A National Care Service for Scotland

Scottish Hazards Response

November 2021

Scottish Hazards response to the Scottish Government National Care Service Consultation: Introduction and key principles

This is an introduction to accompany our full response to the consultation.

Who we are

Scottish Hazards is a registered charity whose aim is to reduce injury, ill health and death caused by work in Scotland. Our Scottish Hazards Centre provides free and confidential information, advice, support and training to (mainly non-unioinsed) individual employees and groups of employees, with an emphasis on those workers who are known to be most at risk, including those in precarious employment, migrant workers, workers from black and ethnic minorities, workers with a disability, workers with underlying health conditions, older workers, young workers.

Scottish Hazards has built a grassroots network of people active at both workplace and community level in improving working conditions throughout Scotland. The majority of our network of over 200 are trade union representatives in individual workplaces. Others include local community group representatives, people involved in specific campaign/support groups and occupational health and safety specialists.

We work closely with the Scottish Trace Union Congress (STUC), Public Health Scotland through its health and work team. We are an active member of the Partnership on Health and Safety in Scotland and the Scottish Social Care Partnership Forum, and also work with the Scottish its Covid Safer Workplaces group.

Social Care

We made this submission to the Independent Review of Adult Social Care.

We would like to include as part of our response the paper Health, Safety and Welfare of the Social Care Workforce, written by our Scottish Hazards Secretary.

We have today submitted our full response to the NCS consultation.

These are the key principles we believe should be incorporated into a Scottish NCS:

*The service should be, as is NHS care, free the point of need;

*An NCS should provide care from the cradle to the grave. We welcome the proposals in the consultation for it to encompass a wide range of care services;

*All care should be not for profit, as has been accepted is the case for children's services, thereby retaining money within the sector;

*There should be an end to competitive tendering – price cannot be the priority factor in care provision;

*Pay and conditions for the social care workforce should be based on national pay scales and national pay and conditions, including training, education and health and safety, which are determined by national collective bargaining;

*Conditions for social care workers should adhere to Fair Work criteria;

*Social care users and workers should not be cinderellas to those in the NHS;

*There should be standardised, paid for, good education and training for workers throughout the sector;

*There should be 'effective voice' for workers and users in social care. For workers this means as well as involvement in national collective bargaining, involvement at community and workplace level if the design and provision of care. For the people in need of care and their supporters, this means a commitment to their being able to exert as much control over their care as possible which could be done collectively rather than necessarily individually. Final arrangements for social care should be agreed through collaboration among government, local government, workers and users;

*The NCS at Scottish Government level should be tasked with:

a) providing adequate ring-fenced resources to provide good quality care to those needing it and fair pay and working conditions to those providing it

b) establishing collective bargaining involving the NCS, employers and trade union representatives to agree national pay and conditions

c) design and provide good education and training for all those working in the sector, including a level of education prior to employment and then continued training and education throughout the time of employment

d) Create a good single IT system including individual health and social care records and collection of data on need, provision, cost, etc

e) Set national standards for care and for social care contracts;

*Within this national framework social care services should be the responsibility of democratically elected and accountable Local Authorities;

*Local Authorities should then further devolve provision of services to local community hubs which can actively involve service providers, those needing care and those with lived experience to create local, flexible, inclusive services;

*The IJB / CHSCB model should be abandoned. Primary and community health services should continue to be part of the NHS and work closely at local level with LA services. The NCS and the NHS should be separate, parallel services working closely together;

*There should be quality equity within local authority areas and across Scotland;

*We agree that human rights should be at the core of the service, but they will only be meaningful if accompanied by **resources** that are sufficient to provide services which can meet need, clarity about where **responsibilities** lie and a system that prioritises the development of good, sustainable **relationships** between those providing care and those in need of it.

*Regulation and enforcement are an important element of any service. The Care Inspectorate and SSSC should be merged and work closely with the Health and Safety Executive whose remit of protecting the health, safety and welfare of social care workers (and those being cared for) is equally relevant.

Scottish Hazards
2 November 2021

A National Care Service for Scotland - Consultation

RESPONDENT INFORMATION FORM

Please Note this form **must** be completed and returned with your response.

To find out how we handle your personal data, please see our privacy policy:
https://www.gov.scot/privacy/

Are you responding as an individual or an organisation?

- ☐ Individual
- ☐ Organisation

Full name or organisation's name

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The Scottish Government would like your permission to publish your consultation response. Please indicate your publishing

Information for organisations:

The option 'Publish response only (without name)' is available for individual respondents only. If this option is selected, the organisation name will still be published.

If you choose the option 'Do not publish response', your organisation name may still be listed as having responded to the consultation in, for example, the analysis report.

preference:

☒ Publish response with name

☐ Publish response only (without name)

☐ Do not publish response

We will share your response internally with other Scottish Government policy teams who may be addressing the issues you discuss. They may wish to contact you again in the future, but we require your permission to do so. Are you content for Scottish Government to contact you again in relation to this consultation exercise?

☒ Yes

☐ No

Individuals - Your experience of social care and support

If you are responding as an individual, it would be helpful for us to understand what experience you have of social care and support. Everyone's views are important, and it will be important for us to understand whether different groups have different views, but you do not need to answer this question if you don't want to.

Please tick all that apply

☐ I receive, or have received, social care or support

☐ I am, or have been, an unpaid carer

☐ A friend or family member of mine receives, or has received, social care or support

☐ I am, or have been, a frontline care worker

☐ I am, or have been, a social worker

☐ I work, or have worked, in the management of care services

☐ I do not have any close experience of social care or support.

Organisations – your role

Please indicate what role your organisation plays in social care

☐ Providing care or support services, private sector

☐ Providing care or support services, third sector

☐ Independent healthcare contractor

☒ Representing or supporting people who access care and support and their families

☐ Representing or supporting carers

☐x Representing or supporting members of the workforce

☐ Local authority

☐ Health Board

☐ Integration authority

☐ Other public sector body

☐ Other

Improving care for people

Q1. What would be the benefits of the National Care Service taking responsibility for improvement across community health and care services? (Please tick all that apply)

☐x Better co-ordination of work across different improvement organisations

☐x Effective sharing of learning across Scotland

☐x Intelligence from regulatory work fed back into a cycle of continuous improvement

☐x More consistent outcomes for people accessing care and support across Scotland

☐ Other – please explain below

An NCS would have the potential to bring these benefits, but only if partnered with Local Authorities who have the capacity to work with their communities to create local, flexible, inclusive services (and who are democratically elected and accountable to their populations). And only if the NCS introduced National Sectoral Collective Bargaining to ensure good education, training, pay and conditions to social care workers.

Q2. Are there any risks from the National Care Service taking responsibility for improvement across community health and care services?

Much of this consultation and the National Care Service which could result from it in our opinion may very well be superficial and not lead to real and sustained improvement.

There is clearly a recognition that there is a need to improve community health and social care and that current structures are inadequate. If we are serious about good practice, 'suggestions for significant cultural and systemic change' have to be explored. This consultation does not fully allow for such an exploration.

For an effective care service we need to take profit out of care, improve pay & conditions for workers, make care local & accountable, ensure adequate funding and make care a free service.

If the National Care Service is publicly run and owned risks will be limited. It should not have any privately run enterprises/organisations. It needs proper well thought out funding catering for person-centred care rather than the current approach of 'anything is better than nothing' approach.

Accessing care and support

Q3. If you or someone you know needed to access care and support, how likely would you be to use the following routes if they were available?

Speaking to my GP or another health professional.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
				x

Speaking to someone at a voluntary sector organisation, for example my local carer centre, befriending service or another organisation.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
			x	

Speaking to someone at another public sector organisation, e.g. Social Security Scotland

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
		x		

Going along to a drop in service in a building in my local community, for example a community centre or cafe, either with or without an appointment.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
				x

Through a contact centre run by my local authority, either in person or over the phone.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
			x	

Contacting my local authority by email or through their website.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
			x	

Using a website or online form that can be used by anyone in Scotland.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
		x		

Through a national helpline that I can contact 7 days a week.

Not at all likely	Unlikely	Neither likely nor unlikely	Likely	Very likely
			x	

Other – Please explain what option you would add.

The best solution would be a local community hub where people could email, phone or drop in where there would be access to social work help in finding solutions, but where the expectation was that people had a right to see a social worker if needed, like they have a right to see a GP in the NHS. The important thing is that whichever of the above options exist, they lead to the same source of assistance so that people are not having to follow up myriad options. The best, most effective and most consistent help would in our experience come from relationships built up over time between local people and local social workers.

A simple understandable route that is used by clients and other professionals alike is preferred, utilising software that prevents duplication and aids meaningful communication for the client is required and the dedicated support.

Q4. How can we better co-ordinate care and support (indicate order of preference)?

☐1 Have a lead professional to coordinate care and support for each individual. The lead professional would co-ordinate all the professionals involved in the adult's care and support.

☐2 Have a professional as a clear single point of contact for adults accessing care and support services. The single point of contact would be responsible for communicating with the adult receiving care and support on behalf of all the professionals involved in their care, but would not have as significant a role in coordinating their care and support.

