottish Government should review national commissioning and procurement policy and guidance to support the delivery of these mandatory parameters in commissioning and procurement decisions delivered locally by Integration Joint Boards.

Training, development and regulation

Significant improvements are needed in training, development and regulation of the workforce, and commitment by employers to workforce development should be a key feature of revised commissioning and procurement arrangements.

As part of the National Care Service, described in Chapter 5, the Scottish Government should establish a national organisation for training and development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development, with appropriate read-across to shared and reciprocal learning with the NHS workforce.

The Scottish Social Services Council (SSSC) has an important role to play in this, along with NHS National Education Services (NES). Neither is currently equipped to meet the needs of the social care workforce in full. A priority for the National Care Service should be to review the role, functions and powers of the SSSC, taking account of activities that could be more effectively carried out in close partnership with NHS NES. This is an important example of a priority task for joint working between the National Care Service and the National Health Service. At the same time, care must be taken not to "medicalise" social care and social work training: what is needed here is better joint working, and joint support, for professionals without losing the core integrity of professions that have developed over many years in different ways in response to different priorities.

Specific attention should be paid to developing professional support and supervision for people who often work in isolation from their peers, providing care and support in people's own homes and communities. Scotland needs to acknowledge and respond to the power of the workforce in these circumstances to transform people's lives for the better, to celebrate that contribution and embed a professional culture to support it. The unique importance of relationships and trust between people providing care and people using support as part of their lives should be central to our understanding of "what good looks like" in this respect.

Carmen Simon

I'm a woman migrant worker. I have been a support worker for adults with multiple/ complex needs since 2011. I currently juggle four part time jobs, two of them still in the field of adults with complex/multiple needs.

In one of my social care roles as a Support Worker for a private provider I get paid £10 an hour, the same hourly rate since 2015. In my other social care role as a Personal Assistant, Option 1 Self Directed Support (SDS), I get paid £9.30 an hour. I rely on benefits to make ends meet at the end of the month.

I've been helping someone with complex/multiple needs to access support through SDS since 2015. After six assessments and two complaints against the local authority, this person who has met substantial and critical criteria to access support, is still waiting on a care package. I am aware of another two adults with complex needs that have died waiting on a SDS care package. The current provision of adult social care has been in crisis long before the pandemic, as described by the Fair Work Convention Report On Social Care 2019. I think that a National Care Service is the way forward. Publicly owned and free at the point of need. The implementation of such a system will require time and investment. In the meantime, as a matter of urgency, I think that we should improve terms and conditions for care workers through sectoral collective bargaining and the involvement of all stakeholders: the Scottish Government, Local Authorities , employers and unions.

> "The current provision of adult social care has been in crisis long before the pandemic, ... a National Care Service is the way forward."

Recommendations

Our recommendations for creating a National Care Service provide a mechanism for delivery of Fair Work in social care and support. To improve terms and conditions for the social care workforce, and to properly reflect the value social care brings to Scotland's economy and wellbeing of its people, we recommend:

42. Rapid delivery of all of the recommendations of the Fair Work Convention, with an ambitious timetable for implementation to be set by the Scottish Government.
43. Conduct a national job evaluation exercise for work in social care, to establish a fair and equitable assessment of terms and conditions for different roles. This should take account of skills, qualifications, responsibilities and contribution.
44. Putting in place national minimum terms and conditions as a key component of new requirements for commissioning and procurement by Integration Joint Boards. Specific priority should be given to pay, travel time, sick pay arrangements, training and development, maternity leave, progression pathways, flexible pathways and pension provision. The national evaluation of terms and conditions should be undertaken to inform these minimum standards and these should be reviewed as required.
45. Establishing a national organisation for training, development, recruitment and retention for adult social care support, including a specific Social Work Agency for oversight of professional development. The current role, functions and powers of the SSSC should be reviewed and appropriate read-across embedded for shared and reciprocal learning with the NHS workforce.
46. Establishing a national forum comprised of workforce representation, employers, Integration Joint Boards and the Scottish Government to advise the National Care Service on workforce priorities and to take the lead in creating national sector level collective bargaining of terms and conditions.
47. National oversight of workforce planning for social work and social care, which respects the diversity and scale of employment arrangements while improving resilience and arrangements for mutual support should be a priority for a National Care Service.
48. The recommendations listed above should apply to Personal Assistants employed by people using Option 1 of SDS, who should be explicitly recognised as members of the workforce, as well as employees of providers in the public, third and independent sectors. This recommendation should be delivered in full partnership with the independent living movement.

Chapter 11
Finance

Finance

> The key issue affecting the social care sector is lack of funding."

As we said at the beginning of this report, we have deliberately not started with finance. We felt it was vitally important to conduct this review from the perspective of people's experience of adult social care support, and the role adult social has to play in Scotland's wellbeing as a whole.

Nevertheless, we must come to money in the end. The proposals we have set out here do not come without cost: but nor are they only about cost. There is clear evidence that social care support is not a drag on our resources; it creates jobs and economic growth. It enables people who access care and support, and their carers, to seek and hold down employment themselves. Accordingly, a major thrust of this section of the report is to describe the investments required to create a system of social care support that will enable everyone in Scotland to get the social care support they need to live their lives as they choose and that promotes and ensures human rights, wellbeing, independent living and equity. As we consider money, we want to reiterate the importance of replacing old thinking with new thinking. Investing in people is beneficial to society: it is an investment in ourselves and one another. As a system, we need to consider investment choices through the constructive, empowering focus of a new mindset:

Old Thinking	New Thinking
Social care support is a burden on society	Social care support is an investment
Managing need	Enabling rights and capabilities
Available in a crisis	Preventative and anticipatory
Competition and markets	Collaboration
Transactions	Relationships
A place for services (e.g. a care home)	A vehicle for supporting independent living
Variable	Consistent and fair

Finance

In this chapter we set out a brief analysis of current expenditure on adult social care; opportunities to spend money better; our recommendations for additional investment; the evidence to support our assertion that that expenditure is itself an investment; and finally some options for raising money to support these changes. We have by necessity used a number of proxies in this assessment to help us "size" the level of investment we think is required. These proxies are often not ideal: for instance, delayed discharge is in many ways an "old thinking" measure, but we have used them here as the best mechanism available to us to understand what needs to happen.

> "Social care is not funded in a way which is sustainable or supports transformation of services."

Current expenditure on adult social care

In 2018/19 expenditure on formal adult social care in Scotland was £3.8bn:

- **Most funding came from the public sector (84%), with the balance from individuals through Local Authority service charges and self-funding of care home places by residents.**
- **Almost two thirds of expenditure was on services for older people.**
- **There was marginally more expenditure on community based services (54%) than on accommodation based services.**

In addition, the economic value of the contribution made by carers is estimated to have been £36bn[45].

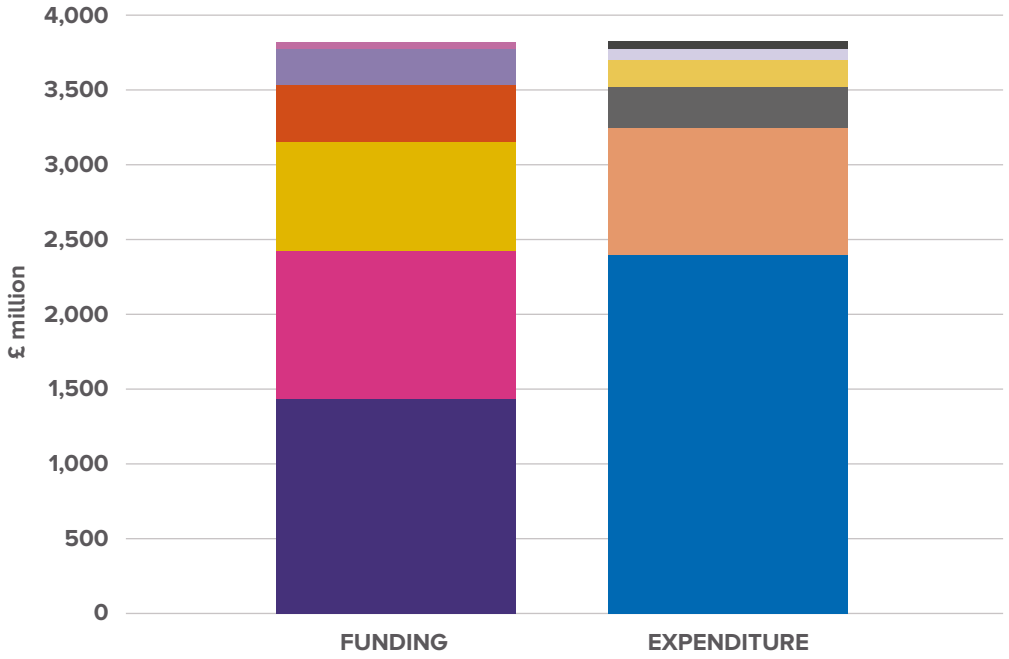
45 Unpaid care work worth £36bn in Scotland – Oxfam Scotland (oxfamapps.org)

Finance

Total adult social care funding and expenditure of £3.8bn are illustrated in this chart:

FUNDING

- Independent Living Fund £51m
- Charges £238m
- Self Funders £381m
- Integration Joint Boards £730m
- Council Tax/Non Domestic Rates £989m
- Scottish Government Grants £1,434m



EXPENDITURE

- Independent Living Fund £51m
- Other needs £71m
- Mental Health £187m
- Physical or sensory needs £268m
- Learning Disability £850m
- Older People £2,397m

Most of the funding came from the public sector (84%) with the balance coming from individuals through Local Authority service charges and self-funding care home residents.

Related expenditure, on community based health services and unplanned hospital care, which are under the control of Integration Joint Boards, totalled £6.1bn in 2018/19.

The proposals we have set out earlier in this report relate to total health and adult social care expenditure of Integration Joint Boards.

In 2020/21 the Scottish Government became responsible for social security payments, with budgets for adult benefits totalling £3bn. There is considerable overlap between people who use social care supports and people who access benefits, but not everyone who uses one uses the other.

