IJB QUESTIONNAIRE ON ADULT SOCIAL CARE

SUBMISSION FROM SOCIAL WORK SCOTLAND TO IJB CHAIRS AND VICE CHAIRS EXECUTIVE GROUP

17 July 2020

Social Work Scotland is the professional body for social work leaders, working closely with our partners to shape policy and practice, and improve the quality and experience of social services. We are a key partner in the national Adult Social Care Reform Programme, creating an operational framework for Self-directed Support across Scotland supporting consistent delivery of social care that is personalised, rights-based and which supports active citizenship.   Another of our current projects is aligned to a Scottish Government programme (Health and Justice Collaboration Board) to test and implement frameworks for the delivery of integrated adult social services in Scottish prisons.

Social Work Scotland welcomes the invitation of the IJB Chairs and Vice Chairs Executive Group to respond to consultation around the strategic changes needed to sustain and take forward the care sector in the light of the experience to date of the Covid-19 pandemic.

You asked for our summary of the main points we think relevant as to how IJBs would revise or replace existing strategies or approaches to local delivery, and also to use your attached short questionnaire. You ask respondents to separate their views between:

a) The immediate focus of the Mobilisation Recovery Group (MRG), established by the Cabinet Secretary for Health and Sport and including representation from the IJB Chairs and Vice Chairs group, "to generate system wide input into decisions around resuming paused services" and

b) "Supporting continuing services for which activity has been intense, such as care homes and care at home services for older people throughout the pandemic"

Our first point concerns the scope of the intended IJB Chairs and Vice Chairs Executive Group submission. We believe this should also include NHS services, not only those subject to IJB direction, but also acute hospital inpatient services, such as intensive care, for which Covid-19 activity has also been intense. We also note that while all adult social care services are subject to direction by all IJBs, there are a number of H&SC partnership agreements that also include some children's social work services and criminal justice social work services, which have also been affected by Covid-19 related issues.

Secondly, it is widely accepted that IJBs must work with other agencies to be effective, and this is stated in your covering note which mentions IJB "central responsibilities to work in partnership as we commission, finance and monitor services as we move through and beyond this crisis". However, while the questionnaire rightly mentions the Third Sector, there is no mention of local

government, only "engagement with local communities". Local government services - including housing, education, welfare services and rights advice, and other community services - all have an important role in promoting and sustaining health and wellbeing, and need to be taken into account and involved in IJB plans and proposals for changing "existing strategies or approaches to local delivery".

Our other main points are as follows:

Q1. Many innovative changes have resulted from a response to the COVID-19 crisis. Within the IJBs scope of delegated responsibilities what consolidation of innovations would you want to see through the commissioning of services by IJBs?

In the [Social Work Scotland response](#) to the Scottish Parliament on the Social Care Inquiry in February this year, we put forward a strong position for sufficient funding to be made available to deliver models of care required to support population need, noting that increased budget constraints have led to tightening of eligibility criteria for social care support. Post-Covid, it will be crucial to model robustly what it will take to deliver national and local aspirations, and to manage expectations transparently.

Taking a human rights approach to care, commissioning should focus on the range of activity necessary for active citizenship: "*including reducing isolation, supporting people to make and maintain friendships, promoting vocational skills, supporting people to develop and enhance life skills, promoting physical and mental well-being, and mitigating health inequalities".*

Personalisation and flexibility

Personalisation is at the heart of good social work, and is the guiding principle of Self-directed Support (SDS) policy and legislation. Under SDS, people can choose from four options designed for maximum flexibility.

During the pandemic, we saw a reduction in bureaucracy of assessment, care planning and budget allocation processes in some areas, which allowed for a more flexible and quicker response. Going forward, we would like to see a shift from traditional 'care management' approach in adult social work to more relationship-based practice with the supported people at the centre of decision making. Systems and processes would need to flow from that guiding principle.

Before the pandemic, we saw that many local policies and procedures were quite rigid around what could and could not be commissioned through a personal SDS budget. In some, but not all, local partnerships we have seen innovative flexible responses to need during the pandemic which are in line with both the letter and the spirit of SDS. In many cases, supported people have been allowed to use their personal budgets more creatively, for example, to employ family members, to purchase items of kit to enable physical activity at home, and to cover costs related to the pandemic.

People with lived experience of social care who are members of the SDS Collective have stated in their call to action that they are happier with a more flexible approach. In some cases the alternatives that people have chosen have proved to be less costly than the traditional models of respite and day care that they had before. ARC Scotland have reported that some supported people would not be keen to return to these traditional models of care and support[1].