☐3 Have community or voluntary sector organisations, based locally, which act as a single point of contact. These organisations would advocate on behalf of the adult accessing care and support and communicate with the professionals involved in their care on their behalf when needed.

Support planning

Q5. How should support planning take place in the National Care Service? For each of the elements below, please select to what extent you agree or disagree with each option:

a. How you tell people about your support needs

Support planning should include the opportunity for me and/or my family and unpaid carers to contribute.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
x				

If I want to, I should be able to get support from a voluntary sector organisation or an organisation in my community, to help me set out what I want as part of my support planning.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		x		

b. What a support plan should focus on:

Decisions about the support I get should be based on the judgement of the professional working with me, taking into account my views.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		x		

Decisions about the support I get should be focused on the tasks I need to carry out each day to be able to take care of myself and live a full life.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
	x			

Decisions about the support I get should be focused on the outcomes I want to achieve to live a full life.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
	x			

Anyone who is seeking information and assistance should be treated in the same way. However, people need support and care in very different circumstances, so the conversation will never be the same. What should be the same is how people seeking help are treated: they should be respected, listened to and have a right to receive advice from a professional. They should be able to meet with a member of a local social work team who can work with them to find out what support they need. If and when they need additional support they should be able to return and discuss things further with their local team. The whole idea of a NCS should be to avoid setting eligibility criteria before someone even gets in the door. The need for voluntary organisations to 'help me set out what I want as part of my support planning' should be much reduced by this approach where people should be able to get this help from the core service itself. People should not have to constantly repeat their story to different people to find a way through the 'system'.

Q6. The Getting It Right For Everyone National Practice model would use the same language across all services and professionals to describe and assess your strengths and needs. Do you agree or disagree with this approach?

☐x Agree

☐ Disagree

Please say why.

Largely having a common language will be helpful, but it needs to be a language of care. Some language problems have arisen because health and other staff have been allowed to undertake what should be social work assessments of need and care needs have as a consequence become reduced to health needs. There also needs to be a recognition that different communities use a different language and imposing “received” care language could alienate many people. In addition, sometimes specific language is needed to describe a particular situation, condition or action to address them. It is can be important for people to be introduced to this language in a way that helps them understand it and empowers them to talk about it with those aiming to assist them.

Q7. The Getting It Right for Everyone National Practice model would be a single planning process involving everyone who is involved with your care and support, with a single plan that involves me in agreeing the support I require. This would be supported by an integrated social care and health record, so that my information moves through care and support services with me. Do you agree or disagree with this approach?

☐x Agree

☐ Disagree

Please say why.

Any practice model needs to be part of an integral part of a cradle to grave service model which integrates adult care with previous family and children's services, mental health, addiction etc However, what is crucial to improve outcomes is not the practice model, but rather everyone involved in providing care and support, has the time to meet needs which will then result in improved outcomes. Adequate resource support and planning are key to ensure the practice model can make a real difference.

Q8. Do you agree or disagree that a National Practice Model for adults would improve outcomes?

☐ Agree

☐ Disagree

Please say why.

Any practice model needs to be part of an integral part of a cradle to grave service model which integrates adult care with previous family and children's services, mental health, addiction etc. However, for outcomes to be achieved, needs require to be met. And part of that requires social workers and care workers to have the time to build relationships with the people they are supporting or caring. It is relationships that should be at the centre of any model of practice, not top-down management of services. Again, Adequate resource support and planning are key to ensure the practice model can make a real difference.

Right to breaks from caring

Q9. For each of the below, please choose which factor you consider is more important in establishing a right to breaks from caring. (Please select one option from each part. Where you see both factors as equally important, please select 'no preference'.)

Standardised support packages versus personalised support

☐ Personalised support to meet need	☐ Standardised levels of support	☐No preference

A right for all carers versus thresholds for accessing support

☐ Universal right for all carers	☐ Right only for those who meet qualifying thresholds	☐ No preference

Transparency and certainty versus responsiveness and flexibility

☐ Certainty about entitlement	☐ Flexibility and responsiveness	☐ No preference

Preventative support versus acute need

☐ Provides preventative support	☐ Meeting acute need	☐ No preference

Q10. Of the three groups, which would be your preferred approach? (Please select one option.)

- ☐ Group A – Standard entitlements
- ☐ Group B – Personalised entitlements
- ☐ Group C – Hybrid approaches

Please say why.

We have not answered the questions in this section because it is our considered opinion that none of the options provide a solution to the issue being addressed. The Scottish Government needs to take a far broader look at how it and a National Care Service could support carers.

We believe that all carers should have the right to respite/breaks from caring. However, simply giving them this right will not ensure that these breaks will be possible or that they will work to the benefit of both the carer and the people they care for. We believe that rights are only real if accompanied by resources, good relationships and agreed responsibilities.

If you give one party in a relationship a right, it affects the rights of the other person/s. Caring relationships, while key to human our happiness, are complex and often messy. Social Workers are trained to help people try and find solutions in such circumstances, it is one of the reasons it is such an important profession. Such work often takes a long time and, while resolution of issues is not always achieved, just by listening and helping parties in a relationship to talk through the issues – making both feel supported without taking sides - makes a real and positive difference.

Instead of being allowed to do this essential work – supporting people to care and live life - Social Workers have been turned into gatekeepers of resource. Creating new eligibility criteria for a legal break for carers, won't change that. The fundamental issue is lack of resources. With resources, where carers and the person they care for agree about a break, there wouldn't be an issue: the National Care Service could enable people to have the type of personalised break that suited all parties. And, where there was disagreement or conflict within a caring relationship, if the Social Work profession was properly resourced, Social Workers would have the time to help people to find solutions to the issues.

Using data to support care

Q11. To what extent do you agree or disagree with the following statements?

There should be a nationally-consistent, integrated and accessible electronic social care and health record.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
	x			

Information about your health and care needs should be shared across the services that support you.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
	x			

Q12. Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection?

☐ Yes

☐x No

Please say why.

We believe that an IT systems that allows people and professionals working with them to access information held about them is required. This should replace the current myriad IT systems. We do not agree that legislation should be used to require relevant parties to provide data. People must have the ability to control what information is held about them. The NHS does not have a legal right to require other parties to provide data they specify so why should a NCS?

A publicly owned and run system could more easily address these issues.

Q13. Are there alternative approaches that would address current gaps in social care data and information, and ensure a consistent approach for the flow of data and information across the National Care Service?

On the whole, there is too much information recorded at present, as a result of practice which is focussed on protection, risk avoidance and back-covering. Huge amounts of time are spent recording and capturing data when both social work and care staff need to be freed up to spend time with the people they are working for. The situation is made worse because so many IT systems in health and care are so clunky and not user friendly. The focus of IT development therefore should be on reducing time spent recording and making it more efficient, effective and easier for staff to do so

Complaints and putting things right

Q14. What elements would be most important in a new system for complaints about social care services? (Please select 3 options)

☐x Charter of rights and responsibilities, so people know what they can expect

☐ Single point of access for feedback and complaints about all parts of the system

☐ Clear information about advocacy services and the right to a voice

☐x Consistent model for handling complaints for all bodies

☐x Addressing complaints initially with the body the complaint is about

☐ Clear information about next steps if a complainant is not happy with the initial response

☐x Other – please explain:

If services are provided locally and if consistent and lasting relationships are developed between those needing support and care and those giving it many problems and complaints (we accept not all) will be able to be resolved at local level and at an early stage. A charter or rights and responsibilities will only help if the service is based on strong relationships and if resources are made available that are adequate to enable all to meet their responsibilities and successfully exercise their rights. If at the same time the system was focussed on supporting people, rather than trying to ration resources, the need to complain would reduce dramatically, as would the need for advocacy services, and most issues could be resolved through discussion rather than complaints. Rather than thinking about a new top-down system for complaints and a single point of access for feedback, we should be focussing on how to improve care. An effective system should direct people to talk to the persons/organisations they are unhappy with and, if they don't want to do this, signpost them to the next nearest person who can address the issue, not to a remote complaints post box.
We believe care should be the responsibility of Local Authorities. To guard against a failure on the part of councils, there should be a right to complain to the independent regulator for care and support services.

Q15. Should a model of complaints handling be underpinned by a commissioner for community health and care?

☐ Yes

☒ No

Please say why.

We are arguing in this consultation that health and care should be parallel services working closely together. Therefore, in our opinion a commissioner for health and care would not make sense. There is already a regulator for care services. This role should be changed and expanded.

Q16. Should a National Care Service use a measure of experience of those receiving care and support, their families and carers as a key outcome measure?

☒ Yes

☐ No

Please say why.

Yes but with this proviso: this is only one measure that should be used. We believe the key issue that a National Care Service must address is the question of unmet need, the reason being that unmet needs clearly focusses attention on resources whereas outcomes may not be met for a whole variety of reasons. We recommend therefore that there should be a statutory duty for a NCS to record ALL unmet social care needs and that the Scottish Government, as the funder of the NCS, should have each year to produce a plan for how they intend to reduce those unmet needs (just as the NHS plans to reduce waiting lists). A precondition for this happening is that eligibility criteria, which are based on prioritising needs, are abolished. With regard to a measure of experience of those receiving care, it is crucial that this not be just a tick box exercise, but real, ongoing feedback and discussion with care users, their families and carers.