Finance

Opportunities to spend money better

Costs arise in our current system because social care supports are often too focused on crisis management and late intervention, and not enough on prevention and empowering people to live fulfilling lives. Costs like these are borne not only by the public sector, but also by people who use social care support[46] and their families and carers, and many are avoidable. We have not carried out an extensive analysis of these costs, but we have looked at examples that we recommend a National Care Service should consider carefully for opportunities to improve. We are not suggesting that the money spent on these areas of activity is currently wasted: we are suggesting that with more effective care planning and delivery it could in some instances be put to better use to support people more effectively:

- **Delayed discharges accounted for 542,000 bed days in 2019/20, i.e., 8.9% of all beds in NHS Scotland, costing £134m[47]. We know that being delayed in hospital when someone is ready to go home is bad for their wellbeing.**
- **There is significant variation in the length of time people spend in hospital in the last six months of their lives. In some circumstances, hospital care is exactly right for people nearing the end of life. In other cases, more time could be spent at home, which is what many people want, if better support were available. The average length of stay in hospital in the last six months of life varies by 66% across Integration Joint Boards. In total, hospital care in the last six months of life amounted to 1.1m hospital bed days in 2019/20, i.e.,19% of all beds[48].**
- **Similarly, there is significant variation in models of care and hospitalisation rates for people with dementia[49], the costs of which in total are £2.6bn per year[50].**
- **In 2019/20, £58m was spent on out-of-area care home placements for adults with learning disabilities, for reasons other than choice, at a median cost per placement of over £87k[51].**
- **Waiting times for adult social care carry a significant burden for people who need support. In 2017/18 the proportion of people with substantial or critical needs waiting more than six weeks for a community care assessment was 7% and 8% respectively[52]. Recent analysis suggests that in 2018/19, older people had 20% fewer unplanned admissions to hospital in the six months after receiving homecare support than in the six months prior.**

46 Follow the money. www.carereview.scot
47 Annual summary of occupied bed days and census figures – data to March 2020
48 Percentage of end of life spent at home or in a community setting. PHS
49 Care co-ordination in Midlothian report | Focus on Dementia | ihub – Care Co-ordination in Midlothian report
50 Projections of older people with dementia CPEC Nov 2019
51 Coming home: complex care needs and out of area placements 2018 – gov.scot (www.gov.scot)
52 Eligibility criteria and waiting times – gov.scot (www.gov.scot)

Additional investment

In this section we cover a number of areas in which we believe additional investment in adult social care is needed.

Expanding access to social care support and investing in prevention

Despite the fiscal effects of austerity in recent years, Integration Joint Boards and Local Authorities have increased expenditure on adult social care in real terms since 2009/10 by 7% in total and by 5% per capita. This is in contrast to the position in England, where expenditure fell in real terms by 1% and 6% respectively[53].

As the older population has increased and resources have been focused increasingly on those in greatest need, a smaller proportion of the adult population is in receipt of social care support than was before austerity, with the result that the needs of a number of people are probably not being met and for others they are being met in a crisis response rather than to anticipate or avoid such interventions. Some of this reduction may reflect substitution of formal services with asset based approaches[54], and some may be the result of genuine reduction in need as other supports have improved people's lives, but this is difficult to quantify. As approximate as the evidence available to us is, it nonetheless suggests to us that there is an opportunity to invest more than we do currently in preventative care that can yield benefits for individuals and the system as a whole.

To assess the extent to which there are opportunities for better investment in social care support, the Scottish Government is currently carrying out a detailed analysis exploring the determinants of social care service use across data-zones. This is important work and we are reassured that it is underway. Its results are not yet available so for the purposes of this report we have carried out a higher level assessment as follows:

- **A longitudinal analysis that used 2009/10 service use data to calculate the expected number of people using social care support in 2018/19, and compared those to the actual number.**
- **An analysis of variation across Integration Joint Boards to calculate the expected number of people using social care support in 2018/19 based on standardised Scottish average rates (i.e. adjusted for differences in age/sex and morbidity and life circumstances), and compared those to the actual number.**

We found that there were 25,505 fewer people (20%) receiving care in 2018/19 than expected based on 2009/10 levels of access. We estimate that it would cost around £288m to cover that "gap". In addition, there were 10,412 fewer people (10%) receiving care in 2018/19 than expected based on the standardised rates. We estimate that it would cost around £148m to cover that "gap". With the caveats noted above regarding the difficulty of interpreting this data, we therefore estimate that there may be approximately 36,000 people in Scotland who do not currently have access to social care support and for whom it would be beneficial, and that it would cost about £436m to meet this need. We recommend investment in social care is increased in order to expand access to social care support.

We have discussed elsewhere the importance of community connections and low-level preventive support for people, and suggested that Integration Joint Boards should commission and grant-fund community organisations.

53 Social care 360: expenditure | The King's Fund
54 ADASS Budget Survey 2019

Fair Work

Our recommendations include implementing the findings of the Fair Work Convention. Investing in Fair Work is an investment in Scottish society, which helps to drive national and local economic growth as well as, in this context, a fair reflection of the importance of the work done in social care supports. We make a clear link between the importance of remunerating the workforce fairly, commissioning social care support ethically and collaboratively, and making good use of available public resources.

We have calculated the costs we anticipate associated with increasing the Real Living Wage to £9.50 per hour, along with ensuring it is paid to all staff working in adult social care support. Increasing the Real Living Wage to £9.50 per hour for frontline adult social care staff would cost £15.5m p.a.. This estimate includes staff working in care homes, home care and housing support, day-care, adult placement services, personal assistants and sleepovers. Extending the Real Living Wage to include auxiliary staff working in adult services would cost an additional £4m p.a.. As discussed in Chapter 10 on Fair Work, we acknowledge that trade unions representing the workforce are keen to exceed the Real Living Wage and are calling for an uplift to £15 per hour. The costs associated with implementing the Real Living Wage represent the 'floor' rather than the 'ceiling'. More accurate assessments will require the job evaluation process described earlier in the report. But in broad terms, every pound beyond the Real Living Wage will increase the national social care support wage bill by about £100m per annum. Of course, there is also a debate to be had about who should bear those costs and how they should be factored into contracts and commissioning.

Removing charging for non-residential social care support

Our "new thinking" approach extends to what is fair and right for people receiving social care supports in their own homes. People should no longer be charged for non-residential social care support such as care and, support at home, and day care. It does not make sense for people to have access to health care free at the point of need but, in circumstances that are equally related to their health and wellbeing, to be charged for support. It also does not support delivery of their human rights.

In 2019/20 Local Authority income raised from non-residential user charges was £51m. We know from the experience of introducing Free Personal and Nursing Care that the removal of charges may lead to increased use of services. We therefore suggest that planning for the removal of non-residential charges should take account of the likelihood of increased use.

Free Personal and Nursing Care for self-funding care home residents

The removal of charging for non-residential care should mean that the only cost for people in receipt of social care should be the means tested accommodation costs for care home residents. However, in recent years the cost of providing Free Personal and Nursing Care has increased significantly and the payment made to providers by Local Authorities for self-funding residents has not kept pace with this. This is not an issue for Local Authority funded placements covered by the National Care Home Contract, which contains reasonable provision for the cost of Free Personal and Nursing Care.

Using the National Care Home Contract as a benchmark, the difference between the costs included for Free Personal and Nursing Care and the sums paid by Local Authorities for self-funders were £191 and £230 per week respectively in 2019/20. We recommend that the sums paid for Free Personal and Nursing Care for self-funders using care homes should be increased to the levels included in the National Care Home Contract, and that this would cost £116m p.a..

Care Home Accommodation Costs

Our recommendations mean that all people in Scotland will receive social care free at the point of need. The only costs that will remain are those for accommodation, either directly through fees for care home residents or indirectly through household costs for those receiving care in their own homes. Although in most cases these are higher for care home residents, they are in principle the same.

An individual's contribution to their care home accommodation costs is funded primarily through their own income, with the Local Authority making up the balance on the basis of a means test on the individual's assets. Below the lower limit the Local Authority meets all of the shortfall and above the upper limit the individual covers the total cost, by drawing down the value of their assets.

We considered whether it is appropriate for people to contribute to their accommodation costs in residential care, or whether this too should be free at the point of use. We concluded that it is reasonable for some charge to be made where the individual's means permit, because in other circumstances that person would be paying accommodation costs at home. The National Care Service could in future consider whether adjustments to the means testing arrangements that are used would introduce greater fairness, but we have not considered this complex question in detail during this review. It is worth noting that many of the alternative approaches suggested previously in the UK and overseas tend to be regressive in nature and we propose that any future work should exercise caution in this regard.

Re-opening the Independent Living Fund

The Independent Living Fund plays an important role in supporting its members' wellbeing and independence. The existing fund has 2,600 members and we estimate that there are a further 3,400 people who would be eligible for an award were we to re-open the fund and retain the existing threshold sum for access.

As indicated earlier in the report, we see the Independent Living Fund operating in future as part of the National Care Service. In effect, it will provide a national service of self-directed support to people with the most complex needs in the country. We recommend that the Independent Living Fund should be re-opened. To ensure that the Fund focuses on people with the most complex needs, we recommend that the threshold sum for entry to the new scheme should be reviewed and adjusted. To give some indication of the likely additional costs, if the threshold sum for new entrants was set at £600 per week, an additional investment of £32m would be required, increasing the total fund value to £85m p.a..

Unpaid Carers

In recognition of concerns we heard about the Carer's Allowance, and the impact of caring on some people's income, we recommend a review of financial support made available to unpaid carers should be taken forward. As part of its focus on improving support for unpaid carers, the National Care Service should also increase investment in a range of respite provision including options for non-residential respite, and for short breaks.

Although charges to carers are waived under the Carer's Act, some Local Authorities allocate charges to the supported person for respite. Removing such charges should be considered alongside other investment priorities.

Future funding

On top of the initial investment set out above, Scotland's ageing demography means that more money will need to be spent on adult social care over the long term. This challenge exists for the rest of the UK as well.

Based on Personal Social Services Research Unit (PSSRU) research[55] a reasonable starting point for projections is a 3.5% p.a. real increase in social care expenditure every year to 2035 in Scotland, but more specific Scottish projections will be vital in the future.

The Scottish Government's Health and Social Care Medium Term Financial Framework[56] includes an assumption of nominal growth rates for social care of 4% p.a. gross and 3% p.a.net of savings until 2023/24. Assuming 1.8% p.a. inflation, the growth rate in the Medium Term Financial Framework is currently 1.3% p.a. lower than the rate recommended by PSSRU. We recommend that future planning for investment in adult social care must factor in demographic change.

Spending on adult social care is an investment in the Scottish economy

When we add up the recommendations we have made above, the total annual additional expenditure we are suggesting is £0.66bn p.a., i.e., about 0.4% of Scottish GDP.

This is a 20% increase in real terms over 2018/19 levels and twice the total real terms increase in adult social care expenditure over whole of the previous ten years (£.3bn). Even allowing for a phased introduction, an investment on these lines will require a long-term and substantial uplift in adult social care funding.