We note that the majority of pre-Covid local Commissioning Plans are weighted towards health-related matters and make little or no reference to personalised care and support. Social Work Scotland would support that the holistic person with the right to choice and control should be central to framing more personalised commissioning practices.

Specific asks are for:

- Inclusion of community-led services and supports, including local micro providers, on the future commissioning framework.
- Continued investment in local relationships which have been developed between HSCPs and providers during Covid-19
- Investment in home-based rehabilitation/ interim care for older people.
- Review of local interpretation of eligibility criteria and charging policies.
- Flexibility to be embedded more fully and permanently in standard procedures.
- Support from national regulators for flexible innovation.

Impact of Covid-19 on provider sustainability

We note a range of factors that impinged on providers during the pandemic. Availability of sustainability funding, testing regimes, availability of PPE, data reporting arrangements and oversight arrangements contributed to real strain on providers at a time when they were experiencing significant challenges in maintaining person-facing care and support.

Commissioning arrangement should explicitly set out issues/expectations related to infection control, recognising the continued presence of Covid-19. The mixed economy that residential and care at home operates led to there being differences in who could access essential kit, and payment of kit, training and advice was variable.

Q2. The ongoing criticism of IJBs is that transformation hasn't been fast enough or innovative enough to date. How have IJBs been able to change, adapt and flex at a fast pace in response to the pandemic and how can this ability to design and implement change at pace can be continued? What has been different about how we have worked in the past 3 months that we can keep?

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[1] ARC Scotland Provider Forums COVID-19 meeting summary: March – May 2020

During the early stages of the pandemic, there was a clearly defined mandate, critical priorities and a common purpose shared by all partners. This imperative transcended many of the differences and challenges between partners for a period.

Research tells us that SDS can only be fully implemented if Chief Officers and other key leaders view it as a priority. During the crisis, examples of good leadership emerge and creative, solution-focused thinking was encouraged. We noted the following features:

- Fast tracking of packages of care (POC) and commissioning the use of previously unused support services not on approved providers lists in order to meet needs and outcomes.
- Encouragement to use SDS creatively and differently. Better focus on getting the right support to those who need it as soon possible.
- More joined-up work with the third sector that has been truly collaborative.

The crisis meant more dynamic appraisal of options and creation/acceptance of doing things differently, and a shift to more outcome focussed approaches.

The usual patterns of care and support were temporarily altered with increased flexibility, increased personalisation, trust in communities to meet their own needs as people opted out of services and others asked for care to be reduced, and new models of community support emerged.

Issues around systems, processes and IT remained as barriers during the pandemic. Partners, whilst in integration arrangements, in the main still operate as separate organisations, with different digital infrastructure.

Through the pandemic, we have learned much about communicating in different ways, using a variety of digital platforms. We have seen good use of digital technology to connect with supported people, their families and other professionals. This has resulted in meetings being more accessible and time efficient, while often creating less intimidating and intruding spaces.

We have heard that many supported people prefer using technology to communicate where communication can be paced better for the supported person, be lighter touch and more frequent, rather than formal meetings. We are also aware of distinct benefits to children's social work contacts where relationships have improved through use of digital platforms rather than face to face meetings.

Digital inclusion needs to be accelerated to ensure that people have access to technology and support to use it. Connecting with services, family and friends through technology has been critical during COVID. Use of web based information has been key but people have to be able to access this.

Q3. The advisory group on economic recovery has identified structure, funding and regulation as the main focus of a review of adult social care.

What specific aspects of these areas would you wish IJBs to consider in relation to Care Home provision?

(i) **Structure**
(ii) **Funding**
(iii) **Regulation**

We understand that further national consideration is to be given to social care reform in the light of Covid-19, and Social Work Scotland looks forward to working collectively with Health and Social Care Scotland amongst other national partners.

While understanding why care home provision has been singled out, we also think that the IJB Chairs and Vice Chairs Executive Group's submission should support the recommendations in the recent report by the independent Advisory Group on Economic Recovery, *Towards a robust, resilient wellbeing economy for Scotland*.

This report reminded readers that:

> Scotland's social care sector employs 200,000 people […] and has a financial value to the Scottish economy of over £3 billion. But care is not only a vital contributor and support to the economy: much more than that, good quality, safe, supportive and effective care is essential to our society. (p51)

> Before the crisis, the sector was confronted by major challenges in relation to procurement of services from public authorities; to the recruitment, retention and pay of its workforce; and to the longer-terms sustainability of its funding, and indeed its entire business model. The crisis has only sharpened the nature of these challenges: but it has brought home to us how precious a function the care sector provides for us all. Care homes in particular have truly been at the front line in the crisis; *we must make sure that, as we come out of the immediate emergency, Scotland takes action to strengthen the capacity and sustainability of the care sector as a whole.* (p51).