Residential Care Charges

Q17. Most people have to pay for the costs of where they live such as mortgage payments or rent, property maintenance, food and utility bills. To ensure fairness between those who live in residential care and those who do not, should self-funding care home residents have to contribute towards accommodation-based costs such as (please tick all that apply):

- ☐ Rent
- ☐ Maintenance
- ☐ Furnishings
- ☐ Utilities
- ☐ Food costs
- ☐ Food preparation
- ☐ Equipment
- ☐x Leisure and entertainment
- ☐x Transport
- ☐ Laundry
- ☐ Cleaning
- ☐ Other – what would that be

NHS services, whether 'residential' or not are free at the point of need. This should be the case for a National Care Service. The cost of the residential component of care should be met through taxation. People should not be forced to give up their total savings and in some cases their homes to access the care they need. If transport is connected to health or care, it should also be covered.

Q18. Free personal and nursing care payment for self-funders are paid directly to the care provider on their behalf. What would be the impact of increasing personal and nursing care payments to National Care Home Contract rates on:

Self-funders

This would hopefully reduce the fees paid by those who self fund (or alternatively provide them with an enhanced service) . However, there is a concern that unless national contracts were introduced, some providers would increase the cost of other aspects of the service, e,g. residential costs, and not pass on reductions to the resident.

Care home operators

In the case of residents who are funded wholly or in part by public money, this should increase their income and allow them to provide a better service. However, there is a concern that unless national contracts were introduced, the money might go into profit or higher managerial pay rather than to improving the care offered the residents.

Local authorities

This should allow local authority providers to improve the care offered (or to reduce the cost to the residents) However, since its creation, free personal and nursing care has had the unintended consequence of making care provision ever more oriented to physical tasks rather than care and forced local authorities to prioritise their ever more limited resources on that. Unless fully funded, FPNC is likely to continue to distort care budgets whether responsibility lies with CHSCBs or Councils.

Other

Financiers and financial interests will be leading the applause for what is currently proposed. We firmly believe that the Care Home care should be free but the only way to achieve this is by making all care not for profit. Free personal and nursing care could then be replaced by free care.

Q19. Should we consider revising the current means testing arrangements?

☐x Yes

☐ No

If yes, what potential alternatives or changes should be considered?

As stated above, the full cost of residential care should be met through taxation and the service, as with the NHS, be free at the point of need. Means Testing has distorted care provision, forcing people with social care needs to take what is covered by free personal and nursing care rather than what would make the greatest difference, and created immense barriers to effective social work (it is very hard to trust and confide in a person one of whose primary tasks is to undertake a financial assessment).

While free care would benefit rich as well as poor, it would give everyone a stake in the NCS like the NHS.

If in the short term funding through taxation is not possible, people on higher incomes could pay a contribution to accommodation costs on a transitional basis, this which should be nationally determined as per the cost of care calculator. But this should be based on income alone, now including capital assets. Also, no-one in residential care should be left with less than the current basic rate of state pension. The Scottish Government has the power to do this now that responsibility for social security has been devolved by amending the National Assistance Regulations so that the "Personal Expenses Allowance" for those is care is raised to the level of the basic state pension.

National Care Service

Q20. Do you agree that Scottish Ministers should be accountable for the delivery of social care, through a National Care Service?

☐x Yes

☐ No, current arrangements should stay in place

☐ No, another approach should be taken (please give details)

Scottish Ministers should be accountable for the provision of sufficient resources, for establishing collective bargaining on pay and conditions, for developing care standards, for providing ongoing education and training to the workforce. However, in the delivery of services they should partner with Local Authorities who have the capacity to work with their communities to create local, flexible, inclusive services (and who are locally democratically elected and accountable to their populations)

Q21. Are there any other services or functions the National Care Service should be responsible for, in addition to those set out in the chapter?

Data collection, including unmet need, carers, and statistics

- Assessment of finances required to meet care needs and engagement with councils on this (e.g. allowance needs to be made for additional costs of service provision in rural areas)
- Allocation of resources to Local Authorities according to social care needs
- Lead for pay and conditions and national collective bargaining (liaising with different employing authorities within the NCS on implications)
- Workforce planning

Training, Social Workers, social care staff and ancillary staff (e.g. commissioning)

- Research and creating partnerships with academic and other institutions to deliver this
- National public information (how the NCS operates, rights, services etc)
- Information Technology for all working in the NCS – a single platform that interfaces with other IT systems
- National procurement e.g. PPE, community equipment, equipment for institutional based services)
- National commissioning (specialist nationwide services like secure care, drug and alcohol rehabilitation)
- Liaison at national level with the NHS, housing, environment

Q22. Are there any services or functions listed in the chapter that the National Care Service should not be responsible for?

Strategic direction – that should be set by law

Improvement – with proper resources, local councils, voluntary organisations and staff will be able to improve

Target and target culture – this should have no place in the NCS

Standards – Government has driven a proliferation of standards over the last 20 years and none of it has made any difference. The NCS should adopt a few simple standards that can be understand by all and can be used to inform funding requirements eg that everyone has a right to see a social worker, as they do a doctor, in an emergency; that everyone should be given a copy of their needs assessment, that this should record all unmet needs and any care plan;

Scope of the National Care Service

Children's services

Q23. Should the National Care Service include both adults and children's social work and social care services?

☐x Yes

☐ No

Please say why.

Given the community-based and relationship-based nature of social work across all fields in which it is delivered to the public, it makes sense to include them all in one service: where knowledge and information can be readily shared;, where a one door approach can be applied eg through community hubs, which reduces confusion about access; where transitions eg from childhood to adulthood do not require referral to a completely separate service;, and where staff can work transfer readily across specialisms or transfer between them.

Q24. Do you think that locating children's social work and social care services within the National Care Service will reduce complexity for children and their families in accessing services?

For children with disabilities,

☐x Yes

☐ No

Please say why.

Location and decentralised organisation within community hubs would in our opinion enhance access

For transitions to adulthood

☐x Yes

☐ No

Please say why.

Location and decentralised organisation within community hubs would in our opinion enhance access Transitions are an artificial concept based on organisational needs and this necessity could be removed in a generic model using a pedagogical approach where the same worker accompanies the individual through the stages of their life-journey

For children with family members needing support

☐x Yes

☐ No

Please say why.

Location and decentralised organisation within community hubs would in our opinion enhance access It is often the adults who need support who are the focus of help from which children indirectly benefit, and the over-specialisation of services operates against a service that is minimally intrusive and effective. Generic approaches based on a principle of prevention should be adopted where practicable.

Q25. Do you think that locating children's social work services within the National Care Service will improve alignment with community child health services including primary care, and paediatric health services?

☐x Yes

☐ No

Please say why.

Alignment of service does not depend on either organisational or immediate geographical co-location. It is built on local networking that facilitates mutual respect and understanding. Joint management and co-location often confuse this by imposing priorities and introducing unnecessary bureaucratic protocols

Q26. Do you think there are any risks in including children's services in the National Care Service?

☐ Yes

☐x No

If yes, please give examples

It would end the fragmentation of social work.

Healthcare

Q27. Do you agree that the National Care Service and at a local level, Community Health and Social Care Boards should commission, procure and manage community health care services which are currently delegated to Integration Joint Boards and provided through Health Boards?

☐ Yes

☐x No

Please say why.

The IJB model should be abandoned and replaced with a National Care Service based on nationally co-ordinated and funded services administered through Local Authorities, that runs alongside the NHS

Community health care services should be administered and run through Health Boards administered by the NHS.

Q28. If the National Care Service and Community Health and Social Care Boards take responsibility for planning, commissioning and procurement of community health services, how could they support better integration with hospital-based care services?

This would not be an issue if primary health services continued to be run by Health Boards

All Health Services should be free at the point of need and provided by the NHS so the idea that commissioning and procurement are required for community health services is extremely concerning.

We are concerned that some see that the primary role of both community health and care services should be to keep and get people out of hospital. This distorts the proper function of both community health and community care services.

Q29. What would be the benefits of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

- ☐ Better integration of health and social care
- ☐ Better outcomes for people using health and care services
- ☐ Clearer leadership and accountability arrangements
- ☐ Improved **multidisciplinary team** working
- ☐ Improved professional and clinical care governance arrangements
- ☐x Other (please explain below)

None.

We believe that CHSCBs should not be established as organisations to deliver the NCS, but that this should be a local authority function. These questions therefore do not arise as functions in relation to GP contracts would continue to be managed through Health Boards

Currently the GP contract is nationally negotiated and should remain so. The devolution of responsibility for the budgets for GPs and prescription to IJBs has been a disaster as they have no control over these items of expenditure that make up a large part of their budget.

