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Adult social care and support in Scotland

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This briefing describes how adult social care and support operates in Scotland. It includes information on the history, key legislation and policy to help explain the 'system' that comprises adult social care and support. It includes data from key sources and a summary of written evidence provided to the Health and Sport Committee's social care inquiry in 2020.

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Contents

Executive Summary

According the the Scottish Government, adult social care comprises all forms of personal and practical support for adults who need extra support (which also applies to children and young people). It describes services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring role. It means supporting people to:

- live independently
- be active citizens
- participate and contribute to our society
- maintain their dignity and their human rights
- supporting people to stay at home or in a homely setting, with maximum independence, for as long as possible.

Historically, social care has been distinct from health care. The organisation of social care services was the responsibility of local authorities, and services were accountable to elected, local councillors. Health services were the responsibility of health boards, which are directly accountable to the Scottish Ministers. This distinction is important because it means that services were organised through different governance and delivery structures.

Legislation and Policy since 1990 has:

- defined and classified social care support
- created categories of person requiring support
- codified an assessment of need
- created eligibility criteria
- introduced regulation and registration for staff and services
- introduced standards and principles of care (rights based)
- sought to (re)-integrate health with social care support
- sought to empower the individual through choice and control over the support they receive, with a rights-based approach
- acknowledged the role and needs and rights of unpaid carers to improve the consistency of support.

The Self-directed Support (Scotland) Act 2013 makes legislative provisions relating to the arranging of care and support, community care services and children's services to provide a range of choices to people for how they're provided with support. The aim of the legislation is to increase the choice and control individuals exercise in how their care is organised and delivered, and by whom.

Health and social care integration, established by legislation in 2014 (Public Bodies (Joint Working) (Scotland) Act 2014)is a major effort to, in effect, merge what had become two distinct spheres of activity, legislation, governance and resource. The focus has been on handing the control of separate health board and local authority budgets to a new body, the integration authority, to establish 'joined up' services from the point of view of those using them.

Commissioning of social care services is now the responsibility of integration authorities via health and social care partnerships. Commissioning and procurement are frequently talked and written about as if they were part of the same process. However, the distinction is key. Social care is commissioned by the integration authorities through the delivery bodies, health and social care partnerships, not local authorities. Local authorities, though, remain responsible for procuring and contracting care from providers. This means that the procurement of social care services is *not necessarily* distinct from the procurement of other council services in terms of process, such as road resurfacing and transport for example. However, the Scottish model procurement guidance defines value for money as the best balance of cost, quality and sustainability and that this should be reflected throughout strategy development, reporting and procurement processes.

Social care services are regulated by the Care Inspectorate (CI). This body, legally known as Social Care and Social Work Improvement Scotland, registers and inspects care services across Scotland.

Social care staff are regulated by the Scottish Social Services Council (SSSC). The SSSC liaises with the Care Inspectorate, the regulator for social care provision, as well as other partners such as Skills Development Scotland. The SSSC Register was set up under the Regulation of Care (Scotland) Act 2001 to regulate social service workers and to promote their education and training.

In the Programme for Government published in September 2020, the Scottish Government announced a review of social care, due to report in January 2021.

Using the powers that are available to the Scottish Parliament, this review will set out how adult social care can be reformed to deliver a national approach to care and support services. It will include consideration of a national care service.

The COVID-19 pandemic reset and refocused the agenda on the social care, building on the existing reform programme established in 2019.

Despite the overlay of the pandemic in 2020, many of the intractable problems with social care have been rehearsed over many years and much time has been devoted to them, and they remain. Despite radical changes to legislation that have happened in Scotland and not in England, such as introducing free personal and nursing care, the problems have not been 'solved'. These include so-called 'catastrophic costs' - the high costs of care that can accrue quickly in later life by those who have to pay for their own care (often more than £100,000), recruitment and retention of staff, and inequity in how different diseases are regarded and treated by the NHS: cancer and dementia for example. Below is a list of the main issues affecting social care, as identified to the Health and Sport Committee

- Funding
- Commissioning and procurement
- Self-directed Support

- Workforce
- Alternative Models of Care
- Integration of health and social care
- Housing
- Technology
- Human Rights based approaches to social care
- Community focus in planning
- Third Sector
- Accountability see summary of evidence, for a discussion of these topics.

The Health and Sport Committee undertook extensive preparatory evidence gathering for an inquiry on adult social care and support due to be held in the spring of 2020.

The Committee also undertook work on social care in response to the COVID-19 pandemic, and as part of its 2021 Pre-Budget Scrutiny work over the summer of 2020. The Committee received further evidence from stakeholders, organisations and individuals relating to care homes, care at home, resilience and the Care Inspectorate. This evidence contributed to the Social Care Inquiry held at the end of 2020.

The COVID-19 pandemic in 2020 had a profound effect on social care services and how people received their care. Improvisation and innovation were required at speed from providers and people being supported. There have been many reports of how communities became the focus of local support and how the sluggish progress of integration was suddenly accelerated and changes thought too difficult were quickly implemented by local partnerships between public bodies, and between public bodies and the third sector.

Introduction

Health and social care have been formally integrated since was passed in 2016. New bodies, called integration authorities were established and these are now responsible for ensuring that health and care of local populations is organised collaboratively by health boards and local authorities - with services being delivered through health and social care partnerships. These new bodies should focus on primary prevention and good public health outcomes for everyone. Care should be person-centred and, where appropriate, community-based in homely settings. Preventable diseases and conditions should reduce over time, reducing the reliance and burden on hospital care. [1]

There is not a national health and care service, despite integration, and many people, depending on their financial circumstances, will have to pay towards some of their social care support, and accommodation costs if they require care in a care home.

Most studies [2] conclude that the demand and costs for health and social care will increase over the next decades in the following ways:

- *Price effects:* general price inflation within health and social services.
- *Demographic change:* this includes the effect of population growth on the demand for health and social care services, the impact of a population living longer, and demographic change in the workforce itself.
- *Non-demographic growth:* demand-led growth, generated by increased public expectations and advances in new technology or service developments, for example expenditure on new technology and drugs.

People access social care in Scotland through . This is a system which intends to place an individual in control of the care and support they receive, ideally through 'direct payments' to enable them to organise their own care and support.

According to many commentators and reports, some of which are referred to in this briefing (see, for example Audit Scotland's 'Transforming Health and Social Care Hub' [3] and Coalition of Care and Support Providers Scotland (CCPS) publications) [4] , the principles of both integration and self-directed support continue to be confounded and undermined by the complex interplay of persisting structures and entrenched practices, as well as an overarching unresolved problem: a sustainable and fair way of funding social care in the context of rising demand. Overall, these challenges are compounded by a lack of widespread public awareness of the distinction between health and social care domains until they have to navigate it for themselves or their family.

This briefing seeks to explain and explore some of this complexity and challenge and provide a comprehensive guide to how social care operates for individuals, as well as providing a summary of the history, legislation, policy, and structures that underpin social care in Scotland.

Definitions of social care support

Adult social care, which is the focus of this briefing, covers social care support for all adults over the age of 18 (but in some circumstances over 16), such as those with a physical and/or learning disability. It is not just about the care and support available to people who are older. However, the issues facing different groups, policy makers and providers of services do vary. This briefing will highlight issues in common, and in particular, to specific groups. Over the years social care has been defined and described in a range of ways.

The Scottish Government defines social care as :

> " Social care means all forms of personal and practical support for children, young people and adults who need extra support. It describes services and other types of help, including care homes and supporting unpaid carers to help them continue in their caring role... ...Social care support is about supporting people to:
>
> - live independently"
> - be active citizens"
> - participate and contribute to our society"
> - maintain their dignity and their human rights"
>
> We are committed to supporting people to stay at home or in a homely setting, with maximum independence, for as long as possible."
>
> source: Social Care, Scottish GovernmentScottish Government, 2020[5]

The King's Fund provided the following definition of social care, echoing and providing more detail to the Scottish Government's definition:

> " Adult social care covers a wide range of activities to help people who are older or living with disability or physical or mental illness live independently and stay well and safe. It can include 'personal care', such as support for washing, dressing and getting out of bed in the morning, as well as wider support to help people stay active and engaged in their communities. Social care includes support in people's own homes (home care or 'domiciliary care'); support in day centres; care provided by care homes and nursing homes ('residential care'); 'reablement' services to help people regain independence; providing aids and adaptations for people's homes; providing information and advice; and providing support for family carers."
>
> The King's Fund The King's Fund, 2019[6]

According to the UK Department of Health 'Practice Guidance', in a [7] 2013 iteration of the National Framework for Continuing Healthcare , Social care was defined as follows:

> " In general terms (not a legal definition) it can be said that a social care need is one that is focused on providing assistance with activities of daily living, maintaining independence, social interaction, enabling the individual to play a fuller part in society, protecting them in vulnerable situations, helping them to manage complex relationships and (in some circumstances) accessing a care home or other supported accommodation. "

How does this differ from healthcare? By way of comparison, the same document defines healthcare as:

> “ Whilst there is not a legal definition of a healthcare need..., in general terms it can be said that such a need is one related to the treatment, control or prevention of a disease, illness, injury or disability, and the care or aftercare of a person with these needs (whether or not the tasks involved have to be carried out by a health professional).”

These definitions represent a helpful starting point, and allow an understanding that legislation surrounding healthcare and social care remain distinct in key aspects.

In policy, how they are now defined now is less distinct. This reflects the desire of policy makers to remove stark separation between the spheres of health and social care support, along with a move to focus on primary prevention (any activity that prevents the manifestation of disease in the first place: sanitation, reducing poverty and addressing other social determinants of health; providing access to good diet, opportunities to exercise, adequate housing etc are all examples of primary prevention) of health harms and illness; across the life course which is regardless of age, health status or disability.

Changing demography

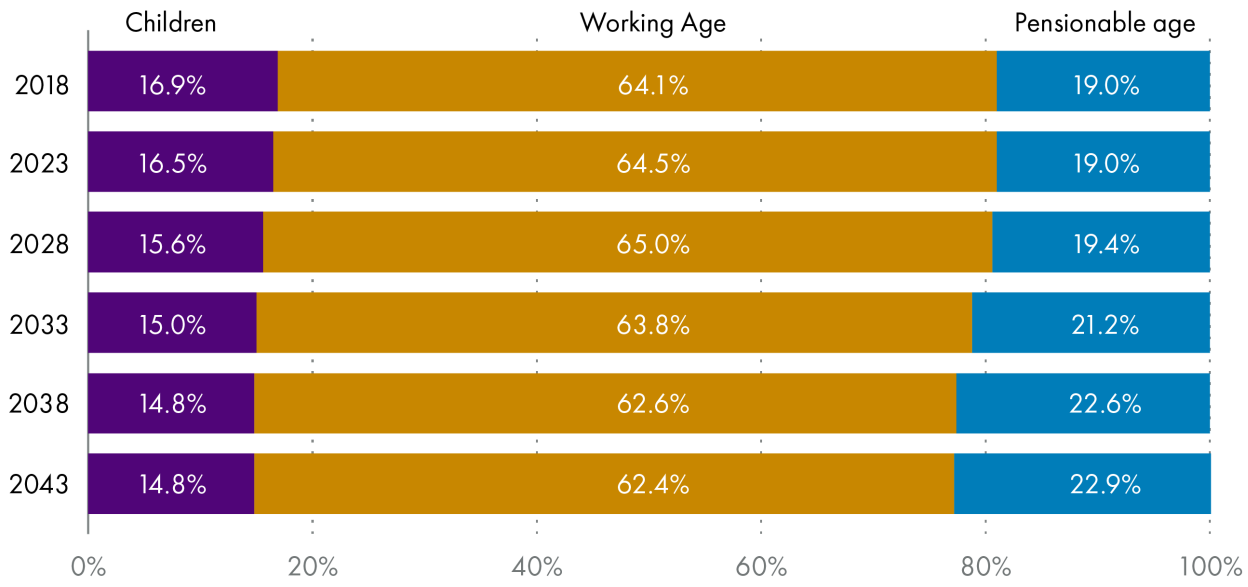
The Scottish Government estimates that the number of people aged 75 and over is set to increase by 85% by 2039. By this estimate then, in 2039, over 800,000 people will be over the age of 75. This changing demography will have a profound effect on social care provision for all age groups who require care and support. As the birth rate also declines, a smaller pool of working age people will contribute to social care and other state-funded services and benefits.

The chart here shows some of the data available relating to the changing demographics in Scotland and the demand for social care.

Figure 1 shows that between 2018 and 2043 there will be an estimated 4 percentage point rise in people of pensionable age.

Figure 1: Estimated future proportions of working and non-working age populations

This chart shows the estimated relative proportions of the population by working age, below working age and over 65.



National Records for Scotland

Figure 2 below shows the frail elderly are the biggest group receiving social care support. However, there is a high proportion of care and support provided to working age people in all groups.

Figure 2: Age breakdown of people receiving social care support by condition

This chart shows the numbers of people in different groups and age sets receiving social care support

SPICe using data from NHS ISD Scotland

History of social care

Health care and social care have very different histories, see the section of this briefing titled Social are is not organised like health care..., and it is worth providing a broad sweep of the social history of social care to provide some context. The introduction of and Self Directed Support, (Social Care (Self-directed Support) Act), also demonstrate the distinct path that Scotland has taken since devolution. The integration of health and social care is another marked structural shift seeking to collapse two previously separate spheres of activity and culture. This section tracks the development of the concept of social care from earliest records of civic organisation.

The responsibility for social care has always been with local communities and authorities, and used to include the healthcare of those who were considered destitute. Prior to the inception of the NHS, public health too was the responsibility of local councils or parishes, and covered the provision of clean water, sanitation, and the control of infectious diseases. Prior to the middle of the nineteenth century, the notions we have of healthcare (and social care) did not really exist at all in the way we think of them today. If we were ill, and could afford it, we went to to the doctor who charged for his/her services. If we were poor and couldn't work, because of infirmity, we approached the local parish authorities, or in earlier times, the monastic bodies.

The National Records Office for Scotland provides information on records relating to poor relief which has been used to provide this background.

Social (and health) care emerged from 'Poor Law' legislation, from as early as 1424 in Scotland .The 'Old Poor Law' dates from 1574, and was the main legislation governing how those who couldn't afford to support themselves and their families should be assisted. After the Reformation (ca. 1560), and the demise of monastic orders, the responsibility for the poor fell on the parish, jointly through the local landowners and the kirk sessions. The landowners often made voluntary contributions to the poor fund in preference to being assessed for a tax on their land or property. It was assumed that anyone physically able to earn a living was doing so, and assumed that there was always access to employment of some kind. Consideration was therefore given to those who, through no fault of their own, by way of disability or illness for example, were unable to support themselves. This set the stage for concept of the 'deserving' and 'undeserving poor', which hadn't previously existed. Once established, it has become hard to shift and persists in current narratives.

Following the Poor Law Amendment (Scotland) Act of 1845 parochial boards were set up in each parish to administer poor relief. There was continuation in that the kirk sessions and landowners made up the boards. Individuals would apply to the boards for assistance and could appeal decisions through the sheriff courts.

Destitution boards were set up after 1846 to cope with the widespread poverty in the Highlands, following the failure of the potato crop. Between 1847 and 1852 the boards distributed meal in return for work, for example road building, fence repair and knitting.

Where the parish system of providing poor relief was found to be inadequate, especially in more urban areas, by sheer volume of people, private charities filled some of the gaps. These charities founded schools, hospitals and orphanages.

A series of UK Acts were introduced between 1875 and 1929 paving the way for a system of local government to be established, that we recognise today. Public health became the

responsibility of councils, in areas such as the control of infectious diseases like tuberculosis and cholera. Concerns about sanitation and spread of disease had grown alongside rapid urbanisation and the associated health hazards of large populations - how human waste was dealt with for example.

Schedule 1 of the Local Government (Scotland) Act 1929 [8] , shows the range of statutory provisions, from various legislation, and functions transferred to county councils including such things as notification of infectious diseases, maternity and child welfare and public health.

TheNational Assistance Act of 1948 [9] covered the whole of the UK and contained provisions about welfare and accommodation for those in need of care and support. However, most of the provisions of this were replaced by the Social Work (Scotland) Act 1968 [10] , which remains the basis for current policy and practice.

Scotland's NHS Act came after the NHS Act in England and Wales (1946) The National Health Service (Scotland) Act 1947 came into effect on July 5, 1948 and created the National Health Service in Scotland. Many sections of the Act were repealed by the National Health Service (Scotland) Act 1972 and the remaining provisions were repealed by the National Health Service (Scotland) Act 1978. These Acts underlined and established the separation of health and social care.

This exchange in the House of Commons in October 1968 provides an overview of the fluctuations in thinking, placement and organisation of health and social care during the twentieth century up to the Social Work (Scotland) Act 1968. [10]

Social care is not organised like health care...yet

Historically, social care has been distinct from health care. However, a long journey to effect better co-ordination between health and care services culminated in legislation in Scotland to integrate the two:The Public Bodies (Joint Working) Scotland Act 2014 [11] .

In simple terms, historically, the organisation of social care services was the responsibility of local authorities, and services were accountable to elected, local councillors. Health services were the responsibility of health boards, which are directly accountable to the Scottish Ministers. This distinction is important because it means that services were organised through different governance and delivery structures.