We believe that the scale of this increase in funding is warranted on the human rights basis we have set out, and also that it represents a good investment in the Scottish economy and has a positive impact on women's employment and the gender pay gap:

- **The social care sector directly employs 205,000[57] people, approximately 8% of the workforce, with 148,000 working in adult social care. In addition, a further 51,000 jobs are generated as a result of adult social care in other sectors. In 2019 women made up 83% of the workforce, and average earnings were 56% of Scottish average in 2016[58].**
- **The contribution of adult social care to the Scottish economy extends beyond the care sector. For every £1 spent on social care, more than £2 is generated in other sectors[59]. A recent report[60] estimates that an increase in social care expenditure of 1% of GDP would create three times as many jobs in the UK economy than it would if spent in the construction industry; and the sums recouped by the Treasury through taxes and NI would be 50% higher.**

55 https://www.pssru.ac.uk/pub/DP2900.pdf
56 Health and Social Care: medium term financial framework – gov.scot (www.gov.scot)
57 Scottish Social Service Sector: Report on 2019 Workforce Data (sssc.uk.com)
58 The Economic Value of the Adult Social Care Sector – Scotland (sssc.uk.com)
59 Investing in the Care Economy – Womens Budget Group (wbg.org.uk)
60 A Care-Led Recovery from Coronavirus – Womens Budget Group (wbg.org.uk)

- **The Women's Budget Group[61] estimates that the majority of new jobs created by investment in social care will be taken by women.**
- **Such investment generates social value. Through the combined influence of emotional wellbeing, health maintenance and sustaining natural support and prevention, social care has a direct, indirect and extended impact: a study of the Independent Living Fund in Northern Ireland estimates that every £1 spent generates £11 of social value[62].**
- **The Social Justice Commission[63] suggests that expenditure on care should be given an equivalence to investment in any other key sector, and should feature prominently in economic policy, not only in post-Covid economic and social recovery, but as a focus of investment supported through organisations like the Scottish National Investment Bank and economic development funding.**
- **Both for people who use social care support, and equally importantly for unpaid carers, the availability of high quality adult social care support can help people to engage in and remain in education and also to enter and remain in work.**

The additional expenditure we are recommending here should not be seen in economic terms as a revenue cost but rather as an investment that encourages job creation and provides economic stimulus. It should play a key part in post-pandemic recovery plans, particularly in light of the Institute for Fiscal Studies' analysis that more women are likely to lose their jobs than men as a result of Covid-19[64].

Options for Raising Revenue

Should the Scottish Government accept our recommendations on investment, it will need to consider a range of options for generating new revenues. We have outlined broad ideas here, many of them drawn from an analysis of how other countries have gone about funding investments in their social care systems.[65] [66] [67] It is for the Scottish Government and Scottish Parliament, in due course, to consider what would be most appropriate. Broadly, the following options are available:

- **Introduction of mandatory social insurance;**
- **Changes to existing devolved taxes to raise additional revenue;**
- **Introduction of a new local tax;**
- **Seeking devolved powers for a new national devolved tax in Scotland; and**
- **Seeking devolution of existing reserved taxes to raise additional revenue.**

61 Investing in the Care Economy – Womens Budget Group (wbg.org.uk)
62 https://ilf.scot/wp-content/uploads/2020/07/44188-ILF-NI-Impact-Evaluation-Report.pdf
63 reform-of-social-care-discussion-paper-september-2020.pdf (socialjustice.scot)
64 COVID-19 and inequalities | Inequality: the IFS Deaton Review
65 Social-care-funding-options-May-2018.pdf (health.org.uk)
66 A fork in the road: Next steps for social care funding reform (kingsfund.org.uk)
67 1555059771_how-to-fund-social-care-briefing-2019.pdf (nuffieldtrust.org.uk)

These options are not uniform in their deliverability. Scotland has no history of mandating insurance, people have been reluctant to insure against future social care need, and the insurance industry is not well prepared for a new market. Changes to existing devolved taxes or the introduction of new local taxes are within the competence of the Scottish Parliament, but would require careful assessment against the Scottish Government's wider tax priorities, and would have to be consistent with the Scottish Government's stated principles for taxation.

There are also a set of specific challenges when considering the options, in particular:

Equity and intergenerational fairness

Any funding mechanism should be progressive in respect of ability to pay. It should also be equitable between people of different age groups. This is particularly important with newly established funded schemes, where the demands on the fund from the elderly are likely to exceed their contributions in the short term.

Hypothecation and the visibility of any new funding mechanism

In the design of any new tax, it is important to consider the degree to which, if at all, new revenues would be hypothecated to protect funding for adult social care. Hypothecation is not commonly used in the UK. It could constrain future options and impact the extent to which funding could adapt over time to meet demand.

There is evidence of public support[68] for hypothecation to fund increased expenditure on social care but it can constrain future allocation decisions and potentially funding across the economic cycle. Consideration would need to be given to whether hypothecation would achieve greater transparency and deliver sufficient funding stability in practice.

Broadly, options could take several forms:

- **Strict hypothecation, where spending is linked directly to new revenue raised and funding is used only for that purpose.**
- **Partial hypothecation, where new revenue raised is ring-fenced to fund increased expenditure, but existing baseline funding is not protected. This is the approach that has been recommended to fund increased investment for social care in a report to the Welsh Government[69].**
- **Indicated spend, where the raising of new revenues is symbolically linked to adult social care, but in practice the revenue raised is not ring-fenced.**
- **No form of hypothecation.**

The speed of reform will have a big impact on the viability of funding options, as do options that can be delivered within the existing devolved settlement, versus options that would require new tax powers or the devolution of existing UK taxes.

68 A fork in the road: Next steps for social care funding reform (kingsfund.org.uk)
69 paying-for-social-care.pdf (gov.wales)

In addition, the design of any new funding mechanism needs to be carefully considered to ensure it is proportionate, sustainable, embeds intergenerational fairness and is consistent with the Scottish Government's wider economic and fiscal strategies and outlook.

Addressing these important questions is a sizeable task in itself, which we recommend requires considerable further analysis and careful consideration before decisions are made.

Recommendations

Adult social care support in Scotland requires greater investment. To secure better access to social care support, better terms and conditions for the social care workforce, better sustainability, the economic benefits of a strong social care sector, and to meet the aspirations and other recommendations we have laid out in this report, we recommend:

49. Prioritising investment in social care as a key feature of Scotland's economic plans for recovery from the effects of the Covid-19 pandemic.
50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.
51. Additional investment in order to:
    - **expand access to support including for lower-level needs and preventive community support;**
    - **implement the recommendations of the Fair Work Convention;**
    - **remove charging for non-residential social care support;**
    - **increase the sums paid for Free Personal and Nursing Care for self-funders using care homes to the levels included in the National Care Home Contract;**
    - **re-open the Independent Living Fund, with the threshold sum for entry to the new scheme reviewed and adjusted; and**
    - **review financial support made available to unpaid carers and increase investment in respite.**
52. Robustly factoring in demographic change in future planning for adult social care.
53. Careful consideration to options for raising new revenues to increase investment in adult social care support.

Chapter 12
Summary and recommendations

Summary and recommendations

We all know from history that major shocks – war, an economic crash or indeed a pandemic – can provide societies with an opportunity for real change. But improvements do not just follow such traumas; they come about as a result of courageous leadership, honesty with one another and a shared will to make things better. The Scottish Government has already displayed bravery, thoughtfulness and foresight by commissioning this independent review in the midst of the Covid-19 pandemic. Next, it needs to act, we hope with support for improvement from across Scottish civic and democratic society, to deliver a system of social care that takes as its central aim the realisation of every citizen's right to participate fully in society, whatever their needs for support. And that system needs to work in full partnership with other aspects of our public services, not least the NHS but not only the NHS either: housing, and justice, education and economic development are all central too.

People have asked us, how can we afford a National Care Service? Given the conclusions we have set out here, we would ask in response – how can Scotland not afford it, ethically or indeed economically?

This is a real opportunity for change. Covid-19 has highlighted more than ever the critical role that social care supports can play in enabling people to live life to the full. The focus however has been on care homes, where lack of visiting, the high rate of deaths early in the pandemic and the lack of PPE for staff were all rightly highlighted in the media and in the Scottish Government's response. There has been a tendency to overlook the many people who receive care and support at home, both formal paid care and informal unpaid care from family members and loved ones.

In the forthcoming Scottish elections there is an opportunity to secure support across all political parties to a vision for the future of care in Scotland and commitments to take radical action to begin to set us on a path to achieve that vision.

This is partly about the fact that Scotland, in common with the rest of the developed world, has an ageing population. By 2036, one in four people with be over 65. Many of us will experience a period towards the end of our lives when we will need some care and support. But, as we have demonstrated in this report, this is not just about an ageing population, or caring well for older people in our society, as vital as those priorities are.

It is too easy for us to think this is about someone else. But this is about our colleagues, our friends, our families, our neighbours, and ourselves. This is about Jack who has dementia. This is about John with cerebral palsy, this is about Jade with autism, Jagdeep with motor neurone disease, Jim the veteran who has lost both legs, Jashree with multiple chronic conditions that limit her mobility, Janet who is in her 90s and too weak to move about her home unaided. Everyone one of us has a right to live a full life. This should be more than whether we can go to the toilet, wash and dress ourselves unaided, though support for these activities of daily living is vital. Everyone should be enabled to live, work and play – to enjoy full citizenship and participation. That means support to get out and about, to join in with groups and activities that we enjoy, to work or participate in adult education and training.

Scotland needs a new approach to social care to make these aspirations a practical, everyday reality across the country. We need to create a National Care Service that is based upon a new narrative, replacing crisis with prevention and wellbeing, burden with investment, competition with collaboration and variation with fairness and equity. And we need to put people at the centre of it: people who use social care supports, their families and carers, and people who work in social care services.

If not now, when? If not this way, how? And if not us – who?

Summary and recommendations

Our recommendations are as follows:

A human rights based approach

1. Human rights, equity and equality must be placed at the very heart of social care and be mainstreamed and embedded. This could be further enabled by the incorporation of human rights conventions.
2. Delivering a rights based system in practice must become consistent, intentional and evident in the everyday experience of everyone using social care support, unpaid carers and families, and people working in the social care support and social work sector.
3. People must be able to access support at the point they feel they need it, including for advice and signposting to local community-based resources and help, and for barriers to this, such as the current eligibility criteria and charging regime, to be fundamentally reformed and removed, to allow a greater emphasis on prevention and early intervention.
4. People should understand better what their rights are to social care and supports, and "duty bearers", primarily social workers, should be focused on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost.
5. Where not all needs can be met that have been identified as part of a co-production process of developing a support plan, these must be recorded as unmet needs and fed into the strategic commissioning process.
6. Informal, community based services and supports must be encouraged, supported and funded to respond appropriately to the needs of local citizens, including for preventative and low level support.
7. A co-production and supportive process involving good conversations with people needing support should replace assessment processes that make decisions over people's heads and must enable a full exploration of all self-directed support options that does not start from the basis of available funding. Giving people as much choice and control over their support and care is critical.
8. More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.
9. When things do not work well for people and their rights have not been upheld, they must have rapid recourse to an effective complaints system and to redress.
10. Packages of care and support plans must be made more portable and supported people should not have to fight to retain support because they have moved home.