Q30. What would be the risks of Community Health and Social Care Boards managing GPs' contractual arrangements? (Please tick all that apply)

- ☐x Fragmentation of health services
- ☐x Poorer outcomes for people using health and care services
- ☐x Unclear leadership and accountability arrangements
- ☐x Poorer professional and clinical care governance arrangements
- ☐x Other (please explain below)

It appears a fundamental contradiction within this consultation that the Scottish Government is proposing to harmonise Social Work pay and conditions but fragment those of GPs. There need to be national pay and conditions for all staff, whether working in the NHS or an NCS. These should be set through collective bargaining in the NCS, as they are in the NHS.

Q31. Are there any other ways of managing community health services that would provide better integration with social care?

The IJB model should be abandoned and replaced with a National Care Service based on nationally co-ordinated and funded services administered through Local Authorities, that runs alongside the NHS – who should continue to administer health services including community health services

Effective partnership working should be built on local networking that facilitates mutual respect and understanding. Joint management and co-location often confuse this by imposing priorities and introducing unnecessary bureaucratic protocols

Social Work and Social Care

Q32. What do you see as the main benefits in having social work planning, assessment, commissioning and accountability located within the National Care Service? (Please tick all that apply.)

- ☐x Better outcomes for service users and their families.
- ☐x More consistent delivery of services.
- ☐ Stronger leadership.
- ☐x More effective use of resources to carry out statutory duties.
- ☐x More effective use of resources to carry out therapeutic interventions and preventative services.
- ☐x Access to learning and development and career progression.
- ☐x Other benefits or opportunities, please explain below:

All of these could be achieved **if** ownership, responsibility and accountability of the service lie with the Local Authority and are separate from Health. Stronger leadership will require an emphasis on professional social work (or social care where appropriate) qualification and experience.

Making services free at the point of delivery negates requirement for procurement through commissioning.

Q33. Do you see any risks in having social work planning, assessment, commissioning and accountability located within the National Care Service?

Whilst these functions should be located within an NCS, yes there are risks attached to the proposed CHSCB model because it will not necessarily facilitate these objectives, based as it is on a model of partnership with accountability to a government minister. These functions should be placed within local authorities, involving accountability and management by local communities.

Nursing

Q34. Should Executive Directors of Nursing have a leadership role for assuring that the safety and quality of care provided in social care is consistent and to the appropriate standard? Please select one.

☐ Yes

☐x No

☐ Yes, but only in care homes

☐ Yes, in adult care homes and care at home

Please say why

But they should have a role in relation to standards in care homes that provide nursing and training and practice of care staff in nursing related procedures

- The model suggested presupposes the continuation of the HSCP model of joint partnerships, with its associated community nursing responsibility. As we are contending that the partnership model should be ended this scrutiny role should not lie within the NHS but become a Local Authority responsibility.
- An equivalent role in a Local Authority should be one involving someone with an appropriate professional qualification in social care (for care home and social care provision). Any nurses working in care homes should be employed on the same terms and conditions as NHS nurses and be professionally accountable to Directors Nursing rather than local authority staff (just as social workers working in hospitals and other health settings are currently accountable to Directors of Social Work/Chief Social Work Officers)
- As our contention is that private care home and commissioned social care provision should be discontinued, no scrutiny role will be required with the private sector (that responsibility would lie solely with the regulatory body); it would however be required for third sector care commissioned to meet individual need whether in the community or a residential/nursing home setting.

Q35. Should the National Care Service be responsible for overseeing and ensuring consistency of access to education and professional development of social care nursing staff, standards of care and governance of nursing? Please select one.

☐x Yes

☐ No, it should be the responsibility of the NHS

☐ No, it should be the responsibility of the care provider

Please say why

The meaning of this question is unclear, there are both professional nurses working in care homes and care assistants, who currently receive very little training, and are expected to perform nursing procedures. Oversight of both of these should be a function within a Local Authority model of NCS delivery of care. As it is our contention that the private sector be excluded from public service care delivery either at home or in residential or nursing home care, this role will only apply to local authority and third sector provision. However, it might be better for professional nurses in care homes to remain professionally part of the NHS – they should be employed on NHS terms and conditions and move jobs easily between the NCS and NHS - while deployed on a day-to-day basis by the NCS.

Q36. If Community Health and Social Care Boards are created to include community health care, should Executive Nurse Directors have a role within the Community Health and Social Care Boards with accountability to the National Care Service for health and social care nursing?

☐ Yes

☐ No

If no, please suggest alternatives

Community Health Care should remain within the NHS. Whatever the role of Nurse Directors in a NCS, the NCS should be a Local Authority remit and nurses have ultimate accountability for their role to local communities and elected councillors. However, they should continue on NHS pay and conditions as well as retaining professional responsibilities to their professional bodies. The NCS at national level should establish standards and procedures to ensure their application.

Justice Social Work

Q37. Do you think justice social work services should become part of the National Care Service (along with social work more broadly)?

☒ Yes

☐ No

Please say why.

Justice social work services should retain their presence within statutory social work services generally and should be delivered through the NCS. The present Criminal Justice Partnerships have a questionable role anyway and would be unnecessary within an NCS framework delivered through Local Authorities

We need to end the fragmentation of social work, with different specialists working with the same families. Criminal Justice social workers have important skills in relation to assessing risks that a person may pose to others and preventing harm which should be utilised across a National Care Service

Q38. If yes, should this happen at the same time as all other social work services or should justice social work be incorporated into the National Care Service at a later stage?

☒ At the same time

☐ At a later stage

Please say why.

To retain its significance Justice Social Work needs to accompany other branches of social work into the NCS Since Justice Social Work is in some ways more centralised than other branches of social work, there is no reason why it should be brought into a National Care Service at a later stage

Q39. What opportunities and benefits do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

☐x More consistent delivery of justice social work services

☐x Stronger leadership of justice social work

☐x Better outcomes for service users

☐x More efficient use of resources

☐ Other opportunities or benefits - please explain

- Better outcomes for service users is central – if that is right the other components will fall into place.
- A joined up approach to care: a disproportionate percentage of people in the criminal justice system experience mental health and addiction problems which themselves often stem from problems with care experienced as a child, with poverty a common factor behind all of this.

Q40. What risks or challenges do you think could come from justice social work being part of the National Care Service? (Tick all that apply)

☐x Poorer delivery of justice social work services.

☐x Weaker leadership of justice social work.

☐x Worse outcomes for service users.

☐x Less efficient use of resources.

☐x Other risks or challenges - please explain:

All these factors are risks if Justice Service lack a strong voice within the NCS. Workers already feel like the poor relations and could get lost even more within a large bureaucracy. This however would become an even greater challenge were they to be excluded from an NCS when other social work services are to be included

Empowering justice social workers to take a wider approach to people in the criminal justice system would not only help the people they work with, it would enhance their status.

Q41. Do you think any of the following alternative reforms should be explored to improve the delivery of community justice services in Scotland? (Tick all that apply)

- ☐ Maintaining the current structure (with local authorities having responsibility for delivery of community justice services) but improving the availability and consistency of services across Scotland.
- ☐ Establishing a national justice social work service/agency with responsibility for delivery of community justice services.
- ☐ Adopting a hybrid model comprising a national justice social work service with regional/local offices having some delegated responsibility for delivery.
- ☐x Retaining local authority responsibility for the delivery of community justice services, but establishing a body under local authority control to ensure consistency of approach and availability across Scotland.
- ☐ Establishing a national body that focuses on prevention of offending (including through exploring the adoption of a public health approach).
- ☐ No reforms at all.
- ☐ Another reform – please explain:

Social Work Justice services should be delivered through a National Care Service delivered through the 32 Local Authorities. This would ensure consistency across the country with local accountability and service adaptability.

Q42. Should community justice partnerships be aligned under Community Health and Social Care Boards (as reformed by the National Care Service) on a consistent basis?

- ☐ Yes
- ☐x No

Please say why.

Partnerships should be abandoned as their function would be further blurred by new arrangements. The retention of Justice Social Work services within Local Authorities within a National Care Service would provide the levels of consistency and service that the Partnerships were supposed to achieve.

Prisons

Q43. Do you think that giving the National Care Service responsibility for social care services in prisons would improve outcomes for people in custody and those being released?

☐x Yes

☐ No

Please say why.

- It is a matter of principle that social care delivered through a National Care Service should be enjoyed by all citizens regardless of their setting or status.

Q44. Do you think that access to care and support in prisons should focus on an outcomes-based model as we propose for people in the community, while taking account of the complexities of providing support in prison?

☐x Yes

☐ No

Please say why.

- There should be seamless care between prison and community and community and prison. Rigorous oversight and strong leadership are required to achieve this.
- At present there are too many organisational overlaps with little meaningful co-ordination to extent that some individuals get no service when one is required.
- No one should leave Prison without a designated GP and access to mental health treatment and support if they require it along with support with re-establishing meaningful care relationships in the community (with all the complexity that implies for people convicted of crimes against others). A properly functioning and resourced NCS working alongside the NHS could ensure this happens.