The integration of health and social care [12] seeks to collapse the distinction between the two governance and accountability structures to ensure that those who plan, design and deliver services, whether employed by the local authority or the health service, do so in close collaboration.

Importantly, strategic planning of health and social care services, commissioning of services and budgets of health boards and local authorities covering health and social care are now the responsibility of new integration authority boards (usually an Integration Joint Board (IJB). The IJB is responsible for planning health and care services, and has full power to decide how to use resources and deliver the services, delegated to them from the NHS boards and the local authorities, to improve the lives of the people in their area. Integration authorities were created by the 2014 legislation. In practice, the collapsing of the structural, financial and cultural boundaries between health boards and local authorities has been challenging. Integration should be viewed from the perspective of the service user: if services and support do not appear to be 'joined up' from their point of view, then integration isn't working (see: Scottish Government Ministerial Strategic Group Progress Review 2019) [13] .

This briefing focuses on adult care and support services, and in particular, those provided by local authorities for those who cannot afford to pay for all or any of their own care. The local authority has a duty to assess anyone's needs, regardless of ability to pay. The local authority also has to ensure that there are services to cover local care and support needs.

However, there is an unknown number of people who pay for their own support needs, whether at home or in residential accommodation. It is also unknown how many people across Scotland might actually need social care and support. The care and support of those with needs not being met by local authorities may be met by family carers, neighbours and friends. Some of these people will not be aware that they are entitled to support, will not be deemed eligible for support or are waiting for support to be put in place.

Also, while local authorities provide some or all of the funding for those they support, they do not provide all the services. There is a mix of private, voluntary sector, not-for-profit and in-house (local authority/Health and Social Care Partnership) provision. Most care and support (around 70%) [14] is provided by private, independent providers. There are, of course, many individuals who purchase their own care and support, and enter into

individual contracts with carers, personal assistants, and care homes, for example, but the local authority is the only 'block' or spot purchaser of care services. This creates a monopsony, a situation where there is a single purchaser and a range of suppliers. This can, in any market or labour situation, drive prices or wages down, as suppliers compete for contracts. See shortbriefing on Market Facilitation [15] by the Coalition of Care and Support Providers Scotland (CCPS) for further information on how the 'market' operates in social care.

A brief aside: Social Care and Social Security Benefits

This briefing does not go into any detail about the support people receive through the **social security benefits system**. Until relatively recently, Scottish government policy could have no direct impact on most benefits. They are two distinct spheres of both legislation and policy, and it looks as though they will remain so. There is at least one important distinction: social security benefits are not audited in the way that direct payments are. Once a person is deemed entitled to social security benefits, they are not audited.

Direct payments for social care and support are very different, however, and are audited by the local authority, to ensure that the direct payment is spent to meet needs and outcomes agreed by the person and the local authority.

Social security benefits applicable to someone who needs care or who is caring for someone are covered below.

Currently, someone over the age of 65 is entitled to Attendance Allowance (not means tested, and not subject to a social work assessment), if they have care and support needs, and someone who cares for them could be entitled to Carer's Allowance (means tested). Both of these are currently administered by the UK Government. People cannot usually get Attendance Allowance if they live in a care home and their care is paid for by their local authority. However, if someone pays for all their care home costs themselves they can still claim Attendance Allowance. That said, because many in Scotland are entitled to free personal and nursing care payments, they would not be eligible for Attendance Allowance.

Attendance Allowance is due to be replaced in Scotland in 2021 by Disability Assistance for older people and Carer's Allowance should be replaced by Carer's Assistance in 2022. See SPICe Briefing SB 19-68, Scottish Social Security Benefits. [16] The Carer's Allowance Supplement was introduced in Scotland in September 2018 and is an automated, twice-yearly payment made to those receiving Carer's Allowance. This is a temporary benefit which will no longer be needed once the transition to Carer's Assistance is completed in 2025. Disability Assistance for working age people is due to replace Personal Independence Payments in 2021.

The Independent Living Fund (ILF) is a discretionary national system (ILF Scotland is a public body and company limited by guarantee, accountable to the Scottish Ministers) for making payments directly to certain severely disabled people so that they can purchase their own care and support. Although originating in 1988 within the domain of social security through the Department of Work and Pensions (DWP), it delivers support now largely in a social care context. The ILF/UK was closed by DWP in June 2015. Since July 2015 the Scottish Government has maintained the model for those already funded in

Scotland through a new public body – ILF Scotland. Because social care and support is now delivered through self-directed support, the number of people receiving ILF payments is gradually reducing because they are moving into residential care or passing away.

Legislation and policy context

This section outlines, chronologically, some of the key legislation since 1968. The box below shows the 'spine' of policy development, and increased codification of 'care' especially since 1990.

Legislation and Policy since 1990 has:

- defined and classified social care support
- created categories of person requiring support
- codified an assessment of need
- created eligibility criteria
- introduced regulation and registration for staff and services
- introduced standards and principles of care (rights based)
- sought to (re)-integrate health with social care support
- sought to empower the individual through choice and control over the support they receive, with a rights-based approach
- acknowledged the role and needs and rights of unpaid carers to improve the consistency of support.

A range of legislation underpins health and social care in Scotland. The following sections cover the main pieces of legislation relevant to social care.

Care Information Scotland also provides links to all the relevant legislation [17] , including legislation covering human rights and mental health, and is a public-facing website that provides basic information and many links useful to the public.

Social Work (Scotland) Act 1968

Part II of the **Social Work (Scotland) Act 1968** (the '1968 Act') [10] made provision for the promotion of social welfare of adults, over the age of 18, by local authorities. The duties include the provision of advice, assistance and the organisation or provision of services. **It also allows for local authorities to charge for services, and can assess someone's ability to pay** , or to provide the services free of any charge. This part of the Act **also sets out the duty to assess the needs of any person over the age of 18 within their area**, if they seek assistance. There is nothing to stop local authorities providing a service without first doing an assessment, but even if they don't provide services directly, they must assess a person's needs and make, arrange or secure provision.

This Act (Section 87) also allows local authorities to recover charges for care and support provided at home, but it does not stipulate that local authorities have to charge for such services.

Part IV of the NHS Community Care Act 1990

Part IV of the NHS and Community Care Act 1990 [18] was the **first legislation to try to bridge the gap between health boards and local council social services**.

Under the Act, **social care departments were given the responsibility for community care for older people**. These services should be designed and delivered according to need, following an assessment of needs. **Home care, day care and respite care were to be developed to help people live in their own homes wherever possible**.

This legislation was the first time that the needs of carers were taken into account, although the '1968 Act' makes reference to the views of carers being taken into account. Note that many of the sections in the Act relating to the NHS in Scotland have been repealed.

The National Assistance (Assessment of Resources) Regulations 1992

The **National Assistance (Assessment of Resources) Regulations 1992** [19] and the associated Charging for Residential Accommodation Guidance (CRAG), published by the Scottish Government, allow, but do not mandate, local authorities to charge for the residential care they provide or arrange. This means that the local authority can charge someone moving into a care home run by the local authority or health and social care partnership, if they are assessed as having the means to pay.

The regulations set out how a care home resident's income and capital should be treated during the financial assessment.

If someone approaches their local authority for assistance, and an assessment of needs is arranged for care and support at home, they might be charged. The 1992 regulations do not refer directly to assessments for receiving care at home. The legislative context for charging for care delivered at home is the Social Work (Scotland) Act 1968 . However,charging guidance for care at home is issued annually by COSLA [20] , and provides templates that local authorities can use to explain their charging policies. COSLA also publishes each local authority's charging policy, together with its guidance to allow ready comparison.

The Regulation of Care (Scotland) Act 2001

The **Regulation of Care (Scotland) Act 2001** [21] **introduced registration, regulation and closer scrutiny of care services and staff** involved in providing care services. Schedule 2 sets out the function, role and remit of the Scottish Social Services Council (SSSC). Many parts of the Act were replaced by the Public Service Reform (Scotland) Act 2010. (The '2010 Act') [22]

The Community Care and Health (Scotland) Act 2002

The **Community Care and Health (Scotland) Act 2002** [23] introduced two key policy initiatives:

- **the introduction of free personal and nursing care for older people**, regardless of income or whether they live at home or in residential care
- **the creation of rights for unpaid carers**, with the intention of providing adequate support services to ensure the continuation of care-giving in the community.

It was was modelled on the Royal Commission Report "With Respect to Old Age" published on 1 March 1999 [24] The Act created the right to a separate carer's assessment' and the responsibility of health boards to produce 'carer information strategies' to be submitted free of charge to carers (now superseded by Carers (Scotland) Act 2016 covered below).

The Act was amended in June 2018 (The Community Care (Personal Care and Nursing Care) (Scotland) Amendment (Regulations) 2018) when **Parliament agreed to extend free personal and nursing care to adults under the age of 65,** regardless of their condition. This came into force on 1 April 2019.

The Act makes clear what aspects of care and support local authorities could not charge for. What denotes 'personal care' is set out in Schedule 1 of the Act and applies to those over and under the age of 65. A range of people - GP, welfare guardian, family member - has to arrange for an assessment of their needs by the local authority. Social work services assess need according to the aspects of care covered in the Act. These are summarised by the Scottish Government as follows:

- *Personal hygiene* - Bathing, showering, hair washing, shaving, oral hygiene, nail care.
- *Continence management* - Toileting, catheter/stoma care, skin care, incontinence laundry, bed changing.
- *Food and diet* - Assistance with the preparation of food and assistance with the fulfilment of special dietary needs.
- *Problems with immobility* - Dealing with the consequences of being immobile or substantially immobile.
- *Counselling and support* - Behaviour management, psychological support, reminding devices.
- *Simple treatments* - Assistance with medication (including eye drops), application of creams and lotions, simple dressings, oxygen therapy
- *Personal assistance* - Assistance with dressing, surgical appliances, prostheses, mechanical and manual aids. Assistance to get up and go to bed. Transfers including the use of a hoist.

More explicit detail on these is given in Schedule 1 of the 2002 Act.

Nursing care cannot be charged for either. Free personal and nursing care guidance was updated in December 2018.

Other aspects of care can be charged for, such as:

- help with housework
- laundry
- shopping
- services outwith your home such as day care centres or lunch clubs
- cost of supplying food or pre-prepared meals
- supply and monitoring of personal alert alarms.

This means that someone will be subject to a financial assessment, if they are looking to the local authority to fund the services.

It is likely that there are people who are entitled to free personal and nursing care who have not approached their local authority for an assessment of need . This would include those who have never had any reason to interact with social work services previously, and choose to pay for any care they receive privately.

Any nursing care required is organised and co-ordinated through district/community nursing services and GP practices when it is required.

However, some care at home and care home services employ their own nursing staff. These nurses would liaise between primary care district nursing services and social care staff. They are employed by these care services, and not by the NHS and are subject to the terms and conditions of the care service rather than the NHS. They are though, registered and regulated by the Nursing and Midwifery Council.

Free personal and nursing care in a care home

If someone moves into a care home, they will not necessarily need personal or nursing care. However, if they become less able, this might change. In this instance the local authority would need to carry out an assessment of needs. If the assessment confirms the need for either or both elements, then the local authority will pay the care home directly for providing them - free personal care and/or free nursing care.

There are amounts agreed every year [25] to cover free personal and nursing care. These are the amounts that the local authority will pay over to the care home to cover the costs of providing free personal and nursing care per person assessed as needing them. Currently (2020-21) these amounts are, per week:

- £180 for personal care
- £81 for nursing care.

If someone is 'receiving' this personal care element, they will cease to be eligible for Attendance Allowance.

If someone was unaware that they might be entitled to the free personal care element, the local authority doesn't have to backdate the payments to the date they moved into the care home.

A person enters into a contract with a care provider when they move into a care home. There are three of contractual routes that people can follow depending how the care is being paid for.

Route 1 – self-determined. This is the route when someone is paying all care home fees themselves (and would not necessarily seek an assessment for free personal and nursing care). They enter into a private contract with the care home.

Route 2 – mutual. This route is used when, being assessed as needing personal care and/or nursing care, the local authority would organise a contract with the care home for the payment of the free personal care/nursing care elements while the person makes a separate contract with the home for their 'boarding' or accommodation costs.

Route 3 – integrated. Even if a person is paying the fees themselves, the local authority can contract with the care home on the person's behalf. This means that the person is protected by the National Care Homes Contract, which was developed to standardise terms and conditions as well as fees for publicly-funded residents. It might also provide some protection in enabling the person to stay in the care home when their money runs down, when they would become publicly funded.

Some care homes will ask for guarantees that a person will be able to fully fund their place for a number of years before agreeing that a person can remain in the home with only public funding after their money runs down.

Recouping payments made for personal and nursing care

Guidance on a common eligibility framework and a shared assessment model for free personal care was issued under Section 5 of the Social Work (Scotland) Act 1968, and following the Sutherland Review of free personal care in 2008. This sought to address some of the problems identified with the2002 Act, such as food preparation and apparent differences between local authorities in eligibility.

The guidance, along with the court case outlined below clarified the situation regarding the point at which a local authority becomes liable for payment of free personal and nursing care.

> “ Local authority resources require to be deployed effectively both in the individual case and across the community care client group. Effective deployment of resources will include ensuring that they are applied in a fair, consistent and transparent manner. Eligibility criteria assist local authorities to achieve fairness, consistency and transparency in how decisions are taken. This guidance promotes a nationally consistent approach to the way in which local eligibility criteria are formulated whilst recognising that eligibility for community care services is fundamentally a matter for the local authority.”
>
> Scottish Government guidance: NATIONAL STANDARD ELIGIBILITY CRITERIA AND WAITING TIMES FOR THE PERSONAL AND NURSING CARE OF OLDER PEOPLE Scottish Government, 2015[26]

The position is supported by a judicial review carried out in 2007. The case involved a

complaint made to the Scottish Public Sector Ombudsman (SPSO) that Argyll & Bute council had failed to provide funding to cover the personal care costs of a resident. The individual had been placed on a waiting list until funding was found to cover the care costs, and the individual's family arranged and paid for care in the interim.

The SPSO investigation concluded that the council was placed under a statutory duty to provide funding by section 1 of the Community Care and Health (Scotland) Act 2002 and therefore that the council should reimburse the family. However, Lord MacPhail took the view that Argyll & Bute council was not required to reimburse the care costs as the care had been obtained by the family rather than the council.

Lord MacPhail's ruling had implications for waiting lists in that he confirmed that a council was not obliged to make payments for personal care unless the care had been provided or secured by it, and was not liable for the costs of care arranged by any other party.

'Frank's Law'

'Frank's Law' was the result of a successful campaign by Amanda Kopel, which began with a petition presented to the Scottish Parliament in 2013 [27] . Her husband Frank Kopel had been diagnosed with dementia at 59. He was therefore too young to qualify for free care. The petition sought to ensure anyone living with disabilities and degenerative conditions could access support, regardless of age.

In 2018, the Regulations accompanying the Community Care and Health (Scotland) Act were amended. The age qualification of 65 was removed and the Act now applies to adults over the age of 18. If a person is not classed as an adult,(definitions of the age of adulthood vary according to different policy and legislation) then personal and nursing care is free. Updated guidance on all aspects of free personal care [28] was published in December 2018

The cost of free personal care and nursing care is borne by the local authority, which commissions and procures the care from a range of providers: in-house, local authority provision, private providers, third sector providers.

Across Scotland, the proportion of providers in each of the three categories varies widely. See NHS Information Services Division (ISD) Insights into social care dashboard. [29]

More detail on the policy and 'structures' of social care and support are provided in later sections.

Part V of the Public Service Reform (Scotland) Act 2010

Part 5 of the Public Services Reform (Scotland) Act 2010 [22] **established Social Care and Social Work Improvement Scotland (SCSWIS), which is commonly called the Care Inspectorate. See How Social Care is Regulated.** The body was created to:

- protect the users of social care services

- to encourage a diversity of services
- to promote the independence of users of care services
- to identify and promote good practice in social care.

Alongside this broad remit, the Care Inspectorate registers, inspects and supports improvement of care services for children and adults. They have the powers to register or refuse to register care services. All care services must be registered with them. They have the power to inspect services, to issue notices of improvement and enforcement, and can ultimately seek to cancel a care service's registration through the Courts.

The Care Inspectorate replaced the Care Commission (Scottish Commission for the Regulation of Care), which had been established by the Regulation of Care (Scotland) Act 2001 (repealed). [21]

The 2010 Act also established NHS Healthcare Improvement Scotland (HIS) to provide assurance about the quality of care within a health setting through inspections and improvement methodologies. HIS does not have the same registration and enforcement powers as the Care Inspectorate, but they do register and inspect independent health clinics - i.e. those not run by NHS Scotland. There are many more independent care services in Scotland than there are independent health clinics. As explained, the governance and accountability of social care and healthcare are very different. All health boards are a particular category of public body ('health bodies') whereas the Care Inspectorate is an executive Non-Departmental Public Body (NDPB). Not all public sector bodies share the same relationship with government, or operate within the same public bodies framework.