Summary and recommendations

Unpaid carers

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

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

13. Local assessment of carers' needs must, in common with assessment of the needs of people using social care support services and supports, better involve the person themselves in planning support.

14. Carers must be represented as full partners on the Integration Joint Boards and on the Board of the National Care Service.

The case for a national care service (NCS)

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

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

17. The National Care Service should oversee local commissioning and procurement of social care and support by reformed Integration Joint Boards, with services procured from Local Authorities and third and independent sector providers. Integration Joint Boards should manage GPs' contractual arrangements, whether independent contractors or directly employed, to ensure integration of community care and support provision, to respect and support professional interdependencies, and to remove the current confusion about where responsibility for primary care sits.

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

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

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

Summary and recommendations

A National Care Service for Scotland – how it should work

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

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

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

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

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

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

A new approach to improving outcomes – closing the implementation gap, a new system for managing quality

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

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

Summary and recommendations

Models of care

28. The Scottish Government should carefully consider its policies, for example on discharge arrangements for people leaving hospital, to ensure they support its long held aim of assisting people to stay in their own communities for as long as possible.

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

30. There must be a relentless focus on involving people who use services, their families and carers in developing new approaches at both a national and local level.

31. Investment in alternative social care support models should prioritise approaches that enable people to stay in their own homes and communities, to maintain and develop rich social connections and to exercise as much autonomy as possible in decisions about their lives. Investment in, or continuance of, models of social care support that do not meet all of these criteria should be a prompt for very careful reflection both by a National Care Service and local agencies.

Commissioning for public good

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

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

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

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

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

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

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

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

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

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

Fair Work

42. Rapid delivery of all of the recommendations of the Fair Work Convention, with an ambitious timetable for implementation to be set by the Scottish Government.

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

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

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

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

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

48. The recommendations listed above should apply to Personal Assistants employed by people using Option 1 of SDS, who should be explicitly recognised as members of the workforce, as well as employees of providers in the public, third and independent sectors. This recommendation should be delivered in full partnership with the independent living movement.

Summary and recommendations

Finance

49. Prioritising investment in social care as a key feature of Scotland's economic plans for recovery from the effects of the Covid-19 pandemic.

50. Careful analysis by a National Care Service, with its partners in the National Health Service, Integration Joint Boards and beyond, of opportunities to invest in preventative care rather than crisis responses, to avoid expenditure on poor outcomes such as those experienced by people who are delayed in hospital.

51. Additional investment in order to:

- **expand access to support including for lower-level preventive community support;**
- **implement the recommendations of the Fair Work Convention;**
- **remove charging for non-residential social care support;**
- **increase the sums paid for Free Personal and Nursing Care for self-funders using care homes to the levels included in the National Care Home Contract;**
- **re-open the Independent Living Fund, with the threshold sum for entry to the new scheme reviewed and adjusted; and**
- **review financial support made available to unpaid carers and increase investment in respite.**

52. Robustly factoring in demographic change in future planning for adult social care.

53. Careful consideration to options for raising new revenues to increase investment in adult social care support.

JANUARY 2021

Addendum

Addendum

You can find background information about this independent review of adult social care in Scotland, including details of meetings, our engagement exercise, submissions made to the review and background papers, here: Independent Review of Adult Social Care – gov.scot (www.gov.scot).

The review was chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. Mr Feeley was supported by an Advisory Panel comprising Scottish and international experts as follows:

- Malcolm Chisholm, Former Scottish Minister for Health and Community Care 2001 – 2004
- Anna Dixon: Chief Executive, Centre for Ageing Better
- Caroline Gardner: Auditor General 2012–20
- Stuart Currie: East Lothian Councillor
- Göran Henriks: Chief Executive of Learning and Innovation, Qulturum, Jönköping County, Sweden
- Ian Welsh: Chief Executive, the ALLIANCE
- Jim Elder-Woodward: Chair of the Scottish Independent Living Coalition (SILC)

Secretariat support to the review was provided by a team of officials from the Scottish Government's Health and Social Care Directorates:

- Alison Taylor
- Christina Naismith
- Lorraine Davidson
- Paul Leak
- Mary O'Toole
- Susan Craig
- Gillian McDonald
- Madihah Iqbal
- Jack Walker
- Kelly Martin
- Morna Macleod
- Sophie Downie

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Midlothian Integration Joint Board

Midlothian Health & Social Care Partnership

Thursday 11th February 2021, 2.00 pm

Finance Update for 2020/21

Item number:	**5.5**

Executive summary

This report provides an update to the IJB on its updated projected year end out-turn, undertaken by both the IJB partners Midlothian Council and NHS Lothian at Quarter 3 and Month 9, with the positions yet to be formally concluded and reported but Partners. This forecast from both IJB's partners' takes into account COVID additional funding that has been confirmed. This report also acknowledges the headline content of the recent Scottish Government Budget announcement and the consequences for the IJB.

Board members are asked to:

1. *Note the Quarter 3 and Month 9 financial reviews undertaken by partners*
2. *Note the impact COVID has had on the IJB financial position*
3. *Note the COVID funding that has been included*
4. *Note the recent Scottish Government budget announcement*

Report

Finance Update 2020/21

1 Purpose

1.1 This report lays out the results of the partner's (Midlothian Council and NHS Lothian) Quarter 3 and Month 9 financial reviews and considers how this impacts on the projected financial position for the IJB for 2020/21.

2 Recommendations

2.1 As a result of this report Members are being asked to:-

- Note the position as laid out below
- Note the impact COVID has had on the IJB financial position in 2020/21
- Note the ongoing impact of COVID and the financial position in 2021-22
- Note the recent Scottish Budget announcement for 2021-22

3 Background and main report

3.1 The COVID-19 pandemic is ongoing and the financial risks to Health & Social Care will continue to change over these uncertain and volatile times. COVID-19 represents an unprecedented challenge for the delivery of health and social care services and there is significant uncertainty and additional costs arising in 2020/21.The financial position for the IJB remains a challenge to report.

3.2 The financial impact of COVID-19, both in terms of the impact of the actual costs incurred to date, as well as the implication for the rest of the financial year continues to be reviewed. Finance teams in both organisations continue to monitor the extent to which the projected overspend relates to: the 'core' (i.e. underlying operational) position; the impact of COVID-19 on costs incurred to date; and any (future) financial consequences of mobilisation/remobilisation.

3.3 The Quarter 3/Month 9 financial reviews position for the IJB is a projected overspend of (£0.9m) as shown in Table 1 below. Please note that the Midlothian Council Q3 financial review is due to be formally reported to Council on the 23rd February 2021, albeit this doesn't include the IJBs position given the IJB will manage its year end position within its resources. The Health forecast is an informal update, based on Month 9, which at the time of writing hasn't yet been through the formal Q3 financial review process or reporting routes. There is £2m improvement from the previously reported position which is a direct result of significant COVID funding now being included within the position. Table 1 below shows the Quarter 3/Month 9 position and a comparison to the pre COVID funding position, our Month 6 projections.

	Annual Budget	Forecast Expenditure	Quarter 3/Month 9 Forecast Outturn	Previous Forecast Outturn
	£k	£k	£k	£k
Core	70,954	71,820	-866	-2,603
Hosted	14,799	14,688	111	4
Set Aside	17,493	18,169	-676	-859
Health	103,246	104,677	-1,431	-3,458
Social Care	44,973	44,427	546	481
Total	148,219	149,104	-885	-2,977

Table 1 IJB Quarter 3/Month 9 review forecasts

3.4 As noted above, funding has been received and is now reflected in the updated forecast for 2020/21. Midlothian HSCP has confirmed funding of £4.2m to cover COVID-19 costs (excluding FHS and Prescribing which will be funded separately and the recently announced winter preparedness allocation). When the funding for these outstanding areas is received the health position, within the HSCP, is expected to breakeven or to have a core under spend similar to that of previous financial years.

3.5 The COVID-19 funding for the Health Set Aside and Hosted budget sits with NHS Lothian and we are currently working with NHS Lothian to allocate this. For 2020/21, the financial risk has reduced accordingly and at this stage in year given the funding being allocated from Scottish Government there is moderate assurance the IJB will breakeven.

3.6 When looking at COVID-19 costs and the additional funding allocated, this highlights that there is a degree of budget cover already in each partner's core funding that can potentially cover some of these COVID costs in year.

3.7 Updated cost projections continue to be fed into Scottish Government through NHS Lothian regularly. The recent value submitted, mid January 2021, overall remains similar but the component parts change. The opening of the additional beds at Midlothian Community hospital has seen an increase in these costs, whilst the level of payments expected for sustainability has reduced.

3.8 As a health and social care system our ability to respond quickly remains key, this requires service plans to be altered regularly. The overall COVID costs projections for 2020/21 were projected at circa £7m. The projections of COVID-19 related expenditure, given the system volatility and uncertainty is challenging as is recruiting to and having the workforce to support these initiatives which sees the cost projections move regularly. As we continue to alter our services to deal with the 2nd COVID-19 wave many of these plans will continue beyond the end of this financial year and become a risk for 2021/22.

3.9 Following the recent Scottish Budget announcement and early discussions with colleagues at the Scottish Government, it is expected that additional funding for COVID-19 related costs will continue in 2021/22. Although not guaranteed to cover

the full extent of costs, the IJB should focus on the underlying cost pressures within the system that are expected.

3.10 At the December 2020 meeting a high level 5 year rolling financial outlook for the IJB was shared. This was based on pre-pandemic conditions and at the time of modelling was showing a £3.8m gap for 2021/22. For a future meeting an updated outlook for 2021/22 will be shared, separating core underlying pressures and those relating to COVID-19. This will allow IJB members to consider the financial forecast alongside budget offers and make an informed decision on whether the offers are fair and adequate.

3.11 For both NHS Lothian and Midlothian Council increases in base expenditure is inevitable due to staff pay awards, increases in National Care Home Contracts, Living Wage increases for external providers and other inflationary cost rises. So without doing anything new or extra the cost base will still rise. How much of these increases will be covered by an increased budget directly from the Scottish Government or through each partners budget process is unknown at this point. The financial consequences of the EU withdrawal also remain unknown and remain a risk.