Alcohol and Drug Services

Q45. What are the benefits of planning services through Alcohol and Drug Partnerships? (Tick all that apply)

- ☐ Better co-ordination of Alcohol and Drug services
- ☐ Stronger leadership of Alcohol and Drug services
- ☐ Better outcomes for service users
- ☐ More efficient use of resources
- ☐ Other opportunities or benefits - please explain

None

Q46. What are the drawbacks of Alcohol and Drug Partnerships? (Tick all that apply)

- ☐x Confused leadership and accountability
- ☐x Poor outcomes for service users
- ☐x Less efficient use of resources
- ☐ Other drawbacks - please explain

Since the inception of ADPs in 2009, drug deaths have skyrocketed whilst alcohol deaths have increased steadily. *ADPs run on target culture*. This means certain targets are created either centrally or locally, but are not necessarily relevant in all areas of a certain locality. For example, a target of one ADP is to distribute X amount of naloxone within their area, despite opiates not being the main harmful drug in all areas they are responsible for. When you are a doctor saying cocaine is creating harm in your area, and you are provided with a naloxone kit by the ADP your trust in the ADP can erode. Targets during COVID were also inflexible, with third sectors still being expected to deliver targets for face-to-face recovery groups during a time when it was illegal to do so. Target culture politicises healthcare by removing the focus away from compassion and care.

Q47. Should the responsibilities of Alcohol and Drug Partnerships be integrated into the work of Community Health and Social Care Boards?

- ☐ Yes
- ☐x No

Please say why.

No, we disagree with the proposed model of CHSCBs, but the integration of ADP functions within broader social work services would in our opinion lead to improvement.

Q48. Are there other ways that Alcohol and Drug services could be managed to provide better outcomes for people?

Yes, we believe so. We believe so, a precis of some are provided below:

- Why not look at prescribing practices by GPs (largely ignored) but which sometimes start people on their addiction journeys? These are known to vary from practice to practice.
- Funding cycles for 3rd sector support organisations inevitably focus scarce resources on making a case for continued funding - rather than services themselves. Mainstreaming services within local authorities or finding more secure funding mechanisms for 3rd sector services of proven value would result in continuity and security.
- Different psychological therapies provided, or a clear therapeutic structure. For example, many services only provide CBT, but the introduction questions can be very past orientated and focuses on relationships, past experiences and abuse. This creates a disengagement as people are asked to bring up painful memories which they no longer discuss in depth later on due to the nature of CBT. Having a range of therapy would be beneficial for people who do not take to CBT. Additionally, individual focused CBT and social focused recovery are two very different theories, if MH and recovery are to integrate, the theories themselves will also need to integrate, so overly focusing on structure and strategy will mean these barriers to good care will be missed.
- In the majority of the cases people with alcohol and drug problems have **multiple needs**, they might also suffer from mental health problems, physical health issues , social exclusion, homelessness, trauma, negative experience with mainstream services , mistrust in professionals (including ,but not only, Social Workers, police, GP.....).The difficulty accessing services suffered by people with multiple needs has been acknowledged in the Feeley report . So we should provide an actual policy and plan for families affected by alcohol and drugs, who are often sharing the same stigma, trauma and burden as the individual living with addiction.
- Assertive outreach to be totally integrated and not a pilot: we know it works. Fund it.
- A separate policy for rural drug and alcohol services as they run on less money and more diluted expertise.
- Be transparent with your data. Encourage FOI and curiosity. Proactively ask why poverty is contributing towards addiction. It is incredible the amount of council based strategy that is created that is not based on very much evidence.
- More investment is needed in housing support services
- Opiate replacement therapy needs to remove the “methadone and that’s it” mentality. Instead of providing a service we are giving people ORT and putting them on a waiting list. This is not an intervention (the same is happening with mental health and antidepressants).
- Numbers of residential detox beds are insufficient (for example, in Edinburgh, the capital of Scotland, there are currently only 16 beds available.

Q49. Could residential rehabilitation services be better delivered through national commissioning?

☐x Yes

☐ No

Please say why.

Yes, in principle. A range of services and practices are required: recovery & abstinence need to be considered that can provide for large numbers of people and these might need to have spiritual components if this is what the person needs. It would also mean that commissioning of 3rd sector charity-based rehabilitation should not cease if they can evidence good practice for the group they cater for. This demonstrates a diverse and inclusive approach to rehabilitation

The number of residential beds is insufficient (for example, in Edinburgh there are currently only 16) A holistic approach is necessary to support people with alcohol and drug problems in order for people to be able to access and engage with services to be supported after the detox is concluded. Back in the community, support should be in place in order to avoid relapses and future admissions. The same support services/practices could be applied for prison services

Q50. What other specialist alcohol and drug services should/could be delivered through national commissioning?

Family services: There is a national strategy for local services to provide support for families but this is patchy. A better focus by preventatively orientated, supportive and relationship based mainstream social work services might help identify gaps where commissioned 3rd sector organisations stemming from local community initiatives could enhance supports. The emphasis here should be on local commissioning to meet local variations and needs rather than national commissioning that hands responsibility to large 3rd sector organisation

Q51. Are there other ways that alcohol and drug services could be planned and delivered to ensure that the rights of people with problematic substance use (alcohol or drugs) to access treatment, care and support are effectively implemented in services?

Replace target cultures with compassion and empathy. This sounds very simple, but it's completely overlooked. An anecdote from a frontline worker: "I once visited a recovery service where the social worker offered his wisdom that perhaps maybe they should offer service users a cup of tea as an act of kindness. I assumed that this was a joke, because I thought they would have already done this since I could see the canteen from the waiting area. I was taken back when told this was not the case, that the visible canteen was for staff only and that a cup of tea was seen as a pioneering example of kindness, rather than just basic care."

For care to be successfully implemented it needs to be at the centre of everything. This might mean having people with lived experience working to deliver support: to care is to readdress power imbalances too.

A better understanding on how drugs and alcohol affect not just the individual, or even the wider economy, would help services become more community focused and less stigmatised. Scotland is suffering an epidemic of sadness: deaths from alcohol, drugs and suicide are causing a totally different bereavement process for those these deaths leave behind.

The consultation itself admits (p80) that there are issues with governance and accountability: this raises questions of leadership, and there is evidence that lack of responsibility at all levels in the public sector can result in poor care – personal and collective responsibility needs to be a priority within the NCS. The consultation does not acknowledge clearly enough that experts by experience can also be successful leaders. Often a "professional" person who is university educated, and is well paid and trained to manage a team, is described as a "leader". Contrastingly an expert by experience who has the same leadership qualities, but gained through hardship rather than enablement, is described as "resilient". We do not see them as potential leaders and by ignoring this potential, we do not go far enough to address power imbalances.

An important issue with the integration of mental health and recovery services concerns lack of ownership for a person's care. There is ample research that tells us that mental illness and addiction go hand in hand, but it's so often the case that people within the system are pushed from one service to the other. They aren't falling through the gaps as the consultation suggests: they're IN the system, they're there. - they're aren't getting missed, they're being pushed out of the door.

Mental Health Services

Q52. What elements of mental health care should be delivered from within a National Care Service? (Tick all that apply)

- ☐ Primary mental health services
- ☐ Child and Adolescent Mental Health Services
- ☐ Community mental health teams
- ☐ Crisis services
- ☐x Mental health officers
- ☐ Mental health link workers
- ☐x Other – please explain

Mental Health is an under-resourced and overstretched area of the Health Service and will not enjoy improvement by being transferred to a new NCS. It should instead be subject to revitalisation within the NHS.

MHOs have a statutory function, involving both scrutiny and assessment, that is best delivered from within the NCS alongside other social work functions from which it must not become separated.

A NCS however as a key role in supporting and developing community infrastructure that creates caring communities and will help tackle the current epidemic of mental ill health

Q53. How should we ensure that whatever mental health care elements are in a National Care Service link effectively to other services e.g. NHS services?

Partnership working through good networking and front-line co-operation does not require joint organisational arrangement and this applies to mental health as much to other services.

Some health services, and mental health is one, are best delivered at community level and some could be delivered effectively alongside other services based in community hubs.

CMHTs need to be better resourced in order to provide support at a preventative and neighbourhood level, alongside and supporting third sector and social work initiatives to improve mental health and tackle issues of mutual concern.

National Social Work Agency

Q54. What benefits do you think there would be in establishing a National Social Work Agency? (Tick all that apply)

☐x Raising the status of social work

☐x Improving training and continuous professional development

☐x Supporting workforce planning

☐x Other – please explain

The establishment of a NSWA within the National Care Service is broadly welcomed as a means of re-establishing the importance of social work and social workers within the care system (with a role akin to doctors in the NHS). But the establishment of such an organisation within a NCS needs to be built on a recognition of where the workforce has been let down through present arrangements. Education, continuous professional development and improvement are all important, but so are supervision, workload management and the provision of sufficient staff to make relationship-based work a reality and not just an aspiration. The NSWA should have an aim of creating an environment where community-based preventative social work becomes the norm: statutory reactive services should be a fall back when preventative services fail, and not the primary focus of social work provision. What is not needed is a set of prescriptive hoops for social workers to jump through to prove their competence in order to uniformly "scale up good practice", which is not to say that social workers should not have guaranteed time set asidefor training. Rather the emphasis needs to be on professional autonomy within a network of professional support (similar to that of doctors)

It would seem logical to make the NSWA the base of Scotland's Chief Social Work Advisor and staff, who could be incorporated into the new structure.