Social Care (Self-directed Support)(Scotland) Act 2013

The **Self-directed Support (Scotland) Act 2013** [30] sets out a framework to underpin the arranging of care and support, community care services and children's **services to provide a range of choices to people for how they're provided with support.** The aim of the legislation is to increase the choice and control individuals exercise in how their care is organised and delivered, and by whom. Since the legislation was passed in 2013, SDS, as it has come to be known, has become the main organising mechanism for child and adult social care and support in Scotland. So, SDS, along with Free Personal Care, can be seen as two distinctly Scottish policy initiatives that are relevant in any discussion on social care and support.

> " *The Social Care (Self-directed Support) (Scotland) Act 2013* was established to ensure that social care is controlled by the person to the extent that they wish; is personalised to their own outcomes (including where they receive social care support commissioned or delivered by the public sector); and respects the person's right to participate in society. "
>
> Scottish Government: Self-directed support strategy 2010-2020: implementation plan 2019-2021 [31]

The legislation envisages a shift in the culture of public bodies and professionals from viewing service users as passive recipients of care to genuine partners in making

decisions over the services they need.

Self-directed support entails a written agreement between the individual and social services. Any support or activity is, in theory, possible as long as it will help someone achieve the outcomes in their support plan. This could include visits to the cinema, gym membership, a pet or access to an allotment.

The 2013 Act introduces four options for people, providing different degrees to which they are directly involved in organising their care.

Options for receiving self-directed support:

After it has identified the person's needs in collaboration with the adult, child/family or carer, the authority is required to offer four options in relation to the relevant support identified at the assessment stage. The four options provided under the 2013 Act are:

Option 1

The making of a direct payment by the local authority to the supported person for the provision of support.

Option 2

The selection of support by the supported person, the making of arrangements for the provision of it by the local authority on behalf of the supported person and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of that provision.

Option 3

The selection of support for the supported person by the local authority, the making of arrangements for the provision of it by the authority and, where it is provided by someone other than the authority, the payment by the authority of the relevant amount in respect of the cost of that provision.

Option 4

The selection by the supported person of Option 1, 2 or 3 for each type of support and, where it is provided by someone other than the authority, the payment by the local authority of the relevant amount in respect of the cost of the support.

Source: Section 8 of Statutory Guidance to accompany the Social Care (Self-Directed Support) (Scotland) Act 2013 [32]

According to NHS Information Service Divisions (ISD's) Insights into social care dashboard, [29] most people select Option 3, whereby the local authority selects and arranges the provision using the person's agreed budget.

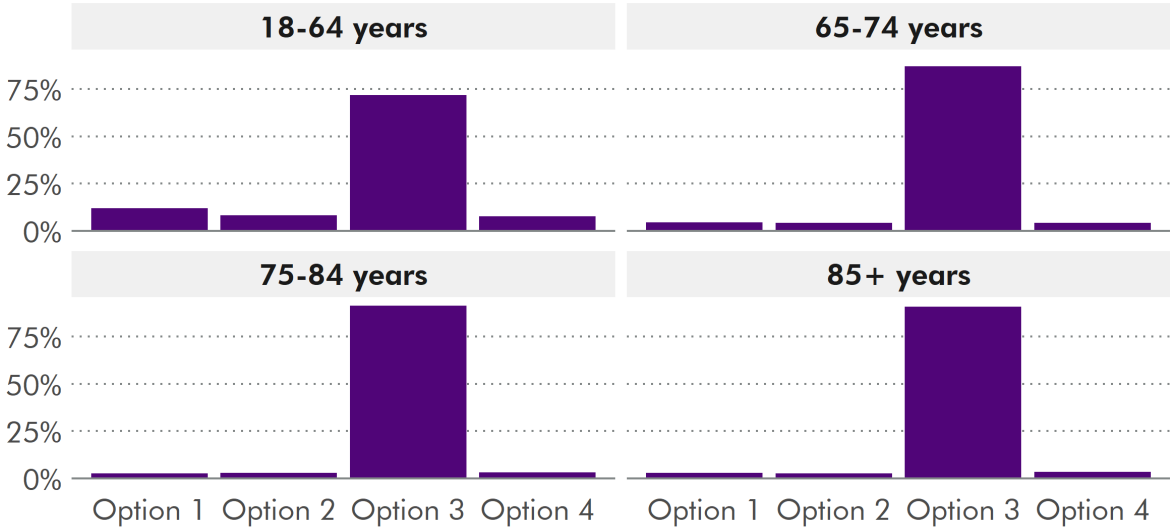
It is important to note that SDS covers all adult (and children's) social care and support, not just older people. It is conceivable that it operates very differently for different populations.

It was introduced in Parliament in February 2012 as the Social Care (Self-Directed

Support) (Scotland) Bill. More information on the Bill as it was introduced can be found in the SPICe briefing on the Bill. [33]

Figure 3 How do people choose to use Self-Directed Support?

These charts show that most people opt to have their care and support organised by the local authority (Option 3)



SPICe using data from NHS ISD

The implementation journey of Self-directed Support

Implementation was considered in a ten-year strategy plan, 2010-20. [31] This has been updated into a two-year implementation plan, 2019-21, [31] based on a review carried out in 2018 and Audit Scotland's Progress Report published in 2017. The Public Audit and Post-Legislative Scrutiny Committee of the Scottish Parliament took evidence on the implementation of SDS, on the basis of the Audit Scotland report and wrote to the Cabinet Secretary in February 2018. Implementation had been slow or not happened in some areas. Progress had apparently been hampered by the challenges presented by the integration of health and social care and the attendant structural upheavals and staff changes. The letter also observed from the Auditor General's report that seven years into the strategy, only 27% of people had made an informed choice about their non-residential care and support:

There were also issues around information on the options and independent advocacy to support people in making the choices. Data on outcomes was also, and remains, an issue that was highlighted. Attitudes and empowerment of front-line staff was also raised:

> “ Stakeholders said they felt the process was still budget driven with decision making powers sitting with the social worker and not the person; and that often an authority will refuse to disclose the monetary value of the award or even how it was calculated. We heard that often authorities’ policies do not fit well with the SDS legislation and are inconsistently applied. For example, one authority area may allow a budget to be spent on services which other areas will not. We also heard that authorities are becoming increasingly prescriptive about how individual budgets can be spent. source:Public Audit and Post legislative Scrutiny Committee (PAPLS) letter to Cabinet Secretary ”

Commissioning was also raised, with the Committee hearing that some authorities had not embraced and embedded the principles of personalisation and choice in commissioning practices. Finally, it was not clear how the money invested by the government on implementation had been allocated or used, nor how much was actually required to fully implement SDS.

The Scottish Government commissioned a research study, and published a series of papers on implementation of SDS.

The study concluded:

> “ The case studies identified that uptake of the four options in a local authority is not a suitable proxy for full and genuine implementation based on the fundamental principles of self-directed support. Although the four options are a gateway to choice and control, what is potentially more important is:
>
> - the quality of the social care assessment and reviews, including a genuinely “good conversation”;”
> - the degree to which there is a focus on the supported person’s outcomes;”
> - budgets being available to meet these outcomes;”
> - the availability of local providers and other resources; and”
> - the enabled creativity and authority of supported people, social workers and the care market to find solutions to meet those outcomes.”
>
> Any future evaluation will need to focus on these elements, alongside cost-effectiveness.”

On cost effectiveness of the policy, the report stated that economic evaluation would remain difficult until outcomes data was properly collated alongside data on the time taken by staff to properly enable choice and control.

Public Bodies (Joint Working)(Scotland) Act 2014

The **Public Bodies (Joint Working) (Scotland) Act 2014** [11] sets the **framework for integrating adult health and social care**. The aim of Health and Social Care Integration **is to establish consistent provision of quality, joined up, sustainable health and care services**. The 2014 Act established new integration authorities. The integration authorities do not employ staff, although the Act does allow this. The Chief Officer and the Finance Officer of integration authorities are seconded (or appointed and then seconded by one of

the partner bodies) from their substantive posts in either the health board or local authority. One person can fulfil both roles. Their role is to direct the devolved budgets [34] , of both local authorities and health boards, to ensure the best health and wellbeing outcomes for their populations. All other staff are employed by either the health board or the local authority. The Chief Officer must be an employee of either the local health board or local authority.

The intention is that the individual budgets lose their identity, to become a local health and social care budget. However, health boards are able to 'set aside' a proportion of their budget to cover activity in devolved services, such as A&E, where it would be impossible to separate/extrapolate devolved from non-devolved costs.

Health and social care integration is a major effort to, in effect, merge what had become, as described in the History section, two distinct spheres of activity, legislation, governance and resource. The focus has been on handing the control of separate budgets (for health and social care) to a new body, the integration authority. What is perhaps unusual is that the integration authority does not comprise a body of staff. Over the past number of years, council staff have moved to work within health boards and vice versa to ensure that services across health and social care are more coherent.

The intention is that budgets paid to local government and health boards lose their respective identities and are directed by the new body (board), with the aim of shifting the focus and locus of care into the community. The aim is for primary prevention of disease through the proactive actions of HSCPs, so, eventually, reducing the burden on the NHS resources by reducing unscheduled care and preventable health harms. See also:

- SPICe Briefing 'Integration of Health and Social Care'
- Audit Scotland:
  - 'What is Integration?' April 2018
  - Update on Progress November 2018
- NHS NES collection of relevant documents relating to integration

Carers (Scotland)Act 2016

The **Carers (Scotland) Act 2016** extends and enhances the rights of unpaid carers in Scotland to help improve their health and wellbeing, so that they can continue to care, if they so wish, and have a life alongside caring. The Act covers both adult and young carers.

The main provisions of the 2016 Act are:

- a duty for local authorities to provide support to carers, based on the carer's identified needs which meet the local eligibility criteria [35]
- a specific adult carer support plan (ACSP) and young carer statement (YCS) to identify carers' needs and personal outcomes
- a requirement for local authorities to have an information and advice service for carers which provides information and advice on, amongst other things, emergency and future care planning, advocacy, income maximisation and carers' rights
- a requirement for the responsible local authority to consider whether that support should be provided in the form of a break from caring and the desirability of breaks from caring provided on a planned basis.

Statutory Guidance [36] indicates how the Act should provide assistance using the options provided under self-directed support.

> " Where the responsible local authority exercises its duty to provide support to the carer to meet the carer's eligible needs or its power to meet the carer's other identified needs (both under section 24 of the Act), the carer must be given the opportunity to choose one of the options for self-directed support (unless the local authority considers that the carer is ineligible to receive direct payments). Any carer support provided for the carer will be provided under section 24 of the Act and cannot be charged for or means tested."
>
> Scottish Government. Statutory Guidance, Carers (Scotland) Act 2016

Other relevant legislation

There is other relevant legislation, particularly the Adults with Incapacity (Scotland) Act 2000 which is relevant to social care if someone has dementia for example, or a learning disability. Not having capacity will affect the degree to which someone can choose and control the social care support they need. The 2000 Act covers others acting as a welfare guardian or attorney for a person when they have lost capacity. Incapacity is defined in Section 1(6) of the Act, and the legislation applies to anyone over the age of 16, not 18. Mental health legislation should also interact effectively with the legislation outlined above.

Local authorities have a duty under the Adult Support and Protection (Scotland) Act 2007 to make enquiries about a person's well-being, property or financial affairs if it knows or believes that an adult is at risk of harm, and that it might need to intervene in order to protect the person's well-being, property or financial affairs.

A multi-agency approach to adult support and protection work is required and much of the work concerning individual adults will overlap with the work of for example registration and inspection bodies. Section 5 of the 2007 Act provides that certain bodies and office holders must, so far as is consistent with the proper exercise of their functions, co-operate with a council making enquiries, and report to the council the facts and circumstances where they know or believe an adult is at risk of harm.

One further Act which will, in time, have an impact on care services is the Health and Care (Staffing)(Scotland) Act 2019. The main focus of the Act is on the purposes of staffing for health care and care services. There should be appropriate staffing in all health and care settings to provide safe and high-quality services, and to ensure the best health care or (as the case may be) care outcomes for service users. It should be noted that most of the Act is not yet in force and is not expected to be implemented until later in 2020.

Accessing social care and support

This section of the briefing explains how social care in Scotland operates.

It might be helpful to think about some hypothetical scenarios in which social care and support might be required or considered.

Care and support is provided to all adults who are assessed as needing it. Not everyone turns to social services for this help and support. Many older people choose to organise their care privately and pay for it. For someone older, it might be merely seen by them as the continuation of a financially independent life, and they seek support from carers when they can no longer do everything for themselves. They might see their home as an investment stored, to be used to pay for this care in a residential care home. Alternatively, they might employ someone to live in their home to care for them or pay for someone to call in several times a day. As long as they can pay for their care, they would possibly remain unknown to social services, (even though they are entitled to seek means-tested support). However, once they have exhausted their financial assets to a certain level, which changes annually, (currently £28,500), they can seek an assessment of need from the local authority.

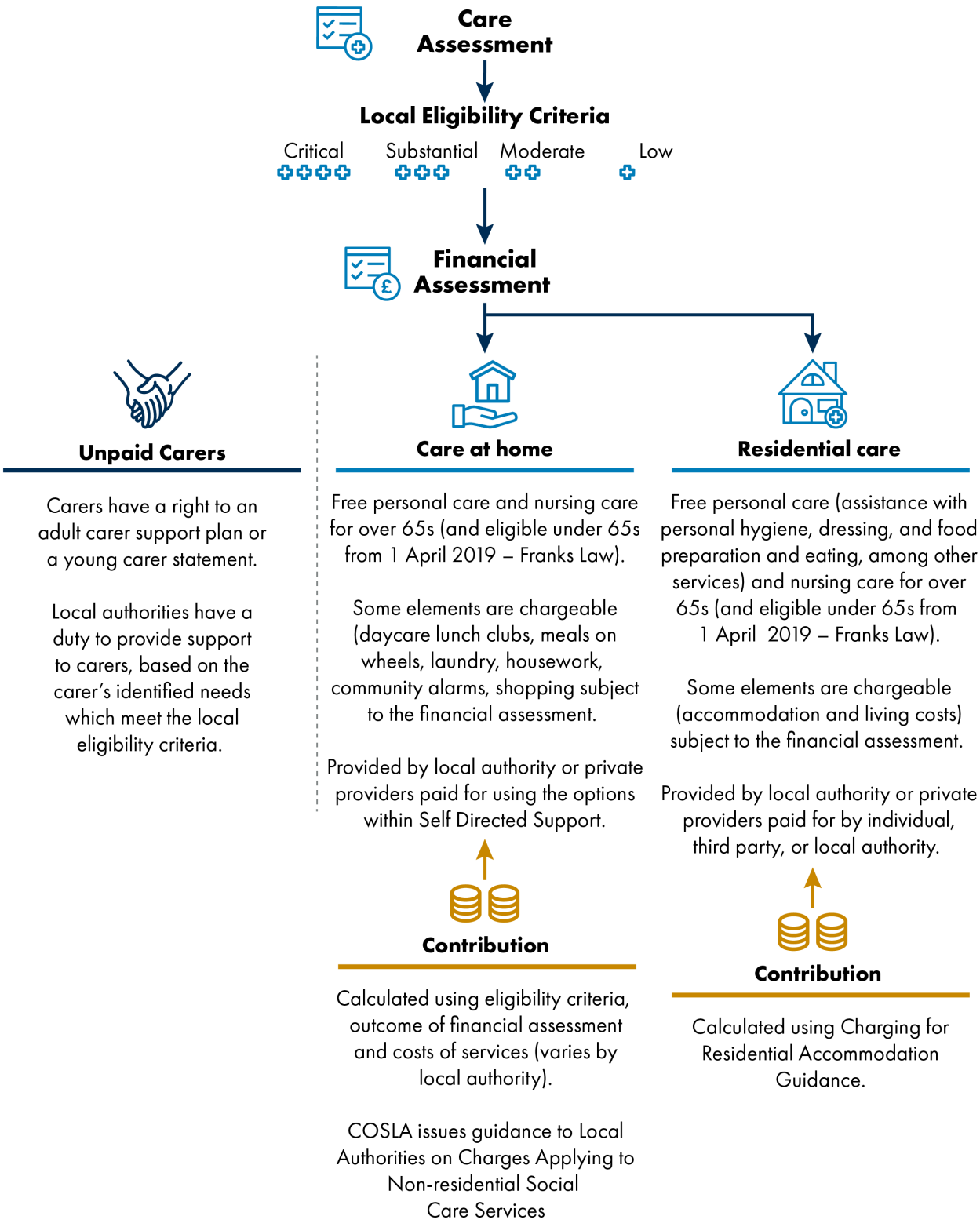
A different scenario: a young adult, over 18, who has required a high level of support throughout childhood, perhaps because of a learning disability, but who has lived at home, will become subject to an assessment of their needs at 18, as well as a financial assessment. The legislation governing children's and adult services is different and the young person will have to transition between services governed by different policy and legislation. A SPICe briefing , Transitions of Young People with Service and Care Needs Between Child and Adult Services in Scotland [37] , covers these transitions. That young person might move into supported accommodation, sharing a home with another, or small number of others, receiving full-time care and housing from the local authority, or other provider, paid for through a mix of social security benefits and local authority support.