3.12 The Scottish Budget announcement for 2021/22 specifically targeted Health with an additional £16 billion across Scotland. This includes continued support relating to the pandemic, increased investment in mental health and primary care services. It also includes further investment on a mission to tackle the drug deaths crisis. All of these have financial consequences for the IJB and as more is known this will be shared at further meetings with members.

4 Policy Implications

4.1 There are no policy implications from this report.

5 Directions

5.1 There are no implications on directions from this report.

6 Equalities Implications

6.1 There are no equalities implications from this report.

7 Resource Implications

7.1 The resource implications are laid out above.

8 Risk

8.1 Like any year end projection, the IJB relies on a number of assumptions and estimates each of which introduces a degree of risk. The “business as usual” risks raised by this report are already included within the IJB risk register.

8.2 Of particular note are:

- forecasts will vary as service driven mobilisation and remobilisation plans are developed and financial impacts crystallised;
- the extent to which COVID-19 costs will be met by the Scottish Government through the mobilisation planning process;
- delivery of the savings and recovery programme in line with projections; and
- That there will be no further waves of COVID-19;
- The impact of Brexit is unknown – and assumed to be cost neutral in estimates to the year end. Any additional Brexit-related costs have no additional funding allocations attached to them at this stage.

9 Involving people

9.1 The IJB papers are publically available.

10 Background Papers

10.1 Finance Update 2020/21 – December 2020
10.2 Scottish Budget for 2021/22

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DATE	February 2020

Midlothian Health & Social Care Partnership

Thursday 11th February 2020, 2.00 pm

Equalities Outcomes and Mainstreaming Report 2021-2023

Item number:	**5.6**

Executive summary

1.1 In order to meet the obligations placed on public bodies by the Equality Act 2010 and associated regulations the Integration Joint Board must

i. publish a set of equality outcomes which it considers will enable the authority to better perform the Public Sector Equality Duty

ii. publish a mainstreaming report setting out how it will mainstream the Public Sector Equality Duty into its day-to-day functions

1.2 At the November IJB meeting it was agreed that an update on progress would be provided to IJB members on 11th February 2021. This report updates the group on the development of the new equalities outcomes and provides a draft Mainstreaming and Equalities Outcomes report for 2021-2023.

Board members are asked to:

Provide comment and direction on the draft Mainstreaming Report and the draft Equalities Outcomes.

Report

Equalities Outcomes and Mainstreaming Report 2021-2023

1 Purpose

1.1 This report updates the group on the development of the new equalities outcomes and provides a draft Mainstreaming and Equalities Outcomes report for 2021-2023.

2 Recommendations

2.1 As a result of this report what are Members being asked to: -

Provide comment and direction on the draft Mainstreaming and Equalities Outcomes report

3 Background and main report

3.1 The Public Sector Equality Duty requires public bodies in the exercise of their functions to have due regard to the need to:

i. Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010
ii. Advance equality of opportunity between people who share a relevant protected characteristic and those who do not
iii. Foster good relations between people who share a protected characteristic and those who do not

3.2 Alongside consultation (detailed in Section 9) available data and other evidence was collated to inform the development and identification of the key equalities outcomes for Midlothian HSCP.

3.3 **The proposed draft Equalities Outcomes are**

Outcome 1: Older people, and people with disabilities in Midlothian will have more equal access to health and social care services and information (via improved digital inclusion, communication, and an inclusive physical environment)

Outcome 2: Adults identifying as LGBT, men, and people with disabilities will have better awareness of and access to, community mental health support, information and treatment.

Outcome 3: BAME People, Women, adults identifying as LGBT and people with disabilities in Midlothian will experience safer, welcoming, and more inclusive communities.

Outcome 4: Older people will be better able to enjoy human rights and fundamental freedoms when residing in care or treatment facilities, or receiving care in their own home, including full respect for their dignity, beliefs, needs and privacy, and the right to make decisions about their care and the quality of their lives.

Outcome 5: The Midlothian Integration Joint Board will support the participation of, and more accurately reflect, the community it serves.

Full Equalities Outcomes and Mainstreaming Report provided in Appendix 1.

Work remains underway to determine the measures for each outcome in order that the IJB can be assured of progress. While measures around sex, age and social-economic circumstance are often available to the HSCP there continue to be challenges around certain population measures, for example information that would allow us to compare service access and experience, for people living in Midlothian who are LGBT or have certain disabilities.

The IJB is expected to publish the Equality Outcomes by the 30th April. A report on progress made is required every 2 years.

4 Policy Implications

4.1 Section 149 of the Equality Act 2010 (the Public Sector Equality Duty), and the Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 as amended, outline the legal duties of the integration authority including preparation and publication of Equalities Outcomes.

4.2 The Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2016 outlines the requirement for listed public bodies to publish the gender composition of their Boards, and to produce succession plans

5 Directions

5.1 Once Equality Outcomes are approved, they will be incorporated into the relevant Directions and/or a specific Direction prepared.

6 Equalities Implications

6.1 The purpose of Equality Mainstreaming is to make the Equality Duty integral to the functions of the IJB. Equality Outcomes will assist the IJB to meet the General Equality Duty and provide a focus to efforts to increase equality across Midlothian.

7 Resource Implications

7.1 There are no specific financial implications arising from this report. However, this should be reconsidered when Outcomes and mainstreaming are approved.

8 Risk

8.1 Failure to publish an Equalities mainstreaming report and Equalities Outcomes will mean that the Integration Joint Board is not meeting its obligations under the Equality Act 2010.

8.2 Failure to take account of the impact of the strategic plan, or significant changes to services, on people with protected characteristics may lead to the Integration Joint Board unwittingly acting unlawfully.

9 Involving people

9.1 A Lothian-wide public consultation exercise was undertaken to support the drafting of the equalities outcomes. (Available on request.)

9.2 A report on consultation responses in relation to Midlothian has been produced. This is provided at Appendix 2.

10 Background Papers

10.1 The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012 https://www.legislation.gov.uk/ssi/2012/162/contents/made

10.2 Equality and Human Rights Commission. Equality Outcomes and the Public Sector Equality Duty: A Guide for Public Authorities, Scotland https://www.equalityhumanrights.com/en/publication-download/equality-outcomes-and-public-sector-equality-duty-guide-public-authorities

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DATE	1/2/21

Appendices: 1) Draft Equalities Outcomes and Mainstreaming Report 2021-2023
2) Draft Midlothian Equalities Outcomes Consultation Report

Midlothian
Health & Social Care
Partnership

Equalities Outcomes and Mainstreaming Report

2021 – 2023

Lois Marshall

Midlothian Integrated Joint Board is responsible for planning and commissioning of services that help people live well and get support when they need it. This includes community health and social care services for adults in Midlothian and some hospital-based services.

What is Equality?

Equality is when everyone can make the most of their lives and no one has poorer opportunities because of things such as the way they were born, what they believe, or whether they have a disability.

Equality is important as more equal societies work better for everyone. It is supported in law by the Equality Act 2010. Discrimination is when a person or group of people is treated differently, unfairly, or excluded. It is against the law to be discriminated against because of

- Age
- Sex
- Sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Disability
- Marriage and civil partnership

(These are called the 9 Protected Characteristics)

What are Equality Outcomes?

There are 3 key things that public sector bodies such as the Midlothian Integrated Joint Board need to do. They are called the General Equality Duty:

1) Stop discrimination, harassment and victimisation and other behaviour that is forbidden by the Equality Act 2010.

2) Advance equality of opportunity between people who share a relevant protected characteristic and those who do not.

3) Foster good relations between people who share a protected characteristic and those who do not.

Equalities Outcomes describe the Integrated Joint Board's intention to make the lives of people in Midlothian who experience discrimination better and meet the General Equality Duty.

What is Mainstreaming Equality?

Created by Hadi
from Noun Project

Mainstreaming Equality means paying attention to equality, and meeting the General Equality Duty, in all day-to-day work of the Health and Social Care Partnership.

This includes the way decisions are made; the way people who work for and on behalf of the Partnership behave; how decisions are made when allocating funding, how service activity is measured, and how services are designed.

Mainstreaming work underway

Staff training, awareness and understanding

Training continues to be important to mainstreaming equality, diversity and human rights in the Health and Social Care Partnership. Employees of both NHS Lothian and Midlothian Council are able to take part in their respective organisation's equality and diversity awareness training.

All Midlothian Health and Social Care Partnership staff were invited to attend a Human Rights and Commissioning workshop delivered by the British Institute for Human Rights in November 2020. This training supported staff to include Human Rights in the commissioning, planning and delivery of public services.

Integrated Impact Assessments

An Integrated Impact Assessment (IIA) is a process which helps staff consider how a change to an existing service or a new proposal might impact on groups of people with different protected characteristics. Integrated Impact Assessment (IIA) training sessions have been organised by Midlothian Council, supporting staff to complete and facilitate IIAs. Completed Integrated Impact Assessments are published on the Midlothian Council or NHS Lothian websites.

Integration Joint Board

The Public Bodies (Joint Working) (Act) 2014 outlines who the members of the Integration Joint Board should be, and which members should have a vote. Membership includes citizens with lived experience of using health and care services and/or experience of caring for those who use health and care services, alongside local councillors, NHS Board members, staff from the Health and Social Care Partnership and a representative from voluntary organisations. A new expenses policy has been developed to support citizens in their roles on the board and ensure these roles are accessible.

Equalities are considered in business planning, Board meetings, other decision-making, and through other policy development and review mechanisms.

Gender Composition of Midlothian Integrated Joint Board

On 18 March 2016 the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2016 came into force. A new requirement exists for listed public bodies to publish the gender composition of their Boards, and to produce succession plans to increase the diversity (across all protected characteristics) of their Boards.

At present the Midlothian Integration Board consists of 4 male voting members and 4 female voting members.

Leadership and Vision

Within its Strategic Plan, the IJB sets out its core value of equality "You should not be disadvantaged due to your ability, ethnicity or caring responsibilities. We will do everything we can to reduce health inequalities and respect your dignity and human rights in the planning of health and social care". Public Protection is also listed "You should feel safe at home and in your community"

Communication

Health and Social Care Partnership Website

A new Health and Social Care Partnership website is in development. This website uses a web accessibility toolbar that makes the website more inclusive for all. The toolbar adds text-to-speech, reading and translation support to the website. The current Strategic Plan is now available on the website to ensure this this is accessible to all citizens.

Engagement Strategy (draft – awaiting IIA)

A new Engagement Strategy has been drafted to support meaningful and sustained engagement with local communities and service users. The strategy commits the IJB and the Partnership to ongoing engagement with people and partner organisations through representatives from the third sector, carers and people with lived experience on all formal planning groups including the IJB, the Strategic Planning Group and service area planning groups. The strategy also provides a helpful framework for planning groups, including those leading change programmes.