The NSWA should monitor resource allocation and ensure that this is equitable across the country and based on need, not simply the decisions of local authorities forced to manage dwindling budgets.

Crucial are supervision and workload management processes, and resources generally – both in terms of the availability or otherwise of colleagues to share the burden, and resources to work with through partnership – this could all be monitored and supported by a NSWA

Relationships and the space to make and sustain them through the journey with the individual or family group also fundamental, and could be supported nationally through a NSWA

What is not needed is a set of prescriptive hoops for people to jump through to prove their competence in order to uniformly "scale up good practice". That is unless time is guaranteed to be set aside so it is not something workers have to do in their own time.

Q55. Do you think there would be any risks in establishing a National Social Work Agency?

A NSWA will find itself marginalised and of little significance if social work continues to be incorporated into an integration model that is, by definition, dominated by Health interests.

If, as we have argued elsewhere, the NCS is run through local authorities, the role of the NSWA needs to fit within a national framework based on this.

The NSWA could ring together Chief Social Work Officers from councils, who within a framework based on local authority delivery, would continue to oversee social work standards in each of Scotland's 32 Councils.

Giving the NSWA responsibility for research implies the abolition of organisations like CELCIS and IRISS because their roles would be incorporated in the new centre of excellence. Careful thought is required about how this should happen and existing staff should be given the opportunity to transfer to the new organisation to prevent a loss of expertise knowledge and skill.

The paper talks about "parity with other professions" but it is not clear which ones and on what basis? –A problem is that the role and task of social work, like care, has no agreed and established formulation or definition and further consultation is required on this and the role of support staff to put an end to the steady encroachment – driven by cuts - of para-professionals on areas of work often (and traditionally) undertaken by QSWs.

The loss of status and understanding of what social workers do has to be seen within the context of negative trends over the last thirty years: the growth of a prescriptive and reactive role in addressing statutory concerns around risk, rather than prevention and relationship-based work. The loss of social work identity within local authorities through diminution of the Chief Social Work Officer role and amalgamation with other functions to save money. These things will not be cured by announcing and setting up a NSWA if social work continues to be marginalised within an agency whose priorities are determined by health models and requirements i.e. IJBs.

We are concerned about the proposal that social workers pay should be somehow determined by the NSWA. There is a strong argument for national rates of pay but this should be established through national collective bargaining as part of the wider care workforce.

Q56. Do you think a National Social Work Agency should be part of the National Care Service?

☐x Yes

☐ No

Please say why

It is important that professional social work is not separated from social care more widely but interfaces with it. More specifically, social work training and development needs to interface with wider social care training within the NCS so that care staff, for example, have routes to become social workers, while pay and terms and conditions for social workers should be part of wider social care workforce collective bargaining and not separated from it.

Q57. Which of the following do you think that a National Social Work Agency should have a role in leading on? (Tick all that apply)

☐x Social work education, including practice learning

☐x National framework for learning and professional development, including advanced practice

☐ Setting a national approach to terms and conditions, including pay

☐ Workforce planning

☐ Social work improvement

☐x A centre of excellence for applied research for social work

☐ Other – please explain

Pay should be part of national collective bargaining for the NCS as a whole. Workforce planning is best done as part of wider workforce planning for the NCS. Improvement should be professionally led, like doctors, with social workers involved at all levels of training (like doctors).

Reformed Integration Joint Boards: Community Health and Social Care Boards

Governance model

Q58. "One model of integration… should be used throughout the country." (Independent Review of Adult Social Care, p43). Do you agree that the Community Health and Social Care Boards should be the sole model for local delivery of community health and social care in Scotland?

☐ Yes

☐x No

Please say why.

The IJBS have failed, as has integration, we need to recognise that care and health are, while interconnected and complementary, separate. We also need to put an end to centralism and restore democratic control over services and that means that delivery of care services should be through Local Authorities.

Q59. Do you agree that the Community Health and Social Care Boards should be aligned with local authority boundaries unless agreed otherwise at local level?

☐ Yes

☐ No

Q60. What (if any) alternative alignments could improve things for service users?

Re Q69, we believe that there shouldn't be joint health and social care boards. We do however firmly believe that in terms of health and social care workforce being facilitated to work together where needed, alignment of boundaries would help, in other words alignment of primary health care boundaries with local authorities would help. However, we believe alignment needs to go beyond that and services be aligned at a much more local level, so that community health services are aligned with local social work teams where possible.

Q61. Would the change to Community Health and Social Care Boards have any impact on the work of Adult Protection Committees?

The creation of a National Care Service should be an opportunity to shift the emphasis from protection to support and refocus social work on working with families and communities. As part of that the need for Adult Protection Committees and the way they operate should be reviewed. We disagree with the proposal to create CHSCBs and believe they are irrelevant, indeed would form barriers, to achieving those objectives.

Membership of Community Health and Social Care Boards

Q62. The Community Health and Social Care Boards will have members that will represent the local population, including people with lived and living experience and carers, and will include professional group representatives as well as local elected members. Who else should be represented on the Community Health and Social Care Boards?

We disagree with CHSCBs but the tokenistic representation of service users and carers on Boards that have no real power won't make any difference. Instead, we believe that local councils should have a statutory care committee and a statutory care advisory Board which includes elected service user, carer, workforce and professional representatives. More important than this, however, is that that every service should be required to set up a Board that includes Service User, Carer and workforce representatives.

Q63. "Every member of the Integration Joint Board should have a vote" (Independent Review of Adult Social Care, p52). Should all Community Health and Social Care Boards members have voting rights?

☐ Yes

☐ No

Q64. Are there other changes that should be made to the membership of Community Health and Social Care Boards to improve the experience of service users?

We have not answered Q63 because we believe IJB should be abolished and proposals for CHSCBs abandoned. Giving unaccountable Board Members a vote is wrong in principle and won't address the democratic deficits. Our alternative model is outlined above but the key issue is the democratic control over individual services by service users, carers and the workforce should increase and we need new mechanisms to revitalise democracy within local authorities

Community Health and Social Care Boards as employers

Q65. Should Community Health and Social Care Boards employ Chief Officers and their strategic planning staff directly?

☐ Yes

☐x No

Q66. Are there any other staff the Community Health and Social Care Boards should employ directly? Please explain your reasons.

Re Q65, while we believe the proposals for CHSCBs should be dropped, each Local Authority should be required to employ a Chief Care Officer as executive head of the NCS in their area and that person should require to be professionally qualified in social work or social care. While we believe each local authority will need a central team to assist with planning and design of care services locally and to act as the interface with the NCS nationally (on matters such as levels of need in their area and the resources required to meet these), the focus within local authorities needs to be on the local design and management of services, in consultation with the people who use and work in them and local communities, rather than centralised top-down managements. The advantage of situating this in local authorities, and within that local communities, is that care will be part of a much wider package of planning, housing, environment, etc.

Commissioning of services

Structure of Standards and Processes

Q67. Do you agree that the National Care Service should be responsible for the development of a Structure of Standards and Processes

- ☐ Yes
- ☐ No

If no, who should be responsible for this?

- ☐ Community Health and Social Care Boards
- ☐ Scotland Excel
- ☐ Scottish Government Procurement
- ☐ NHS National Procurement
- ☐ A framework of standards and processes is not needed

Q68. Do you think this Structure of Standards and Processes will help to provide services that support people to meet their individual outcomes?

- ☐ Yes
- ☐x No

Q69. Do you think this Structure of Standards and Processes will contribute to better outcomes for social care staff?

- ☐ Yes
- ☐x No

Q70. Would you remove or include anything else in the Structure of Standards and Processes?

The "Structure of Standards and Processes" is managerialist jargon which disguises the fact that it is not possible to deliver ethical commissioning within a private market of care driven and through procurement processes. For ethical commissioning to be achieved the private market and procurement needs to be abolished and replaced by a model in which all services are funded according to agreed costs of delivery (most importantly a national pay structure) and the majority are designed and managed locally. There is a need for some inputs to be agreed nationally (e.g. templates for costs) but the more that is specified nationally the less services can be tailored towards local circumstances and need. The best way to ensure standards is not through policy but by giving people real power over the services that affect them: a classic example of this during the Covid crisis where setting standards for care home visiting has had limited success in enabling relatives to support residents in care homes. Instead of treating care issues as a matter of standards, the way to improve care is to involve service users, carers and staff in decision-making.

Market research and analysis

Q71. Do you agree that the National Care Service should be responsible for market research and analysis?

- ☐ Yes
- ☐x No

If no, who should be responsible for this?

- ☐ Community Health and Social Care Boards
- ☐ Care Inspectorate
- ☐ Scottish Social Services Council
- ☐ NHS National Procurement
- ☐ Scotland Excel
- ☐ No one
- ☐x Other- please comment

We do not agree that the market in care should continue, care should be not for profit and planning of services done primarily by local authorities working with local communities. Where there is a need for specialist services at the national level, it would make sense that the planning of these was led by a commissioning section of the NCS utilising staff who currently work on social care procurement at Scotland Excel and such a team would then be responsible for determining whether such services might be best provided by the voluntary sector or provided through a council on behalf of all Local Authorities.