There will be many other scenarios covering many aspects of care and support for adults from the age of 18. Support is available through NHS services, local authorities, a wide range of third sector organisations, further education providers, housing associations and others. Financial support for those with disabilities and/or caring responsibilities is available through the social security system.

The figure below shows a summary of the process someone goes through once they contact their local authority for support for themselves or someone they care for.

Figure 4: Social care support pathway for adults

This graphic shows how adults seek social care support - residential or care at home - if they are seeking assistance from the local authority.



SPICe

Below is the outline of the 'process' of arranging care, providing more detail, from the point of contact with social services. Practices will vary from one partnership area to another, and integration seeks to foster innovation in preventative and early intervention measures. When an adult, or a carer of an adult, feels that they need support they would:

1. Contact their local authority social work department
2. The local authority arranges for an assessment of needs to be done, either at the person's home, or, in hospital, if that is where the person is awaiting discharge. The local authority has a statutory duty to assess the needs of anyone over 18 who requires assistance, including carers. National eligibility criteria [35] and Health and Well-being outcomes [38] are used, among other locally devised measures, to assess those needs.
3. The local authority undertakes a financial assessment of the person's income and assets
4. A 'care package', which could comprise any support that a person wants or needs in order to live their life as independently as possible, and to achieve outcomes that they have identified alongside their social worker - is put together, with the person deciding, under Self-Directed Support, the degree of autonomy they want to have in devising the care and support package, and how it is delivered.
5. Services are commissioned by the health and social care partnership (integration authority) and procured by the local authority, guided by the Health and Care Standards [39] (Exceptions to this are if the person has decided to take a direct payment or self-directed support Option 2 (see below), and to organise their own care and support, or if the care and support is provided 'in house' by local authority/NHS staff).
6. Support and care are arranged and/or monitored by the local authority
7. If someone is deemed to be at 'critical' or 'substantial' risk, as per the [35] national eligibility criteria, personal and nursing care should be in place within six weeks from the confirmation of need. Some other services and adaptations might take longer to arrange.

If someone does not require residential care, and they own their home, then the home is *not* counted as an asset in the financial assessment. However, if residential care is decided upon, then the value of the property could be taken into account, and might need to be sold to pay for that person's care. However, this only applies in certain circumstances. If the person's spouse is living in the house for example, the value of the property will not be part of the financial assessment. Each year, COSLA and the Scottish government agree and update charging guidance to local authorities and integration authorities/health and social care partnerships for both residential [25] and non residential care [40] .

One aspect of social care support in Scotland that sometimes causes confusion is 'free personal care'. It is useful to understand that this does not mean that social care support is free for everyone who feels they would benefit from it.

Personal care is free to those assessed as needing it. In residential care the local authority will pay a nationally agreed amount to the care home for personal care, which is currently (2020-21) £180/week for personal care and £81 for nursing care.

Types of care and support

The following sections do not provide an exhaustive description of all types of care and support provided for adults, but considers three of the most common.

What these descriptions don't include are the many and ever-evolving community-led and community-based innovations. These are becoming increasingly asset-based and configured in partnerships between statutory and third-sector bodies.

Evaluation from the planning stages to ongoing sustainability of many of these innovations remain a challenge when funding streams are short-term however. Variation too is an issue, with no established mechanisms in place for ensuring that best-practice is shared and adopted/modified in different partnerships.

Residential care (care homes)

A care home is where adults live together and have their care needs met by a team of staff. Staff will be on site 24 hours, 7 days a week. They can also be called residential care homes or nursing homes. Nursing staff may or may not be employed by the home or by the company running the home. There is no difference between a home calling itself a care home or a nursing home, although some homes might not employ a nurse and could not offer nursing care. Many, if not most care homes will offer nursing care.

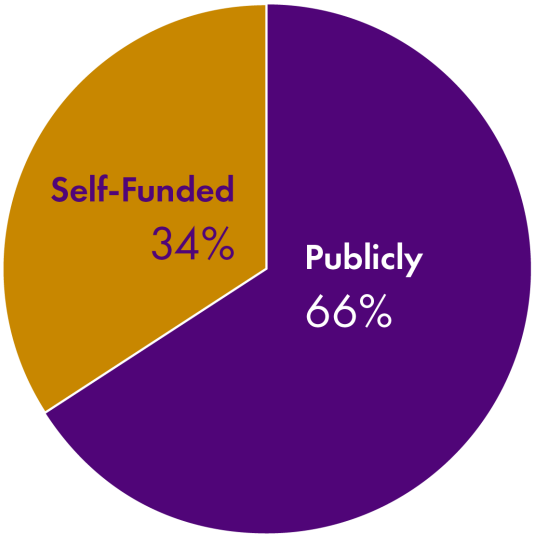
They are usually for people needing more care than they could get in their own home or in supported/sheltered housing. Over recent decades the age profile has got higher, the level of infirmity greater, and the length of stays shorter. [41] This means that care homes are managing far more complex care needs, such as high incidence of people with advanced dementia alongside a number of other conditions such as diabetes, chronic obstructive pulmonary disorder (COPD) or mobility problems.

There are a range of providers of residential care: Health and Social Care Partnerships/ local authorities, private companies, housing associations and voluntary organisations. There are are range of models for providing residential care and sizes of care homes from a few rooms in a domestic setting to over 50 beds in a purpose-built home. Some private homes will only take people who can pay for themselves, some will take a mixture of private and local authority funded residents. Some ask that a person can guarantee to cover the full fees for a number of years, after which time (when their assets and income have fallen below the annually set capital limit (currently £28,500) the person can stay on in the home, supported at the rate paid by the local authority.

The chart below shows the proportions of local authority funded places, NHS and self-funded places there are in care homes in Scotland.

Figure 5: How care home places are funded

This chart shows that most care home places are funded by local authorities, but that nearly a third are occupied by people paying for their care in a home. For further breakdown by sector see Tables 13C in most recent Care Home Census [41]



Public Health Scotland - Care home census (published October 2020)

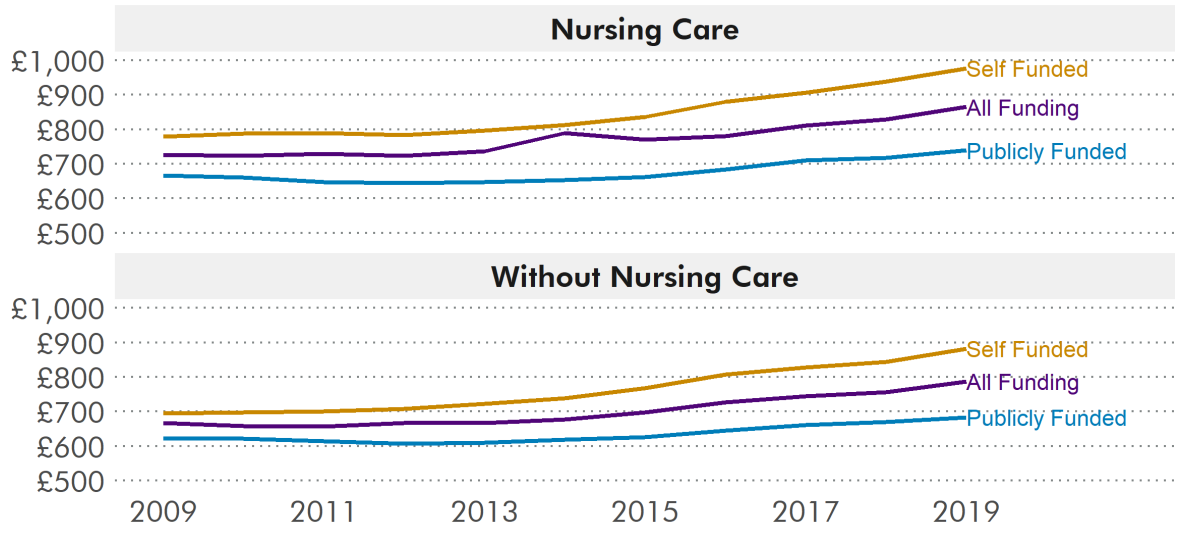
Each year COSLA and the Scottish Government set what are called the 'standard rates' for publicly funded residents. COSLA negotiates these standard rates with Scottish Care, the body that represents independent care providers. From 13 April 2020 the 2020/21 these standard rates were:

- £714.90 a week for nursing care
- £614.07 a week for residential care.

Under Section 22 of the National Assistance Act [9] local authorities are required to set rates for the care homes they own and manage at a rate equal to the actual cost of providing accommodation and care. This means that they could be charging a person considerably more than the standard rates paid to other providers to provide care and accommodation.

Figure 6 Average gross weekly care home charges (cash)

The chart below shows how much care home rates rose over ten years (2009-19). People paying for care and accommodation themselves have consistently paid more than local authorities have paid to providers. Self-funders pay more whether or not they receive nursing care



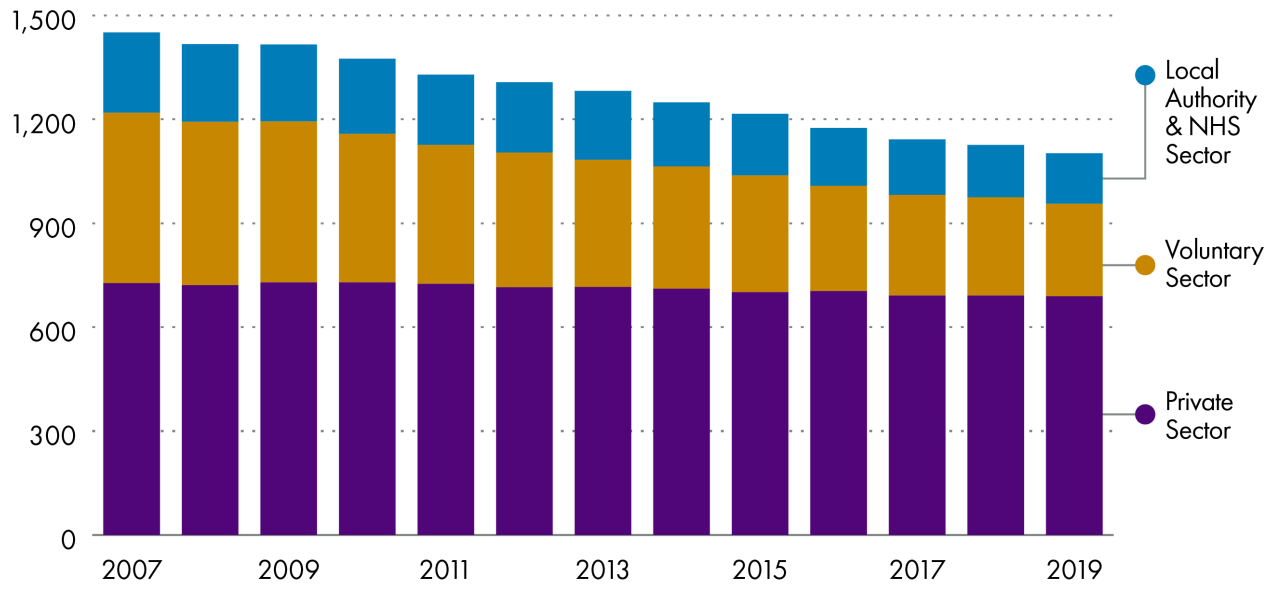
SPICe using Public Health Scotland Care Home Census

Changing provision of residential care

Over recent years, the number of care home places has been falling. There will be a range of reasons for this. One is that some providers are withdrawing from the market. Providers have argued for a number of years that the money provided by local authorities does not cover the cost of care in a care home. To remain viable, we are told, providers are forced to charge self-funders more in order to subsidise residents being funded by local authorities. In 2017, the UK Competition and Markets Authority conducted a UK wide care home review [42] . They published summaries for each of the nations, and this summary for Scotland [42] discusses this issue.

Figure 7: Number of care homes over time

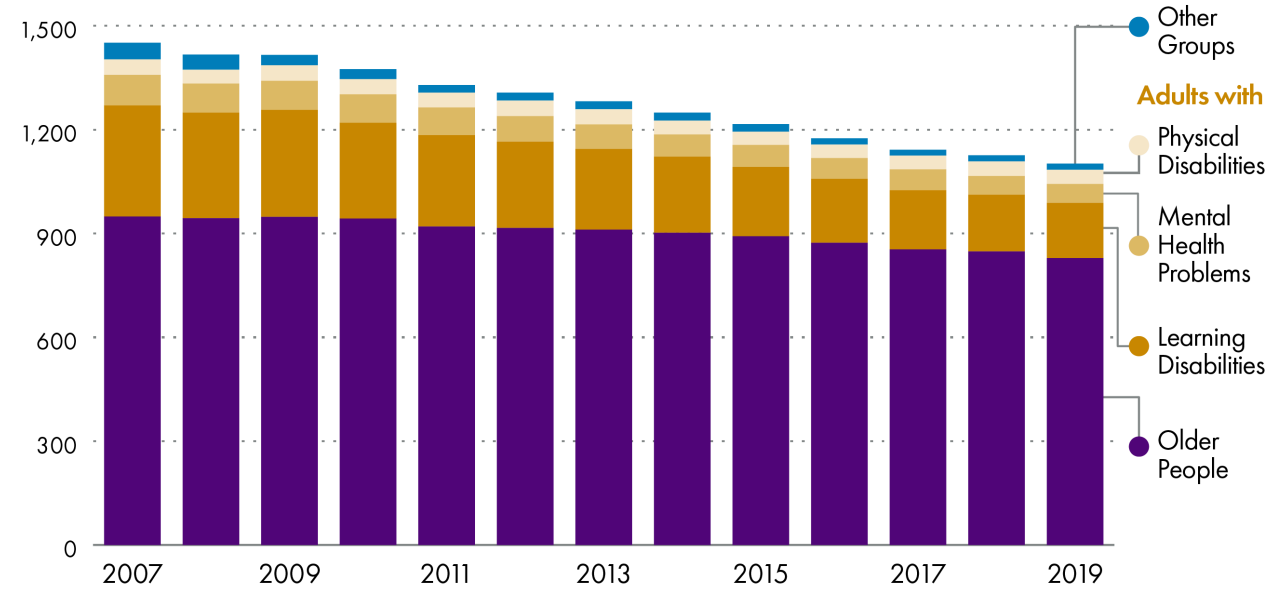
This chart shows the decline in the number of care homes by the voluntary and statutory sector



SPICe from the Care Home Survey

Figure 8: Change in numbers of care homes for all groups 2007-19

This chart shows the numbers of residential provision for different groups and how the number of residential facilities have reduced. Older people use most care home places



SPICe using data from care home census for Scotland

Care at home

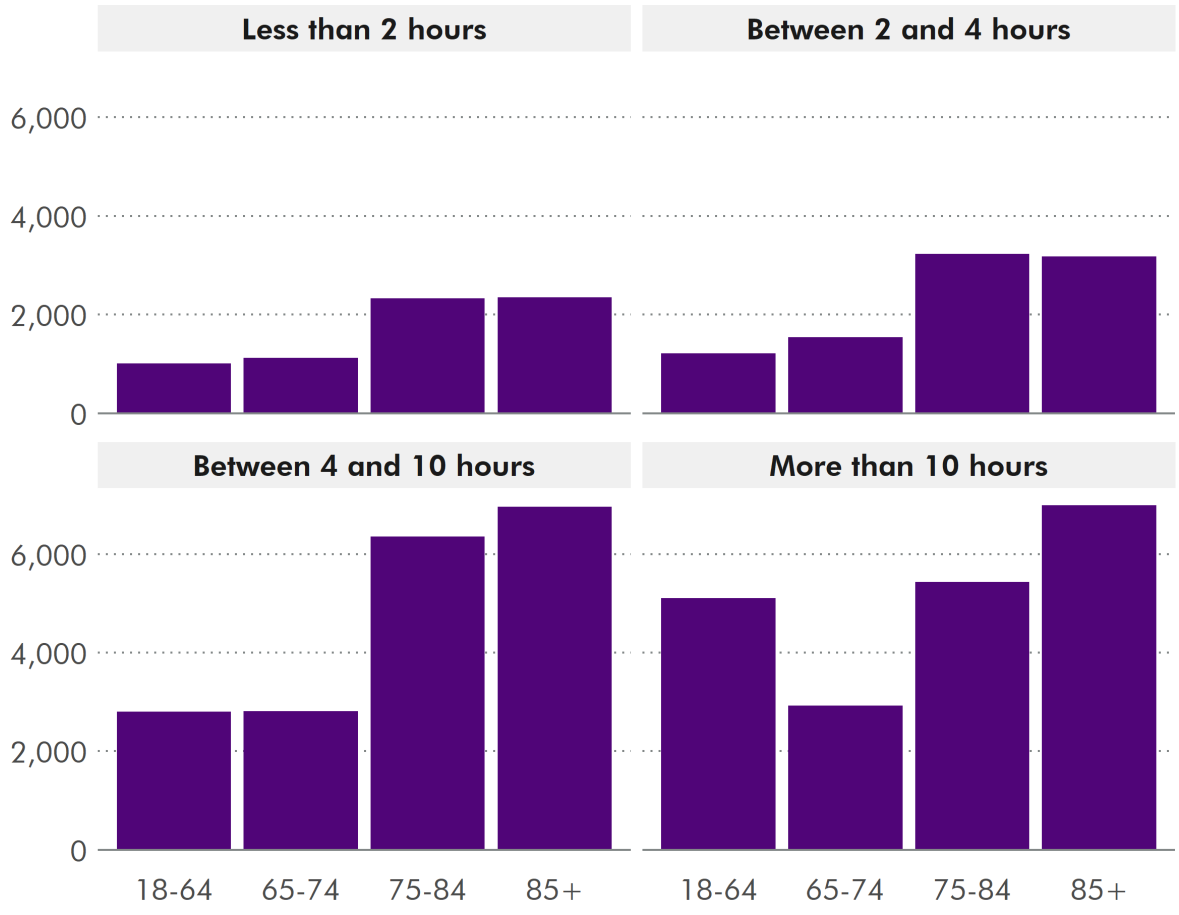
Scottish Government policy seeks to support people to live independently in their own homes for as long as possible, or in as homely a setting as possible. The integration of

health and social care is key in supporting this aim. A person should receive that support through the principles of self-directed support , which entails the person being fully involved in decisions about what support they need and how it will be delivered.