Data and Evidence

The Joint Strategic Needs Assessment was produced in 2019 and is updated quarterly to support the IJB and Health and Social Care Partnership to better understand the current and future health and social care needs of the citizens of Midlothian. This includes research on specific groups with protected characteristics, including older people, people with disabilities, people with mental health problems, people with complex needs and people with palliative care needs.

Partnership

The Health and Social Care Partnership contributes to the work of the Midlothian Community Planning Partnership (CPP). The CPP's Single Midlothian Plan is focused on outcomes and actions that will address equality, diversity and poverty in Midlothian.

Mainstreaming work planned

Integration Joint Board

A diversity succession plan for the IJB will be developed during the period of this report 2021-2023, increasing representation of the board is a focus of one of the proposed Equality Outcomes

The IJB induction and training programme is currently being reviewed. It is proposed that equalities training will be offered.

Staff training, awareness and understanding

Staff across the Health and Social Care Partnership will have opportunities to improve their understanding, knowledge and skills around equality and diversity as well as an understanding of the public sector equality duty and its relevance to their roles. Building expertise across the Partnership will help embed equality and rights in service Design, delivery and review.

Membership of The Midlothian Council Equalities Forum will be extended to Midlothian Health and Social Care Partnership employees. This Forum is made up of employees representing all nine protected characteristics, and others who support the aims of the forum. The forum will be supported by the Equalities Engagement Officer and Corporate Equality, Diversity & Human Rights Officer. It works to embed equality and fairness of opportunity across the council and Health and Social Care Partnership, and to contribute to employee and community equality initiatives. Where required equality and diversity training will be provided to Forum members.

Integrated Impact Assessments

An Integrated Impact Assessment will be continue to be carried out on new policies and proposed service changes.

Integrated Impact Assessment (IIA) training will continue to be offered to Midlothian Health and Social Care Partnership staff and volunteers. This training is delivered by Midlothian Council.

Health and Social Care Partnership Website

The Health and Social Care website will be developed to ensure a wide range of information on the Health and Social Care Partnership is accessible to those with digital access.

Engagement

Staff across the Health and Social Care Partnership will be supported to implement the Engagement Strategy once approved by the IJB.

Data and Evidence

The Joint Strategic Needs Assessment will be make efforts to improve equality data that will aid understanding of current and emerging needs, including those related to asylum seekers and refugees.

Equalities Outcomes

The IJB must set Equalities Outcomes every 4 years. To assist the IJB there were community consultation events, both Lothian-wide and specific to Midlothian. A range of local and national evidence and data was also collated, to aid understanding of the most significant equality issues in relation to the IJB and the remit of the Health and Social Care Partnership.

An Equality Outcome must further one or more of the following duties: eliminate discrimination, advance equality of opportunity, or foster good relations. An Equality Outcome must be specific and measurable.

Draft Equalities Outcomes:

Outcome 1: Older people and people with disabilities in Midlothian will have more equal access to health and social care services and information (via improved digital inclusion, communication, and an inclusive physical environment)

> Duty: Advance equality of opportunity between those who share a relevant protected characteristic and those who do not.

Outcome 2**:** Adults identifying as LGBT, men, and people with disabilities will have better awareness of and access to, community mental health support, information and treatment.

> Duty: Advance equality of opportunity between those who share a relevant protected characteristic and those who do not.

Outcome 3**:** BAME People, women, adults identifying as LGBT and people with disabilities in Midlothian will experience safer, welcoming and more inclusive communities.

> Duty: Eliminate unlawful discrimination, harassment and victimisation and other conduct that is prohibited by the Equality Act 2010.
>
> Duty: Foster good relations between people who share a relevant protected characteristic and those who do not.

Outcome 4: Older people will be better able to enjoy human rights and fundamental freedoms when residing in care or treatment facilities, or receiving care in their own home, including full respect for their dignity, beliefs, needs and privacy, and the right to make decisions about their care and the quality of their lives.

Duty: Advance equality of opportunity between those who share a relevant protected characteristic and those who do not.

Outcome 5: The Midlothian Integration Joint Board will support the participation of, and more accurately reflect, the community it serves.

Duty: Advance equality of opportunity between those who share a relevant protected characteristic and those who do not.

Duty: Foster good relations between people who share a relevant protected characteristic and those who do not.

Outcomes 1 and 3 are shared with Midlothian council and will be delivered in partnership.

Midlothian
Health & Social Care
Partnership

Equalities Outcomes Consultation

Jan 2021

Lois Marshall

Contents:

Midlothian Health and Social Care Partnership is responsible for services that help people live well and get support when they need it. This includes all community health and social care services for adults in Midlothian and some hospital-based services.

What is Equality?

Created by corpus delicti
from Noun Project

Equality is when everyone can make the most of their lives and no one has poorer opportunities because of things such as the way they were born, what they believe, or whether they have a disability.

Equality is important as more equal societies work better for everyone. Equality is supported in law by the Equality Act 2010.

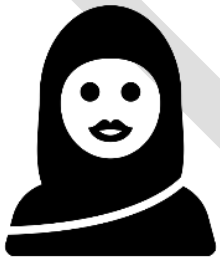
Created by Dmitry Vasiliev
from Noun Project

Discrimination is when a person or group of people is treated differently, unfairly, or excluded. It is against the law to be discriminated against because of

- Age
- Sex and sexual orientation
- Gender reassignment
- Pregnancy and maternity
- Race, religion or belief
- Disability
- Marriage and civil partnership

(These are called protected characteristics)

What are Equality Outcomes?



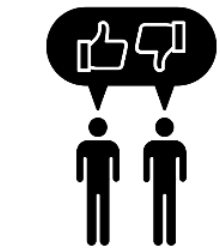
Created by Adrien Coquet
from Noun Project

There are 3 key things that public sector bodies such as the Health and Social Care Partnership need to do. They are called the General Equality Duty:

1. Stop discrimination, harassment, victimisation and other behaviour banned by the Act.
2. Make things more equal between people who share a protected characteristic and people who do not, including taking steps to meet the needs of people from protected groups where these are different from the needs of other people
3. Encourage good relations between people who share a protected characteristic and people who do not, including by tackling prejudice and promoting understanding between people from different groups

Equalities outcomes explain the things the Health and Social Care Partnership is aiming to do, to meet the General Equality Duty, and make the lives of people in Midlothian, who share protected characteristics, better.

What is a consultation used for?



Created by Symbolon from Noun Project

A consultation is when people are asked to give their opinions and feedback on an idea or area of work. A consultation can be online, by paper, by phone, or in person. It can take the form of a survey, questionnaire, focus group, or event and is for a set amount of time (often 6 to 12 weeks).

Scottish government guidelines advise that a consultation should be used to get a valuable range of opinions and feedback. They also advise that consultation should not be used to show levels of public support for an idea or to represent the views of the wider public. This is because often those with strong views will choose to respond to a consultation, but these views are not necessarily typical of the wider public.

What did we do?

Midlothian Health and Social Care Partnership consulted in a range of ways.

Created by Hadi from Noun Project

This included work in partnership with Edinburgh, West Lothian and Midlothian Councils, NHS Lothian, Midlothian Health and Social Care Partnership and East Lothian Integrated Joint Board. Together these organisations created draft equality outcomes. These were based on research and evidence from different sources and on conversations with services and organisations that support and work with people. These draft outcomes were then used for the Consultation, with people, groups and organisations across the Lothians asked to give their opinions and feedback on them.

The Equalities Outcomes Consultation was open for 7 weeks from 3 November to 22 December 2020. In total, there were 255 responses to the online survey and of these 45 responses were for Midlothian. Some people and organisations responded about more than one area.

Responding as...			**Response by area**	
An individual	92%		City of Edinburgh	70%
Public body, organisation or charity	4%		East Lothian	18%
Private business	0%		Midlothian	18%
Community group	1%		West Lothian	14%
Other (please specify):	2%			

45 **responses for Midlothian (18%)**	**Accessibility**	• Online consultation • Paper consultation • Interpretation and translation services • BSL video • Support to fill in consultation • Young person survey • Focus groups
3 **Public Online Information Sessions**	**Promotion**	• 3 Twitter posts reaching 5,364 • 5 Facebook posts with a total reach of 16,108 Video • Shared by Midlothian Voluntary Action (in bulletin updates) • Shared with a range of third sector partners and housing tenants • Shared with local radio

Covid-19

The COVID-19 restrictions in place meant we had to do the consultation differently and try new ways of working. Although we took different steps to help to make the online survey accessible, we recognise that there were barriers to people and groups taking part in the online consultation, or local focus groups, and that the huge impact of COVID-19 on people's lives also affected their ability to take part in the consultation during this time.

We would like to thank the everyone who took part and the many community organisations, staff members and service providers who helped us reach people.

Summary and key outcomes

Created by Hadi from Noun Project

This consultation summary pulls out the key responses in relation to Midlothian and Midlothian Health and Social Care Partnership. In general, many people felt that the draft outcomes and actions needed to be more specific and measurable, and the wording of some outcomes was too complicated.

As this was a partnership consultation it covered outcomes which are not part of the work of Midlothian Health and Social Care Partnership, or where Midlothian Health and Social Care Partnership would have a smaller role in supporting other partners to carry out these outcomes. These include

Equality Outcome 2: Education
Equality Outcome 3: Housing
Equality Outcome 4: Racism
Equality Outcome 6: Workplaces

Draft Equality Outcome 1: Accessibility

Draft Outcome: Services are fully accessible and inclusive to the needs of all people, with no barriers which can limit access for those with protected characteristics. People find it easier to access services through measures to improve digital inclusion using language that is understood in our communications and improving physical access.

Many people felt that clear language and information that everyone could understand was important.

"No jargon. Straightforward language"

"Easy Read readily available. Services understanding what Easy Read is."

It was also suggested that communications could be tested by a panel of service users or by people from protected characteristic groups.

A number of different barriers were highlighted along with some solutions:

"Doctor's appointments are sometimes difficult as the phone choices can be hard to manage… "

"Online is often hard for people or they may not have access... A phone call or face to face is better"

"people traditionally excluded need very significant and ongoing support and encouragement to enable meaningful access to online services…digital exclusion delivers particularly harmful impacts upon those people who are already marginalised and excluded"

"As someone who is disabled, I am excluded by…facilities that able-bodied people take for granted. For example, there is no disabled drop off point from Chalmers hospital… The Western General has the majority of the disabled bays in unprotected parking…"

It was also highlighted that it was important to think about how improvements could be measured

"Without evidence based on gathering data on who uses services, public bodies will be unable to evidence equality of access to services, equality of experience in those services and equality of outcome from using those services."