There is no space to comment on Question 72. Most national contracts are for privately run services like care homes and foster care and we believe these should be phased out so the NCS is not for profit like the NHS. However, there will still be some services, like Secure Care which is run by the voluntary sector, which are best commissioned and managed nationally through a commissioning section within the new National Care Service HQ.

National commissioning and procurement services

Q72. Do you agree that there will be direct benefits for people in moving the complex and specialist services as set out to national contracts managed by the National Care Service?

☐x Yes

☐ No

If no, who should be responsible for this?

☐ Community Health and Social Care Boards

☐ NHS National Procurement

☐ Scotland Excel

The NCS

Regulation

Core principles for regulation and scrutiny

Q73. Is there anything you would add to the proposed core principles for regulation and scrutiny?

It is not possible to decide core principles for regulation and scrutiny before first agreeing the core principles that should underpin the NCS. Those principles will help determine the role of regulation and scrutiny. Following from this, regulation and scrutiny should be redesigned on the basis of all care services being not for profit and democratically controlled. Also, we do see the need to specifically reference workers' employment rights including the right to organise and to have collective bargaining rights across the NCS. If that were to happen, regulation as it currently operates could be fundamentally reformed and the Care Inspectorate and SSSC merged into a single body.

The key to service quality is that power needs to be devolved to staff and the people who depend on services, so that they have real control, and the NCS is properly resourced. If that happened, services would improve and people would work together to resolve issues. The most important principle for regulation therefore is that there is a statutory requirement for staff, service users and carers to be involved in the management of services, e.g. through the creation of boards for every service, akin to a strengthened parent teacher association.

Primary responsibility for ensuring this happens should lie with local commissioners with the regulator providing a last resort when local mechanisms fail.

1. Scrutiny and assurance should support human rights-based care, focus on outcomes for people, and the positive impact community health and social care services are making to their lives, including the relationships staff have with them.

2. Activity should be targeted, proportionate, intelligence-led, and risk-based. This approach will allow the regulator to choose different types of scrutiny, assurance, or quality improvement intervention relative to the individual service and how it is performing.

3. The NCS should generally seek to review, update, and improve standards and practices as an organisation and across the care sector on a regular and ongoing basis (this is a separate role and process from any improvements which those who have responsibility for delivering social care services (or overseeing those) may be required to make arising from enforcement or other action by the regulator).

4. There should be a strong link between the regulation of the workforce and their professional standards and the inspection and scrutiny of the services they work in.

5. Overall national scrutiny should involve the regulator working collaboratively, where possible, with other professions and agencies and continue to be informed by lessons learnt and good practice arising from the experience of the pandemic.

6. Regulation is fundamental to ensure a qualified and skilled social care workforce which enables employers to deliver high quality, responsive care and support.

7. Regulation is a key element in ensuring the safety of vulnerable people, ensuring high standards for practice, conduct, training and education across the workforce.

8. Scrutiny and assurance should aim to reduce inequalities with an emphasis on people, prevention, partnership and performance.

9. Where possible, regulators should involve people in the development and delivery of scrutiny approaches and amplify the voice of people experiencing care.

10. Where appropriate, scrutiny and assurance should take account of legislative requirements, Scottish Government policy, national standards, and codes of practice.

Q74. Are there any principles you would remove?

All the above principles are based on trying to improve the current system, which is based on a private market of care and a low paid poorly trained workforce. It has failed and the principles are not fit for purpose as worded. For example:

There would be no need to scrutinise whether people's rights had been observed and whether outcomes had been achieved if care was properly resourced and needs were met.

The only reason we need "intelligence" in care services is because the primary purpose of the private sector is to make money not provide care, so you need "intelligence" to find out what is going wrong.

There are far too many standards, not even professionals can follow them, and there is little evidence that they have improved care provision.

The workforce is key to improving the quality of services, but improving the workforce should not be driven by regulation but rather by the provision of training and then giving workers the time to do their jobs properly and care for people. Regulation of the workforce should not be used, as at present, as a stick to punish the workforce instead of addressing the lack of resources.

Several of the proposed principles for regulation will embroil regulators in yet more bureaucracy ticking off whether staff and services are aware of Scottish Government imposed policy, standards etc. That won't change anything.

Q75. Are there any other changes you would make to these principles?

- It is difficult to answer any of the above questions or to comment on the principles set out as we fundamentally dispute many of the premises on which they are based. Furthermore, they are assertions rather than statements that can be evidenced; indeed, several are not supported by evidence. Others are meaningless. What, for example is the meaning of 'Scrutiny and assurance should aim to reduce inequalities with an emphasis on people, prevention, partnership and performance'.

These principles do nothing to change the paradigm, as Feeley argues is needed, but buttress a system that is failing and self-propagating. We would make the following key points:

- There is no convincing evidence base to suggest that regulation improves practice; indeed, it has many negative effects on practice and on worker satisfaction and motivation.
- There is no evidence that regulation improves worker skill levels or sense of identity.
- Direct care workers are particularly vulnerable in respect of fitness to practise processes and this demotivates them and leads to risk-averse practices
- There is insufficient expertise within regulatory bodies to be able to regulate effectively – instead, they revert to risk averse and punitive box-ticking.
- Linked to the above, the nature of care does not lend itself to regulation in the auditing way that regulation exists – care, as we argue in other work is a moral/practical endeavour rather than a technical/rational one, whereas regulatory regimes are invariably based on a technical/rational paradigm. Care is hard to count or measure and can't be reduced to a tick-box mentality.
- We need a different way of thinking about care, which builds upon the internal motivation and desire for excellence that emerges out of practice.

Strengthening regulation and scrutiny of care services

Q76. Do you agree with the proposals outlined for additional powers for the regulator in respect of condition notices, improvement notices and cancellation of social care services?

☐x Yes

☐ No

☐ Please say why.

But only on a transitional basis and on condition all services become not for profit. If the private market is allowed to continue, these proposed powers are totally insufficient to address the issues.

If care become not for profit, the market was abolished and services were controlled locally, there would no longer be a need for the Regulator to step in and close down services. Rather, where services were going wrong or were not fit for purpose, the regulator could work with local commissioners to ensure staff and the people using services addressed issues or reconfigured them to meet local needs.

Q77. Are there any additional enforcement powers that the regulator requires to effectively enforce standards in social care?

While the private market in care continues, unless the regulator has powers to investigate how the provider is managing finances and to direct them to spend money on fixing problems, the regular will be unable to operate effectively. While the private market continues, both the current regulators, the SSSC and Care Inspectorate, should have the power to enforce the Employers Code of Practice.

The Regulator should have powers that allow them to bring private sector into public sector/ownership

Market oversight function

Q78. Do you agree that the regulator should develop a market oversight function?

- ☐ Yes
- ☐x No

Q79. Should a market oversight function apply only to large providers of care, or to all?

- ☐ Large providers only
- ☐ All providers

Q80. Should social care service providers have a legal duty to provide certain information to the regulator to support the market oversight function?

- ☐ Yes
- ☐ No

Q81. If the regulator were to have a market oversight function, should it have formal enforcement powers associated with this?

- ☐ Yes
- ☐ No

Q82. Should the regulator be empowered to inspect providers of social care as a whole, as well as specific social care services?

☐x Yes

☐ No

Please say why

The private care market is wrong in principle and unreformable: it has driven staff into poverty, deskilled the workforce and extracted money of the care sector and out of Scotland. In our view the Scottish Government needs to start phasing out private care provision as a matter of urgency. Market oversight was called for after the collapse of Southern Cross and nothing was done in Scotland, unlike England, but the evidence from England since then shows that the idea that a market oversight authority could do anything to prevent money being extracted from the system or could persuade the market to act "responsibly" is wrong. Rather than address the symptoms of the problem, the Scottish Government needs to address the root of the problem, care being provided for profit.

We believe that the regulator should have a national oversight function which ensures consistency, transparency and prudence. However, this should not be based on economic decisions involving privatisation and profitability.

Enhanced powers for regulating care workers and professional standards

Q83. Would the regulator's role be improved by strengthening the codes of practice to compel employers to adhere to the codes of practice, and to implement sanctions resulting from fitness to practise hearings?

The assumption behind this question appears to be that the primary problem with employers and the Codes of Practice is that they are failing to implement sanctions resulting from fitness to practice hearings. This fails to address the real issues. We do not believe that regulation can fundamentally change the private care market which is one of the reasons we think all care should be not for profit and delivered under the aegis of local authorities. In our proposed set-up, a reformed regulator would have an important role in ensuring that councils, as providers and as commissioners of services from other not for profit providers, was supporting the workforce properly, so they were equipped to do their job. That should be the primary role of an independent regulator. With a properly trained and supported workforce there should be far less need for fitness to practice hearings, though these should still take place for serious or repetitive breaches of the codes of practice by employees.

Q84. Do you agree that stakeholders should legally be required to provide information to the regulator to support their fitness to practise investigations?