Adequate funding is the first requirement. Ten year of public sector austerity has severely reduced funding for local government in Scotland, and, while Councils have sought to protect social care, expenditure has fallen in real terms at the same time as the increasing numbers of older people, especially those aged 85 years and over, has increased the need for social work and social care services by 2.9% per year, according to figures in the Scottish Government's 2018 Health & Social Care Medium Term Financial Framework (MTFF), which also gives a figure of 4% per year including pay and price inflation. Given the increasing care being provided by family members and other "unpaid carers", it is vital that the Scottish Government adequately fund the Carers Act (Scotland) Act, especially in relation to replacement (respite) care. (Social Work Scotland can provide a briefing note on this, if required).

The **immediate need** is to **fund the on-going measures necessary to protect people and families who use services, and the staff providing services**, from

Covid-19 infection. That means sufficient PPE, regular live virus testing, and an effective test-trace-isolate system to prevent the spread of infection. The contract tracing human resources needed are significant and it is not always clear that the test-trace-isolate system is being delivered across Scotland at sufficient scale. Some follow-up on isolation advice is also needed so we know whether the advice is followed.

Scotland does not have ongoing random sampling for live virus in a Covid Infection Survey (similar to that being run in England from May 2020 in a joint project between ONS and Oxford University), but the recent Public Health Scotland of a pilot study of blood samples collected by regional laboratories for other clinical reasons might in future provide the firmer epidemiology necessary for current and future planning at national and regional level.

The other **key early task** is to **stabilise the social care workforce numbers**, currently 7.7% of Scotland's workforce, given that current levels of recruitment from abroad will soon become impossible under the UK Government's proposed post Brexit immigration policies. Since the mid-1990s, the largely female workforce has been increasing privatised, low-paid and often with poor pension and other conditions of service. Staff turnover and vacancies levels are high. According to the Fair Work Convention, nearly 20% of social care workers are not on permanent contracts.

Public recognition of this important work has grown very significantly during the Covid-19 crisis, and the time is right to increase wages and salaries. Clearly that will require significant levels of funding, and also legislation or regulation to intervene in the market – for example, it might be necessary to consider a Scottish Social Care minimum wage at a level above the current Scottish Living Wage.

All the above points about social care services as a whole, also apply particularly to care at home and to care homes. Many of the issues affecting care homes also affect sheltered housing schemes and housing with care schemes where there is a staff team working in shifts to provide care and support to frail older adults, and to other group living arrangements for supported adults who depend on external care workers for support. Such establishments should be included in ongoing pandemic and winter planning.

We need to understand how the very high Covid-19 deaths came to occur in care homes – 46.5% of all registered deaths in Scotland identified as involving Covid-19 by 5 July (weeks 15-27). Certainly, residents in care homes are by definition vulnerable populations with age-related (and in some areas, poverty-related) conditions that are associated with higher death rates from Covid-19. However, the viral infection has to get into care homes for these factors to apply.

The care home sector is highly regulated but this did not protect care home residents during Covid-19.

Apart from the well-publicised shortage of PPE and testing, lessons need to be learnt from discharging patients with untested live virus from hospital to care homes because they were considered medically fit for discharge, where they

passed on the virus to other residents and staff. The overriding focus on preparing acute hospital care for the expected large numbers of Covid-19 admissions without proper regard to the health and social care system as a whole has in England been partly blamed on the lack of integration of between the NHS and social care. In Scotland we consider ourselves further forward with integrating health and social care, yet the high death rate in care homes here does not indicate an integrated system. It also raises questions about governance, if, as seems to have been the case, these decisions did not come through to IJBs.

Lessons also need to be learnt in all parts of the UK from the cessation of normal NHS services to increase bed capacity for Covid-19. Some of the excess mortality in this period will be due to cancelled diagnosis and treatment for people with cancer, heart disease or other life-threatening conditions.

We think that it should be possible to vary registration requirements more quickly and responsively across the social care sector in order to support local need and personalised care arrangements.

Throughout lockdown, several local partnerships have offered a service for a critical few who have been assessed as needing respite during lockdown, using building bases and staffing models which have been fully risk assessed, and which maintain physical distancing and other infection control measures. These critical arrangements have been provided due to the high risk posed to specific individuals and their carers during lockdown. In some cases, these local arrangements have required variations to been made in the registration of building-based services. If these alternative, bespoke arrangements have been well received by people and carers, it is reasonable to imagine that they could continue beyond the pandemic.