Draft Equality outcome 5: Safer Communities & Gender Based Violence

Draft Outcome: Woman, girls and LGBTQ+ communities feel safer as a result of the implementation of programmes and policies to prevent and protect our citizens against domestic abuse and gender-based violence, strengthened by the direct response during and following the COVID-19 pandemic.

Some people felt that the outcome should recognise that men can be victims of violence too. Whereas other people felt that the focus should be only on women:

"More needs to be mentioned re male victims experiencing abuse (GBV)"

It was highlighted that issue of gender inequality affects lots of different areas

"Gender inequality crosses across all the themes not simply theme 5"

"The focus as above should be on those who are disproportionately affected, namely women and girls."

There was a view about where the actions should be focussed

"activities should not just be focused on victim/survivors but must include activities to address perpetrator behaviour."

Some people suggested there was a need for more education and awareness, and for the actions to be made much clearer about what will be done and what difference it will make.

Draft Equality Outcome 7 Mental Health Awareness, Support & Management

Draft Outcome: People are better equipped to manage their own mental health with appropriate and accessible information and support available.

Many people felt that there wasn't enough help and support available

"You are not doing enough to support mental health within acute hospital settings. There's a significant lack of professional support/treatment and an even more significant lack of available beds to be transferred to if they need inpatient care... The strain this puts on the acute hospitals is huge and needs to be urgently addressed."

"I think there is not enough help available for people with mental health problems and this needs to be resolved."

Suggestions were made about what else could be done

"We need universal support services available when people need them (e.g. late at night/ early morning) and not just during office hours… Current waiting lists for services (e.g. counselling; gender clinic; CAMHS) are far too long and are not meeting the needs of the public."

Some people felt that educating people to recognise the signs around their own mental health was important, while others felt that this might not be possible

"Mental health is an important area for focus, educating people to manage their mental health is vital to improving it in society. This includes recognising signs of your own health and knowing where to seek help."

"Do you recognise when your own mental health is at risk?"

Some people felt that the outcome and the actions weren't clear.

"Do we know what the barriers to access for communities are, and which communities? What will be done that's different and more effective?"

Midlothian Health and Social Care Partnership - Additional Outcomes

Following local consultation, it was agreed that 2 further draft outcomes should be developed for Midlothian Health and Social Care Partnership to better reflect the work and remit of the partnership. One

of the Outcomes is focussed on older people in receipt of care, and the other Outcome is focussed on the IJB and representation.

Next Steps

Finalising the outcomes

We will use the guidelines from the Equality and Human Rights Commission (below) along with the consultation responses, and local and national data, to help us identify the most significant inequalities that we can take action to help address, through the Equalities Outcomes for Midlothian HSCP.

Scale	how many people in Midlothian are affected by the issue and how does the issue impact on their life chances? What does the evidence tell us?
Severity	does the issue present a risk to equality of opportunity for particular protected groups? Is it a significant barrier to opportunity or freedom?
Concern	do equality groups and communities see it as a significant issue?
Impact	is the problem persistent or getting worse? What is the potential for improving life chances? Is the problem sensitive to public intervention?
Remit	are the Health and Social Care partnership able to address this issue given our remit?

Monitoring and Action Plan

We will continue to work with partners and services to decide the actions which will best help us to meet the outcomes and how we can measure them, and to put the outcomes into action over the next 4 years.

Work in partnership with Midlothian Council

We will work in partnership with Midlothian Council to finalise the outcomes and to identify which outcomes we will deliver jointly and which individual outcomes we will deliver.

Lothian-wide Outcomes

Continue to be considered.

Midlothian Integration Joint Board

Midlothian Health & Social Care Partnership

Thursday 11th February 2021, 2.00 pm

Clinical and Care Governance Group Report

Item number:	**5.7**

Executive summary

The purpose of this report is to provide assurance to Midlothian Integrated Joint Board as to the clinical and care governance arrangements within Midlothian Health and Social Care Partnership (HSCP). It will highlight good practice and identify any emerging issues or risks.

Additional reports will be attached as appropriate throughout the year to provide updated information from specific service areas.

Board members are asked to:

- Note and approve the content of this report

Report

Report title:

Clinical and Care Governance Group Report

1 Purpose

1.1 This is the Clinical and Care Governance Group (CCGG) report for Midlothian IJB.

2 Recommendations

2.1 As a result of this report Members are being asked to:

- Note and approve the content of this report

3 Background and main report

3.1 Bi-monthly meetings of CCGG are taking place facilitated by Microsoft Teams, to comply with social distancing recommendations. Service leads and managers attend or send a deputy. A meeting of the CCGG took place on Tuesday 19th January 2021.

3.2 There are eight Quality Improvement Teams (QIT) reporting in to the CCGG. These cover all service areas in Midlothian Health and Social Care Partnership (HSCP). Standards are implemented and monitored as part of the QITs and reports on improvement work taking place are submitted to the CCGG.

3.3 Quality Improvement Teams are developing programmes of work to measure or improve standards. Current examples of work include:
Psychological Therapy Service (PTS) has introduced 'SUPER' feedback questionnaire to accompany new model of service delivery to gain feedback from users of the service.
PTS waiting times. Phase 2 of the new model is progressing. Staff engagement events have taken place. Numbers waiting over 18 weeks have reduced by 50%.
AHP service managers noted staff morale is being affected by COVID, pace of work, complexity of work and multiple patient deaths. Psychological support is due to be implemented imminently to improve staff wellbeing.
Dietetic Service Lead has been seconded to Scottish Government National Group, and key NHS Lothian Dietetic staff seconded to East Region projects, involving collaborative working with NHS Fife and NHS Borders, with a view to implementing standards for children and adults in the following work streams: prevention; early diagnosis; intervention; remission. This is a two year programme aimed at implementing a whole system approach.

3.4 Midlothian HSCP overview of Midlothian care homes continues to provide assurance about the standards of care for residents. All Midlothian care homes continue to submit daily data through the electronic reporting system, TURAS. This system reports directly to the Scottish Government. HSCP managers have access to this data and monitor this as part of the assurance calls to care homes. The Care Home Support Team (CHST) continue to offer regular targeted support to Midlothian care homes in addition to the regular weekly support visit to all care homes. The weekly teleconference, chaired by Midlothian Service Manager continues with all Midlothian care homes. The HSCP Daily Care Home Assurance meeting continues to monitor all data and reports, agree actions required and escalate concerns.
Due to failings in care first raised by Midlothian Care Home Support Team, Thornlea Care Home in Midlothian was closed on 18th January 2021. Prior to this date, safe alternative accommodation was arranged for all residents.

3.5 A number of inspections have taken place in Midlothian HSCP in recent months, reports were received and action plans developed where appropriate. Learning from these inspections has been shared through the CCGG.

3.6 Healthcare Improvement Scotland (HIS) carried out an unannounced inspection in Midlothian Community Hospital 22-24 September 2020. The final report from HIS was received in December 2020. The report highlights the many areas of good practice within the hospital and particularly notes the following:

- Patients were treated with dignity and respect.
- There was good verbal communication between the ward teams to ensure safe delivery of care.
- Good availability and range of snacks for patients.
- Staff well supported by management throughout COVID-19.

The report also highlights seven areas where improvement is required. Midlothian HSCP responded to each of these requirements as detailed in the attached Action Plan. A number of actions are now complete as indicated within the Action Plan. In addition a Standard Operating Procedure has been developed and is now in place for use with Falls Alarm Risk Assessments, as per Requirement 4. Midlothian Dietetic Lead will facilitate the reinstatement of the Midlothian Food Fluid and Nutrition Group by March 2021.The requirement for an assessment within the electronic TRAK system for oral health has been escalated within NHS Lothian.
Within Midlothian Community Hospital (MCH) a local programme of inspections and reviews continues. A local action plan has been commenced by the Service Manager to facilitate early response to any issues identified from these inspections.

3.7 Midlothian HSCP's intermediate care facility, Highbank, was inspected on 10th November 2020 by the Care Inspectorate as a registered care home for people aged over 60. Although Highbank is an intermediate care facility, there are no specific standards for intermediate care at this stage. The report was published in December 2020. The inspection report grades the areas of inspection from 1 (Unsatisfactory), to 6 (Excellent). This inspection report graded the three areas as follows:

- People's health and well-being are supported and safeguarded during the COVID-19 pandemic. **4 - Good**
- Infection control practices support a safe environment for people experiencing care and staff. **4 - Good**

- Staffing arrangements are responsive to the changing needs of people experiencing care. **4 - Good**

3.8 Midlothian Council Care at Home service was inspected by the Care Inspectorate in November 2020, over a period of two weeks with the resulting report being published in December 2020.
This inspection report graded the three areas as follows:

- How good is our leadership? **4 - Good**
- How well is our care and support planned? **4 - Good**
- How good is our care and support during COVID pandemic? **4 - Good**

The Care Inspectorate noted that there had been significant progress made since the last inspections in August 2018 and May 2019, including the service meeting pre-existing requirements.

3.9 Remodelling of MCH. There are pressures on beds within Lothian and across Scotland due to the current COVID-19 Pandemic. In addition there are staffing pressures in all areas due to increased demand in the system, at the same time as reduced capacity due to staff isolation and absence. To meet increasing demand for beds within Lothian it was agreed at Gold Command meeting in November 2020 to provide funding to reopen the additional 16 available beds in Glenlee Ward, to support additional Rehab within MCH. The model for the wards in MCH was reviewed and a decision reached to reconfigure the three wards ensuring the safest option for managing these going forward.
Edenview will remain as current function – Assessment and Rehab ward.
Glenlee will become the downstream Rehab ward with transfers from Edenview. This allows both Rehab wards to sit side by side on the first floor of the hospital with greater opportunity to share resource more easily and therefore offer mutual support.
Loanesk on the ground floor will focus on HBCCC, End of Life care, Patients stable and awaiting transfer to care home or home to large package of care.
Given national pressures and the local situation in NHS Lothian recruitment of nursing staff has been challenging. As a result there is a limitation to four additional beds initially, subject to review and potential safe increase as additional new staff are appointed. Recruitment continues.

4 Policy Implications

4.1 This report should provide assurance to the IJB that relevant clinical and care policies are being appropriately implemented in Midlothian.

5 Directions

5.1 Clinical and Care Governance is implicit in various Directions that relate to the delivery of care.

6 Equalities Implications

6.1 Any equalities implications will be addressed by service managers as they arise. There are no specific policy implications arising from this report.

7 Resource Implications

7.1 Any resource implications will be identified by managers as part of service development, and additional resource may at times be required to ensure good clinical and care governance arrangements. There exists an expectation of staff time to attend the Clinical and Care Governance Group meetings and that they will ensure this work is embedded in local areas/teams.