It is not clear who the proposed stakeholders (described as external organisations in the consultation document are). This question is not central to the design of an NCS. What is important is that the underlying reasons why such large numbers of social care workers are being referred to the SSSC are analysed, understood and addressed.

Q85. How could regulatory bodies work better together to share information and work jointly to raise standards in services and the workforce?

We believe that the Care Inspectorate and SSSC should be amalgamed in a single regulatory body for care whose primary responsibilities should be a) to scrutinise commissioning, primarily that undertaken through local councils, but also any commissioning undertaken by the NCS nationally rather than inspect services b) to retain residual powers to inspect services, as part its regulation of the commissioning function, either as part of its inspections of councils or in response to serious incidents/failings in care c) registration of the workforce and through that monitoring of continuous professional development d) to take final decisions on fitness to practice, e.g. if a member of care staff is dismissed by a Council a decision should then be made if they are fit to practice.

The important role of the HSE should be recognised in protecting the health, safety and welfare of the social care workforce (and those being cared for), and close collaboration with the joined SSSC / Care Inspectorate will be crucial.

Q86. What other groups of care worker should be considered to register with the regulator to widen the public protection of vulnerable groups?

The assumption behind this question, that the primary function of registration should be public protection of vulnerable, is our view fundamentally wrong. Rather, registration should provide the framework for workforce development, with different qualification levels required for different types of job. The best protection for the public would be a properly trained workforce.

Within such a framework there are three main groups of staff working in care services who should require to be registered: Personal Assistants, who are no different to other frontline care staff; social work assistants and other unqualified care managers who currently work directly with service users and carers; commissioners. All three groups require specialist knowledge and skills relating to care. We don't believe other staff ancillary to care, for example, kitchen and domestic staff, receptionists should require to be registered other than undergoing police checks.

Valuing people who work in social care

Fair Work

Q.87 Do you think a 'Fair Work Accreditation Scheme" would encourage providers to improve social care workforce terms and conditions?

☐ Yes

☐x No

Please say why.

If additional resources were made available, a prerequisite for any improvement in terms and conditions, an accreditation scheme would possibly lead some providers to improve conditions for their workforces. However, a voluntary accreditation scheme would not *ensure* better conditions for anyone, and would, in particular, not create improvement by those providers for whom worker health, safety, welfare and professional development are not a priority. The IRASC called for national minimum terms and conditions as a key component of new **requirements** for commissioning and procurement. This is the minimum that must be delivered. The best practice guidance for Fair Work in Scottish Public Procurement provides very clear examples of what constitutes effective voice as well as the other Fair Work principles with unions being cited as the clearest example of effective voice.

Q.88 What do you think would make social care workers feel more valued in their role? (Please rank as many as you want of the following in order of importance, e.g. 1, 2, 3…)

2	*Improved pay* We have ranked four equally at number 2. It makes no sense to try to rank them further, as they are all related. Improved pay will not be very helpful without any sick pay, annual leave, etc. Improved hourly pay will not be very helpful if workers still do not know how many hours they will be paid for. Consistent job roles and expectations are core aspects of fair terms and conditions and of healthy and safe work.
2	*Improved terms and conditions, including issues such as improvements to sick pay, annual leave, maternity/paternity pay, pensions, and development/learning time*
2	*Removal of zero-hour contracts where these are not desired*

4	*More publicity/visibility about the value social care workers add to society* This is only ranked lower because it should follow automatically from effective voice, improved working conditions, better training and career progression.
1	*Effective voice/collective bargaining* We have ranked this number 1, because, if it is real and effective, it should be able to encompass and bring to pass most of the other changes listed
3	*Better access to training and development opportunities* Again, we have ranked five options at three because they are all related. In order to have access to training and development it is crucial that there be increased awareness of opportunities. Progression, career progression and minimum entry level qualifications are again all linked with access and awareness. We would also add that workers should not have to pay for their own training and should be given paid time toward undertaking it.
3	*Increased awareness of, and opportunity to, complete formal accreditation and qualifications*
3	*Clearer information on options for career progression*
2	*Consistent job roles and expectations*
3	*Progression linked to training and development*
4	*Better access to information about matters that affect the workforce or people who access support* Again, this is only ranked lower because this access to information should be a core part of good training and the support and supervision which is part of fair working conditions.
3	*Minimum entry level qualifications* We believe this is crucial, but is only fair if the resources (including grants or paid time) and infrastructure is there to allow people to gain these qualifications
1	*Registration of the personal assistance workforce* This is given the same ranking as effective voice and collective bargaining as we believe that the PA workforce should be treated as an

	integral part of the social care workforce, and therefore part of that collective bargaining. Registration would be an important step.
1	*Other (please say below what these could be)* Social care workers should be given more autonomy in decision making regarding the day to day care they provide. Such autonomy must be backed up by training, support and supervision and case management. Social care workers should also have a voice in how the services they provide are designed. This is ranked one because it is a core part of effective voice.

Please explain suggestions for the "Other" option in the below box

Other parts of the social care workforce should also require to be registered with the regulator, namely social work assistants and commissioners

Q.89 How could additional responsibility at senior/managerial levels be better recognised? (Please rank the following in order of importance, e.g. 1, 2, 3…):

1	Improved pay
1	Improved terms and conditions
1	Improving access to training and development opportunities to support people in this role (for example time, to complete these)
1	Increasing awareness of, and opportunity to complete formal accreditation and qualifications to support people in this role
	Other (please explain)

Please explain suggestions for the "Other" option in the below box

We have ranked all of these as equivalent because they are all linked. Although ensuring awareness of and access to training and development and formal accreditation and qualifications is important, the crucial thing is that these accreditations and qualifications once achieved are recognised. Methods of doing this include improved pay and conditions, including workload and pay reviews. Financial resources will be necessary to implement this. There should also be an adequate grading system in social care (similar to nurses)

Frontline managers in social care face all the same issues at the rest of the workforce and therefore all the options in question 87 also apply to those managers. A far more comprehensive look needs to be given on management/career structures akin to Agenda for Change in the NHS and this too needs to be subject to collective bargaining.

Q.90 Should the National Care Service establish a national forum with workforce representation, employers, Community Health and Social Care Boards to advise it on workforce priorities, terms and conditions and collective bargaining?

☐ Yes

☐ No

Please say why or offer alternative suggestions

A formal mechanism should be set up involving all parties to take forward collective bargaining for the sector. Collective bargaining should cover pay, terms and conditions and training and development. **It should not simply be an advisory body**. Workforce representation must include all relevant trade unions. Representation should be from the workforce, employers and local authorities. The IJB/CHSC model should be abandoned and replaced with a National Care Service based on nationally co-ordinated and funded services administered through Local Authorities, that runs alongside the NHS – who should continue to administer health services including community health services .

Workforce planning

Q.91 What would make it easier to plan for workforce across the social care sector? (Please tick all that apply.)

☐x A national approach to workforce planning

☐x Consistent use of an agreed workforce planning methodology

☐x An agreed national data set

☐x National workforce planning tool(s)

☐x A national workforce planning framework

☐x Development and introduction of specific workforce planning capacity

☐xWorkforce planning skills development for relevant staff in social care

☐x Something else (please explain below)

Something else:

You state in the consultation document that “the complexity of health and social care, given the number of employers makes workforce planning difficult”

This could be addressed directly by reducing the number of employers involved. We argue that there is no place for the for-profit sector in social care. We would argue that the bulk of provision should be in the public sector with some contribution from the third sector. This would result in a dramatic reduction in numbers of employers and make workforce planning much more manageable. We understand that it may not be possible to eliminate for-profit provision immediately, but this could be done over time (as short a period as possible) by ceasing any new contracts with the private sector, putting caps and other controls on profits and taking any failing provision into the public sector.
In addition, the development of SDS option 1 has hugely increased the number of employers. In the short term nationally agreed terms and conditions should be developed for personal assistants as with all social care workers. In the medium term all personal assistants could be transferred to public sector (local authority) contracts. SDS users would still have a choice from among this workforce as to who would provide their care. This would not only dramatically reduce the number of employers and made workforce planning easier, but would meet the concerns voiced in the IRASC and your consultation document about ‘the administrative burden of securing personal assistant support’

National workforce planning needs to take account of needs and issues in different areas, e.g. differences between urban and rural areas.

Training and Development

Q.92 Do you agree that the National Care Service should set training and development requirements for the social care workforce?

☐x Yes

☐ No

Please say why

The consultation document makes it clear that the aim is to develop a National Care Service that provides a high quality of care. This will to a large extent depend on the social care workforce which provides the care. The consultation acknowledges that social care work is skilled and that stability of staffing is crucial. Skill and stability will only come with good training and development and a framework of qualifications which is easily accessible to all social care workers

There is no space to comment on Question 93 but in our view the main training for qualifications should be provided in Scotland's colleges, with placements in public and voluntary sector services as appropriate. Other training could be offered by public and voluntary sector providers, from statutory training to awareness training.

Q.93 Do you agree that the National Care Service should be able to provide and or secure the provision of training and development for the social care workforce?

☐x Yes

☐ No