Care at home is an umbrella term for a range of statutory and non-statutory provision, some of which is free to all adults, such as personal and nursing care . Others, such as cleaning, shopping, safety alarms, laundry, collecting pensions, prescriptions and help with paying bills are not covered in the definition of 'free personal care'. Local authorities can arrange or provide this type of care, but it can also be provided by private home care providers/companies, the voluntary sector, family, or personal assistants. Personal assistants (PAs) are employed directly by the person seeking support to help with any tasks or activities they want help with.

Figure 9: numbers of people and hours of care and support provided in different age groups

This chart shows that people over 75 account for care received under 10 hours per week. When more than ten hours is required, provision is more evenly spread across the age groups



SPICe using data from Public Health Scotland

Housing support

Housing support services are intended to help people to live as independently as possible in the community. This is a sector where social care support often interacts with the benefits system, when someone is entitled to both social care and social security benefits.

The social care element of housing support is provided by the local authority, and operates in exactly the same way whether someone lives in social rented housing, private rented housing or if they own their own home.

Some of it is supplied as and referred to as 'sheltered housing'. It might be specially adapted or have a level of care attached, such as a warden. However, an individual might also be receiving 'round the clock' care from a team of people through their social care package, and be in receipt of housing support.

Registered housing support services are regulated and inspected by the Care Inspectorate using the Care Standards [39] , as per inspections of all care services.

The largest group of people who receive housing support is older people living in sheltered housing, but a wide range of people with particular needs can receive housing support services:

- people with a chronic illness
- people with a physical impairment or learning disability
- people with drug- and alcohol-related problems
- others who need support, like women escaping domestic violence, homeless people, refugees, and ex-offenders.

Housing support services include help:

- to claim welfare benefits
- to fill in forms
- to manage a household budget
- to keep safe and secure
- from other specialist services to obtain furniture and furnishings, and help with shopping and housework.

The type of support provided aims to meet the specific needs of the individual.

The Scottish Housing Regulator (SHR) publishes reports each year on how social landlords perform against the Scottish Social Housing Charter. According to the Scottish Government's Social Tenants in Scotland report 2017 [43] , (most recent data available) there were an estimated 1.14 million people living in social rented housing in 2017, a similar figure to the estimated 1.17 million people in the previous year, but a decrease of around 18% from the estimated 1.49 million people in 1999. In the social rented housing sector, 25% of adults were retired from work and 12% were permanently sick or disabled.

These services are mainly provided by councils, housing associations and voluntary sector organisations, while Scottish Government is responsible for overall policy.

People often pay rent for supported housing, and the housing is managed by the local council, a private company, charity or housing association. Charges for the support services received are normally included in the rent.

How is social care organised?

The following sections provide information on how social care is currently commissioned, funded and regulated. It also considers social care staffing: workforce planning, training and registration as well as unpaid carers.

How social care is funded

How financial and other data about social care in Scotland is collected and recorded has been changing over recent years, making it difficult to analyse some trends, particularly in spending. [44] This is primarily due to the integration of health and social care. For example, up to 2016, all social care service spending was reported through local government financial data. This shows that around £3.3 billion was spent on social services each year between 2011 and 2016. Since the establishment of integration authorities, funding for a range of community health and care services has been directed by integration authorities. In 2018-19, Integration Joint Board (IJB) spending on these services totalled £8.6 billion. £2.5 billion of this was delegated from local authority budgets, the remainder coming from NHS boards. Money spent on social work prior to integration does not map at all onto more recent data on IJB spending, or delegated budgets, and more than £2.5 billion was spent on adult social care services according to the report (£2.7 billion). It is important to note that this £8.6 billion has been delegated for all integrated health and social care services, not just social care.

> “ At a minimum, IAs need to include governance, planning and resourcing of social care, primary and community healthcare and unscheduled hospital care for adults. In some areas, partners have also integrated children’s services and social work criminal justice services. Highland Lead Agency, Dumfries and Galloway IJB, and Argyll and Bute IJB have also integrated planned acute health services”
>
> Audit Scotland: Health and Social Care Integration update on progress 2018

In November 2019, the Scottish Government published an Integrated Resource Framework for health and social care. This is a high level management document showing the total net expenditure on health and social care provided by NHS Health Boards and at Local Authority level between 2014/15 and 2017/18. It states that "In 2017/18 there was £13.5bn of net expenditure on health (£10.4bn) and social care (£3.1bn) in Scotland." This amount was spread across the following areas:

“

- Care that is delivered in a community setting accounted for 47% (£6.3bn) of the total health and social care expenditure, with the remaining 53% (£7.2bn) being provided in either a hospital or a care home.”
- Of the total health & social care expenditure, 40% (£5.4bn) was on delivering services to people aged 65 and over, who account for 19% of the population. ”
- For those services delivered to people aged 65 and over, £4.1bn (76%) was spent in a health setting and £1.3bn (24%) in a social care setting. ”
- Almost a third of the total expenditure (£1.6bn) within the NHS for people aged 65 and over is a result of unplanned admissions to hospital.”

source: Health and Social Care Integrated Resource Framework NHS Scotland and Local Authority Social Care Expenditure Years ending March 2015 - March 2018 (most recent publication at November 2020)

NHS Digital provide detailed data for social care in England, and how much is spent. It should be remembered that health and social care are not integrated in England, so the data is only from local authorities. However, it does provide an indication on the level of detailed data available on social care activity and spending in England which is not available in Scotland, and could provide a source for some comparison.

Many people make a contribution towards the cost of their support and care, depending on their income and assets. The amount that people will contribute varies widely across the country depending on a local authority's charging policy. Others make no approach to their local authority for support and organise and pay for their care themselves. Data is limited on this latter group, unless they are in residential care (self-funders).

Currently, in Scotland, there is no data on the breakdown of contributions towards care received at home, from those who receive fully-funded packages and those who pay for all the care themselves. So, it is not known how many people fund all of their care, if they have not approached the local authority. Neither is it known how many people approach the council for assistance and do not receive it because they are assessed as not meeting the eligibility criteria [35] . Contributions towards care packages will also vary over time for any individual as income and assets vary and charging policies might be modified.

Local Authorities block purchase the majority of social care services in Scotland. However, many people will purchase their own care with their own resources. The funding for social care comes the money local authorities receive from the government, council tax, etc. and reserves and from charges they make to those receiving support. The total money spent on social care in Scotland up till 2016-17 can be shown by the Gross Expenditure by Local Authorities, as this gives the amount spent on services, irrespective of the source of funds. Net revenue expenditure is the amount spent by local authorities after deducting expenditure that is covered by income (charges to users etc.)

The Scottish Government Medium Term Health and Social Care Financial Framework [45] , published in October 2018, provides a helpful overview of the relative amounts spent on different aspects of health and social care up till 2016-17. Since then, as explained above, health boards and local authorities delegate part of their budgets to integration authorities to direct towards a range of health and social care services. This has created a more complex picture and made it much harder to identify the total amount being spent on social care.

Audit Scotland publishes annual reports on both local government and NHS finances. The total revenue income of local authorities in 2018-19 was £17.7 billion. This includes all income streams, not just those connected with social care.

The total revenue income of the NHS in 2018-19 was £13.4 billion. A proportion of this is now under the direction of integration authorities for delegated (integrated services) which includes some adult social work services. Health accounted for 42% of the Scottish Government's budget in 2018-19. NHS boards delegate a significant proportion of their budgets to Integration Authorities (IAs) to fund health services such as primary and community care. In 2018-19, territorial boards delegated £6.1 billion to IAs, 52 % of their budget. Only a proportion of this would cover social care for adults.

The Scottish Government publish quarterly consolidated financial reports for integration authorities, local authorities and health boards in respect of integrated services. Quarter four data for 2019/20 shows that local authority expenditure on services was £3,075,154 for that financial year, and that the total funding from local authorities for the year was £2,829,437.

In 2016 the Scottish Government published a summary report social work and social care statistics for Scotland. [46] The intention was that this would be an annual exercise, but there are no more recent reports. This report describes the breakdown of how money was spent in social work and social care between 2011 and 2014, that is, before health and social care were formally integrated. Despite its age, the report does provide some insight into social work and social care activities which still apply.

COSLA have called for reconsideration of local authority funding in its 2019 report, Fair Funding for Essential Services. In the report they emphasise the renewed focus that local authorities have on health and wellbeing and preventive services. They cite the changing demographics, a real terms increase of 6.3% in spending on care for older people since 2010/11 and the 10% increase in the demand for home care services as more care is delivered out of hospital.

> " Health is wider than the NHS; Local Government plays a vital role in the health, wellbeing and social care of Scotland and should therefore receive its share of health consequentials... ...Health is not only delivered by the NHS and we must ensure a whole system approach to funding if we are to meet targets, in particular in early intervention, public health, adult health and social care."
>
> Fair Funding for Essential Services

Calls for reform of social care funding

Reform of social care funding has been on the political agenda in the UK for at least 23 years. The King's Fund have produced an interactive timeline [47] of the many attempts, and starts from the Royal (Sutherland) Commission, established in 1997, through green papers, white papers, further commissions and legislation. The timeline refers mainly to England. However, despite some key policy decisions taken in Scotland, such as free personal care, the Scottish Government recognises that structural issues remain and are similar to those that have troubled successive UK governments such as: rising demand, rising costs, inequity, staffing, 'catastrophic care costs' for some individuals and a widespread lack of awareness among the public of how social care operates.

The King's Fund has published reports and other media on reforming the funding of social

care in the UK. One, 'A Fork in the Road: next steps for social care funding' [48] , considered reform in England, where there is not 'free personal care' nor has there been the structural change of health and social care integration. The report considers both of these. One stark finding was the high level of misunderstanding amongst the public; most believe that social care, like health care is free at the point of need. This misunderstanding, the authors argue, make it difficult to discuss, for example, further or dedicated taxation to pay for any reform. Arguably, free personal care policy in Scotland has exacerbated the misunderstanding among the public.

Sally Warren, a former UK civil servant who worked through the complete reform trajectory so far published a blog stating:

> “ The new Prime Minister (Boris Johnson) is now joining a long line of politicians, going back to Tony Blair in 1997, who define the problem as ‘removing the fear of selling your house to pay for care’ in older age. This is an extremely narrow frame of reference. Where is the positive vision for the quality of life we would want for ourselves or for our family? Where is the vision for how we can support independence and wellbeing as we grow older? What about improving the quality of life for working-age adults, who account for half of all public spending on social care? ”

The challenge of costing outcomes

Since 2007 the Scottish Government has sought to foster a focus on outcomes from policy, rather than to create a balance sheet of inputs and outputs. The new (2018) National Performance Framework and the new Scottish Parliament budget process [49] demonstrate a will to embed an outcomes approach in both delivery and scrutiny of policy. However, it is not straightforward and especially difficult when budgets are constrained. Establishing indicators and evidence is challenging in health and social care, as highlighted by Audit Scotland. In June 2019 Audit Scotland published a briefing, Planning for Outcomes. This is a high-level document but with practical approaches to performance planning and reporting. [50]

How social care is commissioned and procured

Commissioning and procurement are frequently talked and written about as if they were part of the same process. However, they are very different activities.Social care is commissioned by the integration authorities through the delivery bodies, health and social care partnerships, not local authorities. Local authorities, though, remain responsible for procuring and contracting care from providers. This means that the procurement of social care services is *not necessarily* distinct from the procurement of other council services in terms of process, such as road resurfacing and transport for example.

Strategic commissioning is required by the Public Bodies (Joint Working) (Scotland) Act 2014 and the Statutory guidance [51] describes how commissioning should be approached:

> “ (The)Integration Authority is required to take into account the integration planning and delivery principles set out in the Act, and the national health and wellbeing outcomes set out in Regulations, in preparing a strategic commissioning plan. This is to ensure the **principles and national outcomes are at the heart of planning for the population and to embed a person centred approach, alongside anticipatory and preventative care planning**.”

In addition, commissioners must consider a number of other complementary elements of policy and legislation such as; the Health and Care Standards [39] , the legislation and principles of Self-Directed Support, equity of provision, Fair Work and the new Health and Care Staffing (Scotland) Act. Most of the Act is not in force at time of writing.

Integration authorities have now completed their second iteration of the three-year strategic commissioning plans since the institution of integration, and a review was undertaken by the Ministerial Strategic Group for Health and Community Care in January 2020 for plans to 2023. The Group statess that redesigning social care support should be a strategic priority.

The review also considers that guidance encourages a collaborative approach to commissioning (see the comprehensive collection of Coalition of Care and Support Providers Scotland publications on commissioning) at a locality level (as defined by the Act). The statutory guidance on localities [52] states that localities provide one route, under integration to ensure strong community, clinical and professional leadership of strategic commissioning of services.

Commissioning then, should be the result of a joint exercise by all the relevant local partners, including those in social work, health, housing, the voluntary sector, planning, etc. that considers the needs of the whole local population in terms of health and care. Some areas will have different priorities from others, and some partnerships will work more or less closely with the wider community planning structures, local people, the third sector and private providers of care in identifying those priorities. Overall though, the major partners will be the local health board, the local authority and the associated integration authority/ies.

That said, the Statutory guidance to accompany the Procurement Reform (Scotland) Act 2014, [53] includes an annex, to accompany section 13 of the 2014 Act, about the procurement of health and social care services. The Scottish Model of Procurement defines value for money as the best balance of cost, quality and sustainability and this should be reflected throughout strategy development, reporting and procurement processes. The guidance [53] makes specific reference to contracts for health and social care services.

Examples of considerations regarding **quality** include:

- the quality of the service
- the continuity of the service
- the affordability of the service
- the availability and comprehensiveness of the service
- the accessibility of the service

- the needs of different types of service users
- the involvement of service users
- innovation.

When budgets are tight and/or providers are scarce fulfilling these expectations can be challenging.

The Coalition of Care and Support Providers (CCPS) published a study report in 2019, Handing Back Contracts: Exploring the rising trend in third sector provider withdrawal from the social care market [54] . The report draws clear conclusions and explains why contracts are being handed back in the voluntary sector.

- The 'hourly rate' offered is not sufficient to cover Scottish Living Wage costs or overheads.
- It is challenging to recruit and retain staff (cannot offer attractive wages for skilled and emotionally challenging work).
- 'Second level' adjustments to improve practices - to eliminate 15 minute visits, increased use of technology, training etc do not address underlying deficits and operational challenges caused by lack of funding.
- Commissioners, as the only 'customer' can hold down prices (and therefore quality).
- Providers carry all the risk of the arrangements/contracts.
- 'spot' contracting to ensure choice under SDS for the person needing support, has a perverse effect on contracting, such as an increase in piecemeal or zero hours contracts.

The research's reading and analysis of the problem renders procurement guidance ineffectual in the context of the structural and funding issues described. [54]

How social care is regulated

Social care services are regulated by the Care Inspectorate (CI). This body, legally known as Social Care and Social Work Improvement Scotland, registers and inspects care services across Scotland.

The CI is an executive non-departmental public body (NDPB). This means they operate independently from Scottish Ministers but are accountable to them and are largely publicly funded. Their functions, duties and powers are set out in the Public Services Reform (Scotland) Act 2010 [22] and associated regulations. They are audited annually by Audit Scotland.

Their regulatory work includes registering and inspecting care services, dealing with complaints and carrying out enforcement action, when required. They play a role in supporting improvement in care services and local planning and health and social care partnerships.

According to their most recent annual report ,they regulate, inspect and support to improve 12,886 registered care services across Scotland. The remit is broad. This number includes children's services. Some of the services are: childminders, care homes, care at home, daycare of children, and housing support. The CI's quarterly reports provide information on the number of care services, registrations and cancellations of services, enforcement notices, complaints about services, and quality of services. Many of their inspections are unannounced. If areas for improvement are found then follow up visits are undertaken to ensure that recommendations have been followed.

The CI recognises that their remit extends beyond the inspection of individual care services, particularly in the context of the integration of health and social care. Some of their inspections are joint inspections with other bodies, such as NHS Healthcare Improvement Scotland and other scrutiny partners (eg education and police) for other services they monitor.

They also carry out inspections of health and social care partnerships' strategic planning and commissioning.