More generally, there needs to be a shift of perspective around care home provision. Care homes should be viewed as a valued part of community provision helping to meet national wellbeing outcomes, in a spectrum of services supporting prevention, maintaining communities and increasing personalisation.

Care homes are often seen as a final destination when in fact they can be utilised very well as a form of step-down or rehabilitation provision.

There should be a wider focus on the whole system of care and support, with greater focus on early intervention and prevention such as intense care at home/rehabilitation services for people leaving hospital who might otherwise go into a care home.

Q4. It can be reasonably anticipated that there will be more care required in home or homely settings. The Third sector play a crucial part in IJBs achieving effective care in the community. How can IJBs ensure greater resilience of and contribution from the Third sector?

The third sector plays an important role, accounting for around 27% of Scotland's social care workforce, according to the Scottish Centre for Employment Research

(2018). However, a bigger role is currently played by the for-profit private sector. In a mixed economy, the balance between the public, voluntary, independent and private sectors need not be left to the market, but is a proper subject for public debate and democratic decision-making.

We know of positive examples of partnership working with the Third Sector throughout the pandemic, affording independent sector partners the ability to step up and step down support in a flexible way, which has increased trust, confidence and flexibility in how these partnerships work. We would support further learning through analysis of how this was achieved, the funding needed to deliver partnership collaboration, cost effectiveness for support delivery and opportunities for continuing these partnerships.

Much has rested on the goodwill of communities being willing and able to support people in need, and we should aim to support this as we emerge from Covid-19. While checks and balances need to be robust there should be consideration of how we can reduce bureaucracy and make best use of available funding. Involving local communities in the process is a good starting point but supporting them to lead the process may be even better.

Social Work Scotland has learned that some local authorities have taken a community-led support approach, involving the contribution of third sector organisations, to supporting individuals with early intervention and prevention activity. These include Edinburgh's Three Conversations Model and Health Improvement Scotland's Community Hubs in 9 test sites across Scotland.

By allowing people advice, information at the lowest level from third sector organisations and partners before establishing higher level needs, this has resulted in some issues being resolved quickly without lengthy waits for assessments or even the need for higher level care and or supports. Only those where it is established need higher level care and or supports are then referred into the normal SDS routes for social care.

In a community-led model, workers stick with people until an outcome is achieved. This prevents a person having to tell their story repeatedly to multiple organisations, and outcomes are tracked more easily.

Commissioning frameworks could be much less restrictive and more supportive of third sector/independent/ social enterprise inclusion. We would support clearer strategic links within Community Planning Partnerships and with Public Health Scotland, and closer involvement of TSIs within integration arrangements.

We would support greater use of Individual Service Funds (ISFs), so that the supported person is the commissioner of services, in particular care at home. In this way, the person can chose how, when, where and in what way their support is delivered.

We acknowledge that there is some financial risk in departing from traditional service models to new models that might initially be underused. We would support more discussion on how risk might be shared.

Q5. Engagement with local communities is a vital part of identifying how the powers vested in IJBs by the Public Bodies (Joint Working) (Scotland) Act 2014 can be tailored to support local need. What can IJBs do to better engage with the groups you represent?

Social Work Scotland would urge IJBs to engage with supported people and their carers to understand how people's views have been shaped by their experiences of receiving care during the pandemic. In the aforementioned Social Work Scotland response to the Scottish Parliament on the Social Care Inquiry, we noted the strength of feeling across our membership:

"*We feel very strongly that there needs to be consideration of the range of people's lived experience when designing and constructing social work and social care services. Often the focus of social care is older people with personal care needs due to frailty or long-term conditions and people with physical disabilities, with other experiences not well supported including mental illness, learning disabilities, alcohol and drug addiction, domestic abuse, families at the edge of care, care-experienced children and young people, people vulnerable to abuse and those in our justice system, who tend to come from communities experiencing the greatest health and social deprivation*".

This is all the more important as supported people's experiences and views will have been shaped by their experiences of care during the pandemic.

Engagement with local communities is critical to help shape a broad sense of what types and qualities of care and support are required for a local population. However, engagement should not be tokenistic, and requires reciprocity. Too often third sector organisations feel they are used for all their knowledge, skills and ideas but with little return for them

Generic engagement is not sufficient. Services need to be tailored to individual people not general populations, and requests made by individuals in their assessment and care planning should inform wider strategic developments.