8 Risk

8.1 This report is intended to keep the IJB informed of local governance arrangements and any related risks and to provide assurance to members around continuous improvement and monitoring.

8.2 All risks associated with the delivery of services are monitored by managers and where appropriate they are reflected in the risk register.

9 Involving people

9.1 Midlothian staff will be involved in the development and ongoing monitoring of processes related to clinical and care governance.

9.2 Public representatives on the IJB will have an opportunity to provide feedback and ideas.

10 Background Papers

10.1 HIS Action Plan MCH.

AUTHOR'S NAME	Caroline Myles
DESIGNATION	Chief Nurse
CONTACT INFO	0131 271 3947
DATE	11th February 2021

Improvement Action Plan

Healthcare Improvement Scotland: Unannounced hospital inspection

Midlothian Community Hospital, NHS Lothian

22-24 September 2020

Improvement Action Plan Declaration

It is the responsibility of the NHS board Chief Executive and NHS board Chair to ensure the improvement action plan is accurate and complete and that the actions are measurable, timely and will deliver sustained improvement. Actions should be implemented across the NHS board, and not just at the hospital inspected. By signing this document, the NHS board Chief Executive and NHS board Chair are agreeing to the points above. A representative from Patient/Public Involvement within the NHS should be involved in developing the improvement action plan.

NHS board Chair

Signature: _____

Full Name: _____

Date: _____

NHS board Chief Executive

Signature: _____

Full Name: _____

Date: _____

Ref:	Action Planned	Timescale to meet action	Responsibility for taking action	Progress	Date Completed
1	Requirement 1 NHS Lothian must ensure that all older people who are admitted to hospital are accurately assessed in line with the national standards. This includes nutritional screening and assessment including oral health assessment. There must be evidence of accurate reassessment, where required (see page 14). Actions Education and training for the correct recording of MUST to be implemented on all wards for all staff.	November 2020	Chief Nurse / Service Manager	Staff education implemented	Nov 2020
	NHS Lothian will review oral health assessment. The requirement for an assessment in the electronic system has been escalated within NHS Lothian.	June 2020	NHS Lothian Patient Outcomes Board	Escalated to group	
	A monthly audit programme is in place whereby Senior Charge Nurses review a selection of care plans from a food, fluid and nutrition perspective. This includes MUST scores.	November 2020	Chief Nurse / Service Manager	Audit programme in place	November 2020

2	Requirement 2 NHS Lothian must ensure that mealtimes are managed consistently in a way that ensures that patients are prepared for meals, including hand hygiene. The NHS board should also ensure that the principles of Making Meals Matter are implemented (see page 14). Actions Implement Standard Operating Procedure for preparing all patients for mealtimes. Making Meals Matter is included in the Food, Fluid and Nutritional Care Standards 2014 which also includes Protected Mealtimes. NHS Lothian wards work to these standards and will reinforce within these wards	November 2020	Chief Nurse / Service Manger	Developed and implemented Education for staff completed.	November 2020
3	Requirement 3 NHS Lothian must ensure that food record and fluid balance charts are commenced and accurately completed for patients who require them, and appropriate action is taken in relation to intake or output, as required (see page 14). Actions Food, Fluid and Nutritional Care Standards, in particular completion of food records and fluid balance charts, to be reinforced through education sessions for all staff on all wards.	November 2020	Chief Nurse / Service Manager	Education sessions complete	November 2020

	Audit results monitored to ensure consistent approach and accuracy. Part of audit programme detailed above at 1. Food, Fluid and Nutrition Group for Midlothian Community Hospital to be reinstated. This group reports to NHS Lothian Food, Fluid and Nutrition Group.	 March 2021	Chief Nurse / Service Manager Chief Nurse / Service Manager / Dietetic Lead	Audit programme in place Planning stages	November 2020
4	Requirement 4 NHS Lothian must ensure that where falls alarms are in use that consideration is given to the Mental Welfare Commissions Decisions about technology (Good Practice Guide, September 2015) to ensure that the individual's human rights are met. They must also ensure that systems are in place to ensure the correct maintenance and use of the falls alarms (see page 14). Actions NHS Lothian will ensure that following any falls risk assessment, consent will be gained and recorded, prior to utilising a falls alarm. Where consent can't be gained, the decision will be made following assessment to the risk involved and agreed by the MDT. Staff training is provided by manufacturer.	December 2020	Chief Nurse / Service Manager	Consent process in place. Staff training in place SOP being developed	November 2020 November 2020

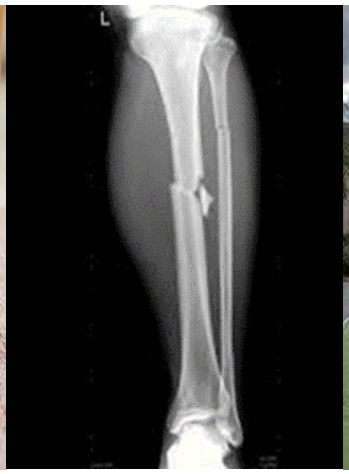
	SOP to be developed.				
5	Requirement 5 NHS Lothian must ensure that all staff perform hand hygiene at appropriate opportunities, as per the World Health Organisation's Five Moments for Hand Hygiene guidelines (see page 16). Actions Hand hygiene standards reinforced with all staff Audit programme in place. Results monitored by SCN / Service Manager	November 2020	Chief Nurse / Service Manager	Complete	November 2020
6	Requirement 6 NHS Lothian must ensure that all staff adhere to the guidance for use of PPE when moving between isolation rooms and the appropriate use of gloves (see page 16). Actions Infection prevention and control standards reinforced including site visits by Infection Prevention and Control Nurses. Correct PPE use reinforced with all staff and included in daily safety briefs Compliance will be formally monitored through SCN local HAI audit	November 2020 November 2020	Chief Nurse / Service Manager Chief Nurse/Senior Charge Nurses	Complete Ongoing - quarterly	November 2020

	Posters in place to remind staff of standards				
7	Requirement 7 NHS Lothian should ensure that patient identifiable information, such as risk alerts and care needs details, are not on public display. This will ensure that patient privacy and is respected (see page 18). Actions Information on white boards has been removed. As an alternative this information now accessible in the patients records.	November 2020	Chief Nurse / Service Manager	Complete	November 2020

Midlothian
Health & Social Care
Partnership

Falls & Fracture Prevention -

Strategic Plan Summary 2021 – 2022


Falls and Fracture Prevention

In the 12 month period October 2019 – September 2020, the Scottish Ambulance Service responded to 784 callouts for falls in Midlothian. The impact of harm from falls and fear of falling affect large numbers of people both directly and indirectly and can have a significant impact on wellbeing and prevent many people from experiencing healthy ageing. Covid 19 has only served to exacerbate this. This year we will focus on increased partnership working and the development of an integrated falls pathway across our services – falls is everyone's business. Across our partner agencies we will also renew our focus on falls prevention to deliver more education, information and appropriate exercise opportunities across Midlothian.

Our plans for 2021-22 – What we are doing

Prevention & Early Intervention

Plan for a safe winter:

- Work with Roads Services to identify residential gritting priority streets and pavements during bad weather for 'vulnerable and at risk' for example Retirement, Extra Care Housing, and Care Home residents.

- Consult with service users groups about the impact of Covid on activity and falls to inform future service planning.

Funded by – Existing Midlothian Council and Midlothian H&SCP budgets

Raise awareness of how to prevent falls:

- Develop and deliver a falls prevention media campaign

- Deliver education community pop up sessions (subject to Covid restrictions) or offer virtual alternatives

- Hold a Midlothian Falls and Fracture Prevention public event.

Funded by – Existing Midlothian H&SCP budget

Assess people for falls:

- Ensure that all clients who present to Health & Social Care will have a Falls screening assessment completed routinely where there is risk of falls.

- Support the British Red Cross to ensure that all clients receiving assessment through their service will be assessed for Falls Level 1 via telephone call, progressing to home visit as Covid19 regulations allow.

- E-frailty Programme - All moderate and severe patients who receive a welfare call from the British Red Cross as part of the COVID19 response will be offered a full assessment including level 1 falls assessment. Calls will also identify any falls and their severity and will be recorded on their Anticipatory Care Plan and Key Information Summary to inform GP's of any changes to a person's mobility.

- Promote digital access to falls self-assessments, assessments by H&SC and third sector staff, information and advice for independent use at home

Funded by – Midlothian H&SCP, British Red Cross

Promote physical activity:

- Develop an integrated falls prevention programme/classes

- Provide options around physical activity through Midlothian Active Choices, Ageing Well, Best Step Forward project or other identified programmes or opportunities within Midlothian

- Introduce a programme of Strength & Balance classes (covering Ageing Well, Sport & Leisure and Third sector)

- Promote activity for falls prevention within Leisure Centres and Older Peoples' Housing (e.g Retirement / Extra Care Housing) working in partnership with third sector

- Increase the use of digital technology to enable people to access guided exercise in their own homes.

- Create a resource bank of digitally led sessions / options.

Funded by – Existing Midlothian H&SCP budget

Train staff on falls and fracture prevention:

- Promote & offer training to staff in falls across services e.g. MCH staff, community settings, Care Homes, Care Providers, Primary Care.

- Promote and train third sector staff and volunteers to support / co-run Paths for All Strength & Balance classes in community settings.

- Review the current number of AHPs and District Nurses trained in Falls assessments.

- Ensure all AHPs are trained to minimum levels across MHSCP – i.e. at least L2 training (Level 1, 2 and 3 interventions as per National Framework)

- Increase the number of Falls Champions across the partnership and third sector organisations (including MCH and care homes)

Funded by - Existing Midlothian H&SCP budget

Unplanned Support &Treatment

Provide Specialist, Personalised Care and Support in a crisis:

- Work in partnership with the Scottish Ambulance Service and Scottish Fire and Rescue Service to review their Falls Pathways

- Support MCH to improve protocols and use of falls monitors.

- Work in partnership with Rapid Response to review their Falls Service Pathway

- Review the On-call (MERRIT) Falls service (resource allocation, level of support available and response time)

FUNDED BY: Existing HSCP budget.

Planned Support, Treatment & Recovery

Build an integrated approach to falls & fracture prevention and treatment:

- Work with Performance and Improvement team to develop a dedicated system for data analysis / reporting of falls data to identify clear priorities and inform future direction of falls work.

- Support the Strategic Falls Group to develop an integrated & coordinated Falls Pathway across H&SC and third sector providers

- Work with Primary Care providers to develop a standard identification process, signposting / self-referral system for all patients at risk of falls (pre-fallers, secondary and frequent fallers) linked into the integrated falls pathway.

FUNDED BY: Existing HSCP budget