They publish 'joint inspection' reports about and across services in all integration authority areas, particularly examining the strategic commissioning of integrated (or delegated) services. In these, they make recommendations for improvement, using the same five key questions (see Health and Social Care Standards [39]) that they use for any inspection of an individual registered care service.

The inspection teams are made up of inspectors and associate inspectors from both the Care Inspectorate and Healthcare Improvement Scotland as well as clinical advisers seconded from NHS boards. The CI plans to have inspection volunteers who are members of the public who use a care service; have used a care service in the past or are carers; Healthcare Improvement Scotland’s public partners on their inspections. It is not clear whether this is yet happening.

The Care Inspectorate's strategic objectives are:

1. People experience high-quality services and support where needed.
2. People experience positive outcomes: the care sector is innovative and carries out high-quality self-evaluation and drives forward improvement.
3. People's rights are respected: people experience person-led, outcome-focused care that respects their rights and reflects the Health and Social Care Standards.

Care Inspectorate Corporate Plan 2019-22

In 2018 the Care Inspectorate published a Framework for care homes for older people, partly in response to the new Health and Care Standards [39] . These are a co-produced set of rights based statements. This Framework is based on a new inspection methodology, informed by the European Foundation for Quality Management Excellence Model (EQFM model) ,that supports continuous improvement, and incorporates self-assessment.

The Care Standards are:

HEALTH AND SOCIAL CARE STANDARDS

I experience high quality care and support that is right for me

I am fully involved in all decisions about my care and support

I have confidence in the people who support and care for me

I have confidence in the organisation providing my care and support

I experience a high quality environment if the organisation provides the premises

The new framework has five key self-assessment questions for services which can be evaluated at inspection including elements such as 'How well do we support people's well-being?'and, 'How good is our leadership?'

The Care Inspectorate publish a range of statistics, reports and publications, alongside their inspection reports.

In 2019, they conducted a thematic review of Self-Directed Support. This was in addition to a number of associated reviews in integration authority areas. The Review made some specific recommendations, as well as wider observations about why Self-Directed Support might not be functioning as intended. These observations are presented in the form of **'national conversations'** that need to be had in four broad areas:

- making SDS **accessible to all**;
- making an **outcomes focused approach work within systems which are not aligned to such an approach** (eg procurement practices);
- how to **evidence, record and report** on outcomes to allow for transparency and comparison;
- **leadership and integration**. The latter should ease implementation, not hinder it. There should be shared ownership by health bodies of the principles of self-directed support, which already align with person-centred approaches in health care.

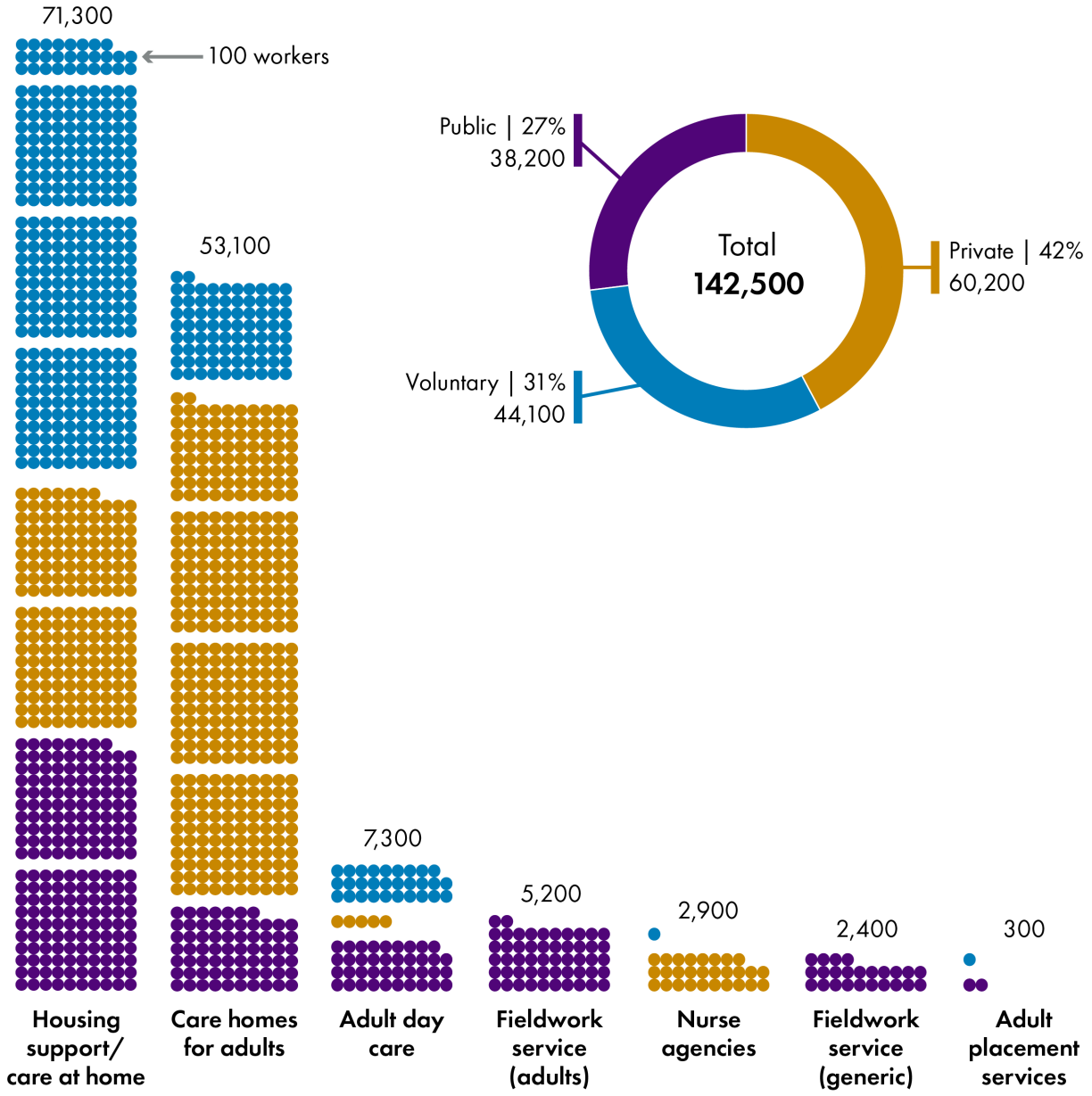
The Care Inspectorate came under close scrutiny during the coronavirus pandemic because of the high number of deaths in care homes (approximately half of the total).

Staffing in social care

This section provides data and information on staffing in social care and support.

Figure 10: Staff employed in different aspects of social care in 2019

The chart below shows the relative numbers of staff employed in the different parts of the care sector by how they are employed: by public bodies, private providers or not-for-profit providers (voluntary).



SPICe using data from SSSC workforce data (2019)

Social care staff are regulated by the Scottish Social Services Council (SSSC). The SSSC liaises with the Care Inspectorate, the regulator for social care provision, as well as other partners such as Skills Development Scotland.

The SSSC Register was set up under the Regulation of Care (Scotland) Act 2001 to regulate social service workers and to promote their education and training.

It is important to note that many registered nurses, as well as allied health professionals and primary care staff such as GPs and community nursing teams are either employed in the sector or work very closely with social care staff. These staff are registered and overseen by other regulators.

Thet Scottish Social Services Council workforce report [55] Was published 22 November 2019. This highlighted that the workforce has increased 1.2% since 2017 to 204,610 staff, equivalent to 7.7% of the Scottish workforce. The median age of staff is over 40, and only 15% of the workforce comprises men. 82% of staff are on permanent contracts

Frequently and continually raised issues about the social care workforce over the past few years include the following, most of which are interdependent:

Issues - social care workforce

- **recruitment and retention** - availability of staff and attractiveness of the profession
- **workforce planning and the impact of Brexit**
- **commissioning and procurement practices** that undermine person-centred care and inhibit strategic workforce planning
- **value of profession and parity of esteem** with other community-based staff
- **training** and development
- career progression vs a desire to focus on the direct caring role, unfettered by additional qualifications and management responsibility
- affordability of additional or agency staff and overnight payments
- delays in assessments and reassessments (of six weeks), making it hard to be responsive to changing needs of people.

The Health and Sport Committee conducted a series of short inquiries on different aspects of social care in Session 5 and one that focused on the social care workforce in 2016 explored some of these issues. The following sections consider some of these issues: recruitment and retention, fairwork and framework contracting, and workforce planning.

Recruitment and retention

Recruitment and retention were affected by terms and conditions which compared poorly against, for example, retail work. Staff did not feel valued, or heard by multi-disciplinary teams in relation to the needs of the people they were paid to care for. Carers sometimes felt embarrassed to tell people what they did for a living, and commissioning and assessment practices undermine person-centred care and flexible arrangements in commissioners' efforts to manage spending. Private and third sector organisations bid to provide services within framework agreements which do not specify particular packages of care. It is up to the provider to work out how they will fulfil the contract in terms of staffing.

The Scottish Living Wage was introduced for social care staff in the 2016 budget, but providers argued that little partnership existed between government, commissioners and employers over the implementation and challenges, and that added costs would present a profound challenge.

A letter from the Convener of the Committee to the Cabinet Secretary provided further

detail and covered the evidence heard from staff: of zero hours and nominal hours contracts, low pay rates, unpaid training and travel, which all contribute to the lack of attractiveness of social care work.

Fair work and framework commissioning

When the Health and Sport Committee looked into the social care workforce in 2016, workforce planning was deemed to be absent in any meaningful way, and 'framework contracting', whereby detail is limited, were seen to push risk away from the commissioner, and onto providers. Framework contracts were also deemed to do nothing to contribute to strategic workforce planning, because within that way of contracting, workforce planning becomes solely a matter for the provider. Scotland Excel, the organisation that supports public bodies in their commissioning and procurement, describe the process in positive terms, stating that it can 'support a consistent approach, provide detailed management information and ensure sustainability of care services.', as well as supporting outcomes focused commissioning.

It seems that this optimism is not borne out by evidence. Three years on from the Committee inquiry, The Fairwork Convention published a report in 2019, 'Fair Work in Scotland's Social Care Sector' [56] providing information and detail on many of these issues, from the point of view of the workforce. On commissioning, the report states:

> “ The current method of competitive tendering based on non-committal framework agreements has created a model of employment that transfers the burden of risk of unpredictable social care demand and cost almost entirely onto the workforce. We have deliberated carefully over the nature of the contractual frameworks, and it is our belief that this method of procurement creates a situation that is untenable. source: Fair Work in Scotland's Social Care Sector”

They recommend:

> “ that the current commissioning practice of hourly rate based non-committal competitive tenders and framework agreements should end. Social care providers should be commissioned based on their level of skill, expertise, understanding and application of the Fair Work Framework, and on costs based on the right numbers of staffing required and a satisfactory and fair income level for each member of staff. Commissioners should be responsible for assessing and predicting the level of demand and commissioning the right levels of staff from the provider organisation, with no expectation that the provider or worker carry the risk for working time not being required.”

Workforce Planning

At around the same time as the Fairwork Convention's report [56] was published, the Scottish Government published An Integrated Health and Social Workforce Plan for Scotland December 2019 . This followed a series of three separate preparatory documents covering workforce planning in primary care, social care and healthcare.

The Integrated Workforce Plan is a strategic document, taking a high level view of future

demand and supply across health and social care, possibly the first time that this has been attempted.

The Medium Term Financial Framework for health and social care, published in 2018 projects demand for social care over five years to rise by 4%, and a non-pay average annual growth of 1.7% for social care.

The Integrated Workforce Plan has estimated staff needed in key groups up to 2030. This includes 1500 more allied health professionals, 8,800 more care home staff and over 14,400 more home care and housing support staff.

They highlight the potential impact of Brexit on the supply of these staff, with estimates that around 5 - 7% of staff in a range of staff groups are currently non-UK EU nationals. In addition, turnover and vacancy rates among relevant staff groupings are relatively high, and growing in some professions.

The government seek to address some of the challenges in a number of ways: creating more training places, supporting recruitment into care careers, widening access, improving fair work practices and improving workforce planning.

Historically, workforce planning was seen as the responsibility of the health boards, local authorities and care providers. However, in evidence heard by the Health and Sport Committee during the scrutiny of the Health and Care Staffing (Scotland) Bill, it became clear that workforce planning was based on past supply, not future demand. There was no national overview of the demands of changes in policy, such as integration, in future requirements for staff. Only some training places are controlled by government (eg. medicine). There was no national intelligence on the training places required to meet future demand. While the published plan does not provide reliable projections based on data (because much data doesn't exist) a single workforce data platform is being developed, and work to understand the care labour market is being developed. It has also been recognised that the skills required to conduct large-scale workforce planning do not necessarily exist, and a qualification is being developed.

Shortly before the Workforce Plan was published, an independent report, 'The Implications of National and Local Labour Markets for the Social Care Workforce' [57] commissioned by the government and COSLA, was published (November 2019). This study took an in-depth look at the care labour market including topics such as retention, recruitment, training, motivations of staff, movement of staff and conducted a range of surveys with stakeholders. Many observations, from a much larger pool, reflect those heard by the Committee in 2016.

Training

The Scottish Social Services Council (SSSC) is responsible for developing the qualifications for social work and social care staff as well as registering and regulating staff. They also promote the sector. Most of the materials are available through their website, where people can find out about careers in the sector, how to register. Continuing professional development resources are also available. Providers will also design and implement their own training.

People can become a care support worker without any formal qualifications. However, a

condition of registration is an undertaking to work towards a qualification. Accepted qualifications are also listed on the website and depend on the role.

Currently, there is little financial support available for undertaking courses, but this possibly reflects the reality that most people enter the workforce and train and gain qualifications 'on the job'. If a person joins as an apprentice they do not pay for training.

Staff at all levels have to pay a fee to join the register.

Personal Assistants

Personal Assistants is the term that covers a person that is employed or paid directly by someone needing care and/or support. Direct Payments, under Option 1 of Self-directed Support, can be used to pay for the services of PAs. The Scottish Government has produced the Personal Assistant Employer Handbook for people choosing Option 1, and wanting the support of one or more PAs. It covers all the aspects that need to be considered from recruitment, contracts and responsibilities of both parties. The local authority monitors the arrangement in relation to agreed outcomes, so some record keeping is required by the person employing the PA.

The person needing support becomes the employer of the personal assistant, or the PA will be self-employed and will invoice the individual. If the person is employing the PA, they will need to think about their responsibilities as an employer such as tax, national insurance and pension payments. If the PA is self-employed then the person will need to think carefully about what should be in the contract. Support is available from a range of sources, via Self-directed Support Scotland for example, who can arrange advice and peer support.

Personal Assistants do not have to register with the Scottish Social Services Council and are not regulated by them or the Care Inspectorate. However, like all social care staff, they are expected to uphold the SSSC code of practice:

Social service workers must:

- protect the rights and promote the interests of supported individuals and carers
- work to establish and maintain the trust and confidence of supported individuals and carers
- promote the independence of supported individuals while protecting them as far as possible from danger or harm
- respect the rights of supported individuals while making sure that their behaviour does not harm themselves or other people.

PAs have increasingly become recognised as having the same status and rights as any other social care worker. This has been demonstrated in discussions on living wage, sleepover payments and more recently, during the COVID-19 pandemic when they were explicitly recognised as key workers.

Because there are no registration requirements, then there are no qualification requirements for PAs. Anyone can call themselves a PA if they are receiving payment for

looking after or supporting someone.

Unpaid carers

While not part of the 'workforce', unpaid carers are recognised in law for the contribution they make in social care by looking after family members, neighbours and friends.

The actual number of carers is not known but according to the Scottish Government, was previously estimated to be between 700,000 and 800,000. This included 29,000 who were under the age of 18. The Scotland's Carers research report (March 2015) [58] provides statistical analysis and research on caring and carers. Recent polling has indicated there are an additional 400,000 people in Scotland who have taken on caring responsibilities during the COVID-19 pandemic.

The Scottish Government has collated information on legislation, policy and support for carers of all ages.

Carers UK conducted a more recent study,Will I Care? [59] in 2019, looking at the likelihood that someone would become a carer. What is striking is that most are carers in middle age, not after retirement. The study revealed that although one in two men in Scotland will be a carer by age 57, this drops to age 45 for women.

Analysis by the universities of Sheffield and Birmingham, who conducted the study, show that between 1991 to 2018, 65% of adults in Scotland have been an unpaid carer for a loved one. The research also shows that the average person in Scotland has a 50:50 chance of caring by 49 years-old. There is not a huge variation in these figures in other parts of the UK. Researchers derived their data from large scale national surveys such as the British Household Panel Survey/ Understanding Society.

The Carers (Scotland) Act was passed in Scotland in 2016 and came into effect on 1 April 2018. The intention of the Act is to ensure that carers (including young carers below the age of 18) are better supported on a more consistent basis so that they can continue to care, if they so wish, in good health and wellbeing, allowing them to have a life alongside caring.

The Act gives carers a right to a support plan from the local authority, taking account of the person's individual circumstances. They are also entitled to an assessment of their needs, and, if local eligibility criteria are met, then support will be put in place. As with eligibility criteria for social care, it is likely that bespoke Self-directed support from the local authority will only be available to those deemed to be at 'substantial' or' critical risk' because of their caring responsibilities. However, this does not mean that authorities are not providing more universal services and means of support, such as the funding of local organisations that provide support.