East Ayrshire's Thinking Differently approach has evolved a very open and transparent model where people with lived experience of social care actively involved in decision-making forums to drive improvement practice and contribute to decisions about budget spend. This approach goes beyond engagement to real involvement and empowerment of people accessing care and support services.

Consideration should be given to widespread use of remuneration and expenses for supported people and carer representatives where this does not routinely happen.

More focus should be put to achieving the intentions of the Community Empowerment (Scotland) Act 2015. Involvement of local community engagement teams and NHS, investment in TSIs and enterprise support organisations, involvement of local authority economic development, collaboration with funding bodies are all features supportive of achieving the requirements of the Act.

Local elected members are influential in this regard. Good communication with elected members on the benefits and opportunities of community empowerment and building trusting relations could enable a power shift to community led approaches.

As mentioned previously, there has been an upsurge in volunteer activity at community level. We think it should be possible to attract volunteers into the social care workforce, and would support consideration of continuing post-Covid the national campaign, 'There's more to care than caring'.

Partnerships can engage and support the work of professional organisations that support their frontline and leadership workforces, such as the Scottish Association of Social Workers and Social Work Scotland. Professional organisations offer corporate memberships and opportunities to promote good practice and share communications. HSCS can ensure social work and social care professional associations are included as stakeholders with significant expertise which can help to improve consistency and quality of strategic planning.

Q6. Integration of Health and Social Care (HSC) staff is a key component of the successful deployment of the IJBs strategic aims. Do you have examples of where further levels of HSC staff integration would help you achieve your organisations aims and ambitions?

Social Work Scotland believes that there is much to be gained by the proper integration of health, social work and social care. However, this needs to be on the basis of a differentiated understanding of the principles and values of each profession, and consideration of retaining each profession's unique contribution and impact within local integration arrangements.

Local partnerships should aim to work in ways that promote good relationships between specialists. People do not fit well into our traditional service silos. People have mental health issues also need support with their children, may be carers themselves and could have a physical disability or sensory impairment.

In some rural areas, NHS staff, local authority staff and third sector staff work as one team. The community nurse may carry out a social care task like giving the person a meal. A personal assistant is given instruction on how to apply a dressing by the nurse so that the nurse can attend to other patients in greater need of medical intervention. Volunteers provide older people with foot care support trained and monitored by the NHS podiatry services and delivered in a church hall once a week, allowing the podiatrist to attend to more serious cases. This type of blended approach requires flexibility to be built in to commissioning processes.

We see many instances where innovative service design is bolted on to more traditional bureaucratic systems and processes, which hinder the overall aim. We believe that the key ingredients to effecting sustained change are adaptive

leadership, trusting relationships, confidence and putting the person at the centre of process and service design.

During the pandemic, arrangements were put in place and communicated very quickly but at times were very confusing. We can learn from this how communication can be improved between partners and key contacts identified to ensure routes to information, decisions and actions are clearer. Delegated responsibilities were not always clear and this led to delays in decisions or progressing actions.

True partnership working encompasses whole system responsibilities. While SDS is the primary responsibility of social work, in reality SDS is about ensuring that those who need support get the right support at the right time in order to meet their identified needs. This should be a key priority for all and will be better achieved with real partnership working.

Q7. Data and information which help identify how best to deploy HSC resources are critical to direct these resources. Are there more effective ways in which information you hold could help IJBs monitor improvements in services delivered by HSC which support your organisation.

Currently there is no national requirement to capture outcomes achieved for adults and older people. There are however some local authorities who track outcomes achieved, not achieved and partially achieved for people and the success or failures behind each is used to inform staff learning and the improvement of services and targeting resources. An outcome approach can provide rich information to help target resources more effectively and more personalised to what matters to people. Following an outcomes approach allows clarification of what 'good' looks like.

There is a difference in resource allocation across client groups that does not comply with a rights-based approach. Algorithms underpinning Resource Allocation Systems favour younger adults over older adults, leading to some outcomes being unfunded or underfunded. In many cases, only critical personal care needs are resourced.

Data that is useful to improve frontline operations currently has less priority than aggregated performance management data, which we argue from an implementation perspective is not sufficient as little can be learned from it.

Much time and effort is spent on managing outdated information systems that do not link well around the person. It would be helpful to learn how well local data systems withstood the collation of information that was asked for during the pandemic, and how public and independent sector fared with this. We know, for example, that data requested from care homes during the pandemic put an extraordinary burden on managers at a critical time. To understand the purpose of and the use to which the collected data was put, whether there was a good shared understanding of what was required and whether the data gathered measured

impact effectively; and to consider whether early data requests are feasible during an exceptional event like the pandemic and how accurate can they be.

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