Most authorities will make information on how eligibility works locally available through their websites. This is just one example from South Lanarkshire.

Integration authorities have had to develop carer strategies and eligibility criteria for their area. There is no automatic right to a break from caring, but authorities have to involve carers in the development of their carer strategies and short break statements. The needs of carers are, of course, inseparable from the needs of the person they care for, and the

Act recognises that a carer's needs will be quite individual. The continuation of the policy of personalisation and person-centredness inherent to Self-directed Support is clear, as is the reflection of the long-standing processes of assessments of need and eligibility criteria. It is important to note that carers are entitled to self-directed support, using the same principles, and options available to the person they care for. The first step in this process is arranging for a carer support plan.

The Coalition of Carers in Scotland produced a document to explain the Act and what people should expect: 'What to Expect...The Carers (Scotland) Act'

The Coalition of Carers in Scotland has also produced a range of leaflets explaining different aspects of the Act.

1. What to expect when you make an adult carer support plan

2. What to expect if the person you care for is being assessed

3. What to expect when you are considering a short break

4. What to expect when accessing Self-directed support as a carer

5. What to expect when you make an emergency plan

6. What to expect when the person you care for is discharged from hospital

Unpaid and paid carers responded in large numbers to Health and Sport Committee survey asking about care and support at home during the pandemic.

Scottish Government and COSLA Reform of social care

In their Programme for Government published in September 2020, the Scottish Government announced a review of social care, due to report in January 2021. This was prompted in part by the exposure during the COVID-19 pandemic, of differences between social care and the NHS. These became apparent in how Personal Protection Equipment was made available for staff in different sectors for example.

Emergency legislation [60] , relieved local authorities of the duty to carry out full assessments of need and to consult the person or the family in advance of arranging care. However, if they did not carry out a full assessment, they could not charge for support provided until a full assessment was completed.

Also, testing capacity was not adequate to carry out testing in any widespread or consistent way to protect care home residents from incoming infection, and reliance was put on the use of Personal Protection Equipment (PPE) and infection control measures to protect staff and residents. PPE was not always available, especially during the early weeks. Independent care providers were initially responsible for sourcing their own PPE (as they always had been). See Health and Sport Committee COVID-19 inquiry in which meetings were held on PPE, Testing and Care homes.

The high number of deaths in care homes, and a high profile case concerning a private care home on Skye stimulated calls for an inquiry. The Care Inspectorate started legal proceedings to cancel the home's registration.The private care home was sold to NHS Highland.

The Scottish Government responded to the issues in its announcement of the wide-ranging social care review, and resisted calls for an immediate public inquiry.

The 2020 review of social care and support:

> The aim of the review will be to recommend improvements to adult social care in Scotland, focused on the outcomes achieved by and with people who use services, their carers and families, and the experience of people who work in adult social care. The review will take a human-rights based approach with a particular but not exclusive focus on the views of those with lived experience, about what needs to change to make real and lasting improvements. Using the powers that are available to the Scottish Parliament this will set out how adult social care can be reformed to deliver a national approach to care and support services. It will include consideration of a national care service.

The pandemic reset and refocused the agenda on the social care, building on the existing reform programme established in 2019.

In June 2019, the Scottish Government launched a national programme in a bid to reform social care . The reform programme was launched following the collection of evidence from organisations and individuals, who shared their thoughts on the challenges facing social care and any changes they believed were needed.

The priorities for the Government in implementing the reforms are to invest in social care support, change attitudes towards it, and to achieve a “shared agreement” on social care support with an emphasis on human rights.

In order to carry out the reforms set out in the programme, there are seven workstreams .

- The purpose and value of social care support and self-directed approaches
- Consistent experience and expectations
- Models of care and support
- Workforce conditions and skills
- Investment in care and support
- Commissioning and procurement
- Communities, care and support

Inclusion Scotland, an organisation representing disabled people's interests, have written a Statement of Ambition for social care.

Issues for social care (for twenty years and counting)

As explained above in Scottish Government and COSLA Reform, 2020 reset the timetable for reform of social care and an updated review is underway in autumn/winter 2020.

This section provides some links to reports written on the main issues highlighted below. Some of the information referred to is based on social care in England and Wales but there are enough parallels with some aspects of social care in Scotland to make them relevant. The publications, along with others referred to in the briefing provide further background and information useful in considering reform.

The main issues are highlighted below and reflect what was raised in written evidence presented to the Health and Sport Committee and summarised in a separate document.. Where there are specific sections relating to a topic in the briefing, cross references have been added. Reference to other issues run through the briefing.

- Funding
- Commissioning and procurement
- Self-directed Support
- Workforce
- Alternative Models of Care
- Integration of health and social care
- Housing
- Technology
- Human Rights based approaches to social care
- Community focus in planning
- Third Sector
- Accountability see summary of evidence, for a discussion of these topics.

Because so much has been written about the problems with social care, there is little value in repeating it here. The King's Fund, although with a focus on England, has summarised key aspects of these issues in 'What's you problem, social care? the eight key areas for reform' ahead of the 2019 UK General Election.

It is a brief report which offered solutions to the incoming government. While chiefly considering social care in England, all of these also pertain to Scotland.

At around the same time, another think tank, the Nuffield Trust published a briefing paper entitled 'Social Care: the action we need' This paper proposes a fair and transparent funding system and refers to other reports done on how social care operates in Japan and

Germany. They argue that any funding proposals for social care be scrutinised using four 'tests' that ask about the sustainability of the funding model; whether it is fair; will people understand it and does it pool risk across the population.

See also a range of briefings and reports written by the UK Parliament:

Paying for Social Care : 20 years of inaction

Adult Social Care in England: possible reforms

Economic Affairs Committee (HoL) Report: Social Care Funding: time to end a national scandal

Citizens' Assembly on Social Care: Recommendations for Funding. Report

Audit Scotland have also published a number of relevant reports. These recognise the impact of the policy and structural innovation that integration entails, and considers social care in this context in its current publications.

Self-directed Support (progress report) 2017

Changing models of health and social care 2016

Social Work in Scotland 2016

Implications for public finances in Scotland (COVID-19) August 2020

As this briefing has outlined, the Scottish Government has introduced significant policy and legislation, seeking to improve social care: free personal care, self-directed support, support for unpaid carers and the integration of health and social care. Lack of sustainable funding has meant that the full expectations of these has not been realised.

...and proposed remedies in Scotland

The following sections consider the efforts made to reform the care of older people in Scotland over the past ten years, with a programme for change from 2011-21. This programme took on board the recommendations of Christie and Dilnot. Prior to the integration of health and social care, the Scottish Government introduced a 'change fund' to stimulate the development of community-based services for older people who might otherwise remain in hospital, and to prevent emergency admission in the first place. The expectation was that a reduction in unscheduled (unpredictable) hospital care costs would result, and money be reinvested in prevention and investment in community-based services. These efforts prefigured and have run in parallel with the ongoing process of integration of health and social care.

Reshaping care for older people

In 2011 a vision document was produced by the Scottish Government, COSLA and NHS Scotland called 'Reshaping care for older people: a programme for change 2011-21' The vision was that *“Older people are valued as an asset, their voices are heard and they are supported to enjoy full and positive lives in their own home or in a homely setting.”.* This was followed up by an update paper on progress in 2013 which reflected that the

principles of personal outcomes for individuals was becoming embedded:

> “ In line with Christie (2011), a personal outcomes approach supports sustainability by moving the focus away from service led approaches. This requires supporting people to make the move from viewing the delivery of service as the endpoint, to focusing on the purpose of engagement and activity with individuals. When the starting point is clarifying purpose (outcomes), the next stage is identifying how those outcomes might be achieved - this includes considering the role of the person and other resources in their lives, as well as services, consistent with an enabling culture.”

This seems to suggest that statutory services should become less significant in a person's life, or that there is a change of emphasis, such that services should not be put in place to address problems (a deficit model), but to support the capacity and abilities of the person and the access to facilities and other people around them (an assets based model). [This all sounds great providing you don't have severe dementia or advanced MND, or profound learning disabilities and really require 24/7 personal care/nursing care...].

The original report concluded that two actions were necessary to address the increase in demand as a result of demographic change:

- that current resources were being used to meet agreed policy goals ie, more robust research and data on outcomes
- how additional resources could be secured to create sustainable services into the future, perhaps by attending to recommendations of the Dilnot Commission (King's Fund briefing paper)(2011)

Shifting the balance of care from hospital to the community

How additional resources are secured for social care has remained at the heart of the problem for reforming social care, across the UK. According to the King's Fund:

> “ The Dilnot recommendations aim to eliminate the catastrophic care costs faced by some people by capping the maximum amount individuals contribute over their lifetime, beyond which the state will meet all future funding. By limiting people’s liability in this way, the Commission expects a market to develop for financial products so that people can insure themselves against the cost of their contribution. ”

In Scotland, the 'Re-shaping Report' prefigures SDS, but also, in its 'next steps' looks to integration to promote 'resource release' from the acute sector. The report recognised the real challenges in this: it is difficult to reduce the number of people accessing unscheduled (emergency) care, where a third of costs are located. Also, it is perhaps unrealistic to hope that a shift of resource is a simple transfer of funds calculation. Several years of integration has shown this to be true.

This difficulty in shifting resource from hospital care to community-based care could be partly because the very nature of unscheduled care; demand is unpredictable, but it also doesn't take account of medical and technological advances and costs of new medicines for example, and other increasing health costs. The NHS cannot do that much in controlling the costs of medicines, devices and new technologies.

The report also concludes that the funding, procurement and affordability of social care are

the main issues, and that it is up to the Scottish Government to assess what policy and legislative levers it has at its disposal. It should be remembered that this programme was being developed alongside health and social care integration, and very shortly after the establishment of the Care Inspectorate.

Audit Scotland conducted its own review of the programme in 2014 , following the introduction by the Scottish Government of the 'Change Fund'. The Fund totalled £300 million to promote tests of change to shift the balance of care and to create interventions that might prevent unscheduled admissions of older people. Audit Scotland recognised that there were a number of good initiatives being explored, but that there was no overall evidence and data gathering of the impact of these tests of change.

> “ The Change Fund represents 1.5 per cent of all spending on older people in 2011/12 and this has led to the development of a number of small-scale initiatives. Initiatives are not always evidence-based or monitored on an ongoing basis and it is not clear how successful projects will be sustained and expanded...There is no clear national monitoring to show whether the policy is being implemented successfully and what impact this is having on older people.”

One of the key recommendations from the Audit Scotland report was that the Scottish Government should:

> “ Set out clear measures for success when a new policy is introduced. The Government should monitor progress and publicly report on performance against these measures and use them to underpin local commissioning and scrutiny. These indicators should include measures that cover outcomes, quality, community services and services to prevent or delay ill health.”

Despite the overlay of the pandemic in 2020, many of the intractable problems with social care have been rehearsed over many years and much time has been devoted to them, and they remain. Despite radical changes to legislation that have happened in Scotland and not in England, such as introducing free personal and nursing care, the problems have not been 'solved'. These include so-called 'catastrophic costs'(because many people have to pay for their own social care some people with significant care and support needs will end up paying very large sums – £100,000 and above. Many will have to sell their main, or only asset,their home, to pay these costs), recruitment and retention of staff, and inequity in how different diseases are regarded and treated by the NHS: cancer and dementia for example.

Scottish Parliamentary scrutiny and activity

The Health and Sport Committee hosted an event, *Scotland 2030: A Sustainable Future for Social Care for Older People* , on 16 November 2018, in collaboration with Scotland’s Futures Forum , to consider the future of social care for older people in Scotland. The event considered the general proposition of how social care would look (and be financed) in 2030.

The difficult questions surrounding social care were addressed by a number of speakers at the event and the report summarises some of these alongside some of the options for the future of social care. Extensive quotes are presented here because they are not available through the Official Report.

Professor Bell provided a brief history of long-term care policy in Scotland, noting the 2001 work of the Care Development Group, the introduction in 2002 of Free Personal Care and the Sutherland Review in 2008. However, he stated, not much has been done since then to look at the overall funding of care.

English ideas

Professor Bell referred to previous reviews in England, including the Barker Commission, which suggested making social care free at the point of use for those with “critical” needs, extending to those with substantial needs as the economy improved and to those with moderate needs by 2025. The Commission also floated four different ways of funding these changes:

• remove exemptions for prescription charges, while making them cheaper;

• restructure National Insurance to collect more from those aged over 40 and high earners;

• increase contributions from older people such as by limiting winter fuel payments to those on low incomes; and

• review wealth and property taxes

What do we mean by fairness?

Professor Bell suggested that decisions on funding come down to what we mean by “fairness” in the context of long-term care, and he pointed to these areas for consideration.

• Condition: is it fair that there is free care for people with cancer but not for people with dementia?

• Income: what share of cost should be borne by low or high-income households and families? Does the prospect of high care costs cause a disincentive to save?

• Wealth: should we use wealth rather than income when considering ability to pay?

• Place: how far should local communities be able to set their own levels of long-term care support?

• Generational: will subsidies to care for the baby boomers adversely affect following generations?

Bell goes on to consider the proportion of the older population supported by national care services in England and Scotland, compared with Germany and France. In England and Scotland the proportion is steadily decreasing. The opposite trend is seen in Germany and France.

Dee Fraser, from the Coalition of Care and Support Providers Scotland (CCPS), that represents not- for-profit providers of social care and support, also presented at the event and spoke specifically about the so-called 'market' of social care.

Context

As context, Ms Fraser noted that 80% of social care is delivered by non-statutory partners in the voluntary and private sectors, with 69% of social care workers in those sectors. The fact that the majority of work is done under contract rather than directly by public authorities is the reason why commissioning is so important.

Not a market. Although we talk about a market for social care, Ms Fraser noted that we really have a monopsony, where there are lots of providers but only one purchaser. In such a situation, the purchaser has a lot of control, over price for example, but the long-term effect can be toxic. Providers unable to meet the requirements drop out, leaving only one large provider, and a monopoly emerges. Given that situation, and the fact that the opportunities under self-directed support are not being used by much of older population, Ms Fraser suggested that we end up with an overly bureaucratic system that provides decreased availability and choice of care.

A new mindset. In response, Ms Fraser called for a new commissioning mindset. Rather than let commissioning be led by finance, purchasing and practice of procurement, we should fit services around people and consider the whole system rather than just the parts. With that in mind, Ms Fraser suggested five areas to consider for the future.

1: **Pay attention to effects** Ms Fraser provided an example from a local authority in Scotland – although simplified, it showed how reaching a quick fix can cause more problems. Social care expenditure was increasing, so the authority's reaction was to re-tender with a lower, capped hourly rate. Providers withdrew as the rate was not financially viable, meaning that the external providers market reduced. The statutory duty to provide support lay with the local authority, which had to buy in agency staff to cope with the demand. This, in turn, increased the social care expenditure. A better solution would have been to develop an understanding of cross-sectoral expenditure, with collaborative allocation leading to a better use of resources.

2: Alliance contracting Alliance contracting (a process used in places such the oil and airline industries) is a vehicle to share risks, responsibilities and opportunities. It is not a legal entity, so there is no need to merge any bodies; it is an alignment based on outcomes and a commitment to principles and behaviours. 8 Traditional contracting involves one commissioner and several providers, with separate contracts with each party. In it, there are separate drivers for each party, performance is individually judged and does not drive collaboration, the commissioner is the co-ordinator, provision is made for dispute and contracts are based on tight specifications. As such, change can not be easily accommodated and the process is not responsive to changing demand. Under alliance contracting, the public body is commissioner but is also part of the contract – this gives it a greater involvement in the outcomes. Under one agreement and performance framework, with aligned objectives and shared risks, success is judged on overall performance, with shared co-ordination and collective accountability. There is an expectation of trust and an agreement which describes outcomes, and change and innovation in delivery are expected.

3: Confident collaboration in a competitive context. Ms Fraser's third area to consider was an example from a local authority that, seeing massive gaps in provision, invited all the providers to breakfast meetings over six months to discuss

the situation. Following a process of collaborative allocation, they encouraged providers to work together to fill gaps, rather than compete (or not compete) for provision. This has worked well, including by helping the providers come together to meet the requirement for the living wage to be paid for overnight support.

4: Systemic planning. Ms Fraser suggested that public authorities suffer from both bureaucratic redundancy (asking staff to do unnecessary work) and failure demand – where they create demand for services by failing to meet people's needs earlier. If we can help people who do not need to be in the system to stay out of the system, that leaves more resources to support those who need it.

5: Self-directed support. Finally, Ms Fraser noted that that if there were a real move to people taking control of their own budget, it would unlock the social care market, bringing it closer to a real market with individuals making own choices and services growing to meet that demand. Conclusion In conclusion, Ms Fraser suggested that we need to stop doing the wrong thing a bit better and, instead, we need to do the right thing, even if it takes some time to do it properly. In particular, we need a change in mindset and courageous cross-sectoral systems leadership.

While private businesses are intimately entailed in the NHS, the costs of healthcare are pooled across the population, meaning that private profit is removed from the relationship between the providers of healthcare and the public. The question is how could this be achieved in social care, and should it be?

Because the catastrophic costs for individuals mainly relate to accommodation costs, sometimes called 'hotel' costs, of staying in residential care, any future planning must consider housing for the future. The Futures Forum hosted a further even in the series: Scotland 2030: Housing and Ageing. Clearly, this opens up any discussion on social care, into a discussion on community planning and infrastructure planning. The event considered the report from a UK wide engagement study: 'Housing and Ageing: linking strategy to future delivery for Scotland, Wales and England', which included the input from a wide range of stakeholders and policy makers. The report from the programme concluded that housing should be at the centre of health and social care integration and preventative local strategies, and made the following recommendations:

- Invest in early intervention and prevention within the home and community
- Achieve meaningful co production/co-working and consultation with older people
- Focus on accessible information and advice for older people living in urban and rural communities
- Build new suitable housing, such as intergenerational and lifetime homes that are adaptable, flexible, inclusive and affordable across all tenures

Committee scrutiny and third sector research: Social care and COVID-19

The Health and Sport Committee undertook extensive preparatory evidence gathering for

an inquiry on adult social care and support due to be held in the spring of 2020. These documents summarise evidence from over 200 submissions. All the topics listed as issues above are covered in a comprehensive summary, analysis and consideration of the evidence received by the Health and Sport Committee early in 2020 for its Social Care Inquiry on the future delivery of social care in Scotland. The inquiry was postponed by the Covid-19 pandemic.

Individuals also submitted evidence to the inquiry early in 2020.

The Health and Sport Committee also undertook work on social care in response to the COVID-19 pandemic, and as part of its 2021 Pre-Budget Scrutiny work over the summer and autumn of 2020. The Committee received further evidence from stakeholders, organisations and individuals relating to care homes, care at home, resilience and the Care Inspectorate. This evidence contributed to the Social Care Inquiry held at the end of 2020.

The COVID-19 pandemic in 2020 had a profound effect on social care services, how people received their care, and required improvisation and innovation at speed from providers and people being supported. There have been many reports of how communities became the focus of local support and how the sluggish progress of integration was suddenly accelerated and changes thought too difficult were quickly implemented by local partnerships between public bodies, and between public bodies and the third sector.

The pandemic prompted organisations to take the opportunity to carry out research and qualitative enquiry into the effects of COVID-19 at a time when many care and support services were unable to provide support as they had previously.

ARC Scotland is an organisation that supports people with learning disabilities or other additional support needs. They conducted a survey with social care staff during the COVID-19 pandemic to assess how the sudden changes associated with 'lockdown' and the virus impacted on services and ways of working.

Key findings of the report included the following:

“

- Supported people are perceived to be better able to cope and more resilient than their staff expected”
- Support should be constructed around people’s needs and preferences and provided in a more relaxed and non-pressured way”
- Social care staff are motivated, adaptable, resilient and proud of their work, but feel undervalued”
- Covid-19 gives us a unique opportunity to rethink how social care functions, and to move towards more flexible, autonomous and creative ways of working.”

Voluntary Health Scotland conducted a survey very early in the pandemic and published a briefing on the effects on voluntary organisations in April 2020.

The Coalition of Carers in Scotland conducted research to discern whether self-directed support could be used more flexibly during the pandemic by unpaid carers. July 2020

Bibliography

1 NHS Scotland. (n.d.) A Route Map to the 2020 Vision for Health and Social Care. Retrieved from https://www.nhshighland.scot.nhs.uk/Publications/Documents/Route%20Map%20to%20the%202020%20Vision%20for%20Health%20and%20Social%20Care.pdf [accessed 24 September 2020]

2 Scottish Government. (2018, October 4). Medium Term Financial Framework for Health and Social Care. Retrieved from https://www.gov.scot/publications/scottish-government-medium-term-health-social-care-financial-framework/pages/3/ [accessed September 2020]

3 Audit Scotland. (2020). e hub-transforming health and social care in Scotland. Retrieved from https://www.audit-scotland.gov.uk/reports/e-hubs/transforming-health-and-social-care-in-scotland

4 Coalition of Care and Support Providers Scotland. (2020). Hot Topics - Integration of health and social care. Retrieved from http://www.ccpscotland.org/hot-topics/integration-health-social-care/

5 Scottish Government. (2020). Social Care. Retrieved from https://www.gov.scot/policies/social-care/#:~:text=Social%20care%20means%20all%20forms,continue%20in%20their%20caring%20role.

6 The King's Fund. (2019, November). Key Facts and Figures about Adult Social Care. Retrieved from https://www.kingsfund.org.uk/audio-video/key-facts-figures-adult-social-care [accessed 27 January 2020]

7 Department of Health (UKGov). (2013, April). National Framework for Continuing Healthcare. Retrieved from https://apexhealth.net/wp-content/uploads/2016/04/National-Framework-for-NHS-CHC-NHS-FNC-Nov-2012.pdf [accessed 27 January 2020]

8 UK Parliament. (1929). Schedule 1, Local Government (Scotland) Act 1929. Retrieved from http://www.legislation.gov.uk/ukpga/Geo5/19-20/25/schedule/FIRST/enacted [accessed 29 January 2020]

9 UK Parliament. (1948). The National Assistance Act 1948. Retrieved from http://www.legislation.gov.uk/ukpga/Geo6/11-12/29/contents [accessed 29 January 2020]

10 UK Parliament. (1968). Social Work (Scotland) Act 1968. Retrieved from http://www.legislation.gov.uk/ukpga/1968/49/contents [accessed 29 January 2020]

11 UK Parliament. (2014). Public Bodies (Joint Working) (Scotland) Act 2014. Retrieved from http://www.legislation.gov.uk/asp/2014/9/contents/enacted [accessed 22 January 2020]

12 Audit Scotland. (n.d.) Integration of Health and Social Care - ehub. Retrieved from https://www.audit-scotland.gov.uk/reports/e-hubs/transforming-health-and-social-care-in-scotland

13 Scottish Government Ministerial Strategic Group. (2019, February). Progress review: health and social care integration. Retrieved from https://www.gov.scot/publications/ministerial-strategic-group-health-community-care-review-progress-integration-health-social-care-final-report/pages/1/

14 Care Inspectorate. (2020). Quarterly statistical summary report (Q3 2019). Retrieved from https://www.careinspectorate.com/index.php/publications-statistics/133-public/statistics/quarterly-statistical-summary-report-qtr-3-2019-20 [accessed 15 June 2020]

15 CCPS. (2018). Market Facilitation Guide. Retrieved from http://www.ccpscotland.org/wp-content/uploads/2018/11/ccps-marketfacilitation-guide.pdf

16 Kidner, C. (2019). Scottish social security benefits. Retrieved from https://sp-bpr-en-prod-cdnep.azureedge.net/published/2019/10/31/Scottish-social-security-benefits/SB%2019-68.pdf

17 Scottish Government NHS Scotland. (2020). Care Information Scotland: Public Information on social care in Scotland . Retrieved from https://careinfoscotland.scot/

18 UK Parliament. (n.d.) National Health Service and Community Care Act 1990 Part IV. Retrieved from https://www.legislation.gov.uk/ukpga/1990/19/part/IV

19 UK Parliament. (n.d.) National Assistance (Assessment of Resources) Regulations 1992. Retrieved from https://www.legislation.gov.uk/uksi/1992/2977/contents/made

20 COSLA. (2020). Charging guidance for non-residential care. Retrieved from https://www.cosla.gov.uk/about-cosla/our-teams/health-and-social-care/social-care-charging-information

21 UK Parliament. (n.d.) Regulation of Care (Scotland) Act 2001. Retrieved from https://www.legislation.gov.uk/asp/2001/8/contents

22 UK Parliament. (2010, undefined). Public Service Reform (Scotland) Act. Retrieved from http://www.legislation.gov.uk/asp/2010/8/contents [accessed 2020 June 21]

23 UK Parliament. (n.d.) Community Care and Health (Scotland) Act 2002. Retrieved from https://www.legislation.gov.uk/asp/2002/5/part/1/crossheading/charging-and-not-charging-for-social-care

24 Royal Commission on Long Term Care, London, . (1999). With respect to old age Long term care - rights and responsibilities (summary by the Health Foundation). Retrieved from https://navigator.health.org.uk/theme/respect-old-age-long-term-care-rights-and-responsibilities

25 Scottish Government. (2020, April). Charging guidance for residential accommodation. Retrieved from https://www.sehd.scot.nhs.uk/publications/CC2020_01.pdf

26 Scottish Government. (2015). NATIONAL STANDARD ELIGIBILITY CRITERIA AND WAITING TIMES FOR THE PERSONAL AND NURSING CARE OF OLDER PEOPLE - GUIDANCE. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2015/01/personal-and-nursing-care-of-older-people--national-standard-criteria-and-waiting-times-guidance/documents/personal-and-nursing-care-of-older-people---national-standard-criteria-and-waiting-times-guidance/personal-and-nursing-care-of-older-people---national-standard-criteria-and-waiting-times-guidance/govscot%3Adocument/National%2BStandard%2BCriteria%2Band%2BWaiting%2BTimes%2Bfor%2Bthe%2BPersonal%2Band%2BNursing%2BCare%2Bof%2BOlder%2BPeople%2BGuidance%2B.pdf

27 Scottish Parliament. (2013). PE01480: Alzheimer's and dementia awareness. Retrieved from http://external.parliament.scot/GettingInvolved/Petitions/alzheimers

28 Scottish Government. (2018). Circular No. CCD3/2018. Retrieved from https://www.sehd.scot.nhs.uk/publications/cc2018_03.pdf

29 NHS NSS Information Services Division (ISD). (2019, June). Insights into Social Care in Scotland (Experimental Statistics Publication). Retrieved from https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Publications/2019-06-11/2019-06-11-Social-Care-Report.pdf? [accessed 15 June 2020]

30 UK Parliament. (n.d.) Social Care (Self-direct Support) (Scotland) Act 2013. Retrieved from https://www.legislation.gov.uk/asp/2013/1/contents/enacted

31 Scottish Government. (n.d.) Self-directed Support Strategy 2010-2020 Implementation Plan 2019-21. Retrieved from https://www.gov.scot/publications/self-directed-support-strategy-2010-2020-implementation-plan-2019-21/pages/2/

32 Scottish Government. (2014). Statutory Guidance to accompany the Social Care (Self-directed Support) Scotland Act 2013. Retrieved from https://www.sdsscotland.org.uk/wp-content/uploads/2018/11/Statutory-Guidance.pdf

33 Payne, J. (2012). SPICe Briefing: Social Care (Self-directed Support) Bill. Retrieved from https://www.parliament.scot/ResearchBriefingsAndFactsheets/S4/SB_12-32.pdf

34 Scottish Government. (2020, January). Directions from integration authorities to health boards and local authorities: statutory guidance. Retrieved from https://www.gov.scot/publications/statutory-guidance-directions-integration-authorities-health-boards-local-authorities/

35 Scottish Government, . (2009, undefined). NATIONAL STANDARD ELIGIBILITY CRITERIA AND WAITING TIMES FOR THE PERSONAL AND NURSING CARE OF OLDER PEOPLE - GUIDANCE. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2015/01/personal-and-nursing-care-of-older-people--national-standard-criteria-and-waiting-times-guidance/documents/personal-and-nursing-care-of-older-people---national-standard-criteria-and-waiting-times-guidance/personal-and-nursing-care-of-older-people---national-standard-criteria-and-waiting-times-guidance/govscot%3Adocument/National%2BStandard%2BCriteria%2Band%2BWaiting%2BTimes%2Bfor%2Bthe%2BPersonal%2Band%2BNursing%2BCare%2Bof%2BOlder%2BPeople%2BGuidance%2B.pdf [accessed 30 January 2020]

36 Scottish Government. (2018, March). Statutory Guidance. Carers (Scotland) Act 2016. Retrieved from https://www.gov.scot/publications/carers-scotland-act-2016-statutory-guidance/pages/0/

37 Scottish Parliament SPICe. (2019). Transitions of young people with service and care needs between child and adult services in Scotland. Retrieved from https://digitalpublications.parliament.scot/ResearchBriefings/Report/2019/3/29/Transitions-of-young-people-with-service-and-care-needs-between-child-and-adult-services-in-Scotland#Executive-Summary

38 Government, S. (2015). Health and Wellbeing Outcomes framework. Retrieved from https://hub.careinspectorate.com/media/1282/national-health-and-wellbeing-outcomes-a-framework-for-improving.pdf [accessed 2 March 2020]

39 Scottish Government. (2017, June). Health and Care Standards. Retrieved from http://www.newcarestandards.scot/ [accessed 2 March 2020]

40 COSLA. (2020). NATIONAL STRATEGY & GUIDANCE Charges Applying to Social Care Support for people at home. Retrieved from https://www.cosla.gov.uk/__data/assets/pdf_file/0016/17521/2020-21-COSLA-Charging-Policy-for-Social-Care-Support.pdf

41 NHS Scotland Information Services Division. (2020, October). Care Home Census for Adults in Scotland. Retrieved from https://beta.isdscotland.org/find-publications-and-data/health-and-social-care/social-and-community-care/care-home-census-for-adults-in-scotland/

42 Competition and Markets Authority UK. (2017). Care Homes Market Study. Retrieved from https://www.gov.uk/cma-cases/care-homes-market-study

43 Scottish Government. (2017). Social Tenants in Scotland . Retrieved from https://www.gov.scot/publications/social-tenants-scotland-2017/pages/5/

44 Audit Scotland. (2012). Commissioning Social Care. Retrieved from https://www.audit-scotland.gov.uk/docs/health/2012/nr_120301_social_care.pdf [accessed 31 January 2020]

45 Scottish Government. (2018). Medium term health and social care financial framework. Retrieved from https://www.gov.scot/publications/scottish-government-medium-term-health-social-care-financial-framework/

46 Scottish Government. (2016). Social Work and Social Care: a statistical summary. Retrieved from https://www.gov.scot/binaries/content/documents/govscot/publications/corporate-report/2016/02/social-work-and-social-care-statistics-for-scotland-a-summary/documents/social-work-social-care-statistics-scotland-summary-pdf/social-work-social-care-statistics-scotland-summary-pdf/govscot%3Adocument/Social%2BWork%2Band%2BSocial%2BCare%2BStatistics%2Bfor%2BScotland%2B-%2BA%2BSummary.pdf

47 The King's Fund. (2019). (Video) Short History of social care funding reform in England 1997-2019. Retrieved from https://www.kingsfund.org.uk/audio-video/short-history-social-care-funding

48 The King's Fund. (2018, May). A Fork in the Road: next steps for social care funding reform. Retrieved from https://www.kingsfund.org.uk/sites/default/files/2018-05/A-fork-in-the-road-next-steps-for-social-care-funding-reform-May-2018.pdf

49 Burnside, R. (2018). Guide to the new budget process. Retrieved from https://digitalpublications.parliament.scot/ResearchBriefings/Report/2018/5/10/Guide-to-the-new-Scottish-budget-process

50 Audit Scotland. (2019, June). Planning for Outcomes. Retrieved from https://www.audit-scotland.gov.uk/uploads/docs/report/2019/briefing_190603_planning_outcomes.pdf

51 Scottish Government. (2015, December). Strategic Commissioning Plans: guidance. Retrieved from https://www.gov.scot/publications/strategic-commissioning-plans-guidance/pages/9/

52 Localities Guidance to accompany Public Bodies (Joint Working)(Scotland) Act 2014. (2015). Retrieved from https://www.gov.scot/publications/localities-guidance/

53 Scottish Government. (2016). Statutory Guidance , Procurement Reform (Scotland)Act 2014. Retrieved from https://www.gov.scot/publications/guidance-under-procurement-reform-scotland-act-2014/pages/1/

54 CCPS/ University of Strathclyde, Glasgow. (2019, May). Handing Back Contracts: Exploring the rising trend in third sector provider withdrawal from the social care market. Retrieved from http://www.ccpscotland.org/wp-content/uploads/2019/05/Handing_Back_report_CCPS.pdf [accessed 24 June 2020]

55 SSSC. (2019, November 22). Scottish Social Service Sector: Report on 2018 Workforce Data.. Retrieved from https://data.sssc.uk.com/data-publications/22-workforce-data-report/216-scottish-social-service-sector-report-on-2018-workforce-data [accessed 12 February 2020]

56 Fairwork Convention. (2019). Fairwork in Scotland's Social Care Sector. Retrieved from https://www.fairworkconvention.scot/wp-content/uploads/2018/11/Fair-Work-in-Scotland%E2%80%99s-Social-Care-Sector-2019.pdf

57 Scottish Government and COSLA. (2019). Implications of labour markets for the social care workforce: report. Retrieved from https://www.gov.scot/publications/implications-national-local-labour-markets-social-care-workforce-report-scottish-government-cosla/

58 Scottish Government. (2015). Scotland's Carers. Report. Retrieved from https://www.gov.scot/publications/scotlands-carers/

59 Carers UK. (2019). Will I Care? The likelihood of being a carer in adult life. Retrieved from http://www.carersuk.org/images/News__campaigns/CarersRightsDay_Nov19_FINAL.pdf

60 UK Parliament. (2020). Coronavirus Act 2020. Retrieved from https://www.legislation.gov.uk/ukpga/2020/7/section/16/enacted

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