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**INDEPENDENT REVIEW OF ADULT SOCIAL CARE**

Carr Gomm is a leading Scottish social care and community development charity (SC033491). We currently support about 2,000 people every day across Scotland to live their lives safely and well according to their choices, whilst making plans to achieve their hopes and dreams for tomorrow.

Everyone is unique and we all need support with different things at different times in our lives. Carr Gomm helps with any area of someone's life: from small things to being fully involved in all aspects of someone's life. Our philosophy is based on taking a person-centred approach. This means that we support everyone differently, according to their individual requirements, desired personal outcomes, and plans for the future. We tailor our support to each individual and we care about always providing the right support, at the right time, in the right way.

We use our knowledge, skills, training and value based approach to identify how we can best add to each person's strengths and abilities, enabling them to live successfully and well within their own home and community. Our role is not to do things *for* people but to work *with* them. On any given day we may be supporting an older woman with dementia to live independently in her home and continue socialising with her friends; or helping a young man with autism move into his first home away from his family; or supporting a father of young children with his benefits claims and understanding his responsibilities as a tenant to reduce his risk of eviction. Every day the support we provide facilitates each person or family living the life they choose. Our commissioned services are registered with the Care Inspectorate and are routinely graded as *Very Good* or *Excellent*.

Whilst our services are commissioned by Health & Social Care Partnerships, local authorities, health boards and the Scottish Government, an additional core part of our work as a charity is to fundraise to fill the gaps in society; to provide support where no one else is. Specifically, this work focuses on tackling the crippling issues of loneliness and isolation.

We are also sector-leading digital innovators, developing the Google award-winning ClickGo, a web-based platform for self-directed support (SDS), and YooToo, a family-led app incorporating sophisticated medication management, a hospital discharge wizard and reablement tools.

In responding to this invitation to submit our experiences and views to the Review, we have gathered perspectives from across Carr Gomm, and now respond under the key areas being considered and explored by the Review.

## Dimensions of high-quality social care

Within Carr Gomm and other not-for-profit providers throughout Scotland, high quality and high impact social care is already provided every day; we know this from Care Inspectorate grades in which the not-for-profit sector consistently outperforms the statutory and for-profit sectors[1]. Not-for-profit organisations are not broken. Support provision is not broken. The sector is not broken. ***The perpetual crisis narrative is damaging and unhelpful, and we urge the Review to seek to re-set the prevailing narrative and celebrate the impact that excellent supports have in the lives of people, families and communities***. That being said, there are significant aspects of the adult social care system that could be significantly improved.

The application of eligibility criteria based on urgency or criticality of need undermines the agenda for prevention & early intervention; moreover the focus is often purely on "*personal care*". This focus seems misaligned with Christie's principles of actively intervening before people's needs become critical. ***We urge the Review to explore the priority given to proactive preventative supports versus reactive crisis interventions.***

As noted, Carr Gomm supports people to live their lives safely and well today whilst making plans for tomorrow. We support young people in transition to adult services and looking ahead to life's opportunities and joy, people at the end of their life being supported to maximise their choices in their final moments, and everyone in-between. Whilst the language of statutory authorities can often reduce people to "*lots*", "*client groups*" and "*packages*", we see everyone as a unique person with their own strengths, desires and opinions. The language of adult social care speaks to the importance of registration definitions, lists of practitioner tasks, service specifications and contract conditions, but in our experience people and families are more interested in the supportive relationships that we develop. It can often feel as if we are acting as a translator: supporting people to interpret and understand how they navigate 'the social care system' rather than simply supporting them to retain or regain control of their own lives so that they can make their own decisions, live the life they choose and look forward to a better future.

The prevailing view of adult social care in the mainstream media (and possibly within a significant minority of the public) can often be simplistic and reductive, focussing significantly on care homes for older people. We support people and communities to be the best they can be: appreciating that some people and families face tremendous challenges in life, and we provide a skilled and qualified workforce to help people meet these challenges and thereby live the life they choose.

We have excellent legislation and frameworks – including SDS legislation, the Carers Act, guidance for social care commissioning and the Health & Social Care Standards, all of which are built upon a sound value base. Many problems exist in the implementation of these papers, rather than the intent behind them; indeed the guidance on procurement seems oft ignored and rarely a reality; one's experience of SDS as a citizen in Scotland will depend greatly on where

[1] https://bmjopen.bmj.com/content/bmjopen/9/2/e022975.full.pdf

one lives. ***We suggest that the Review considers*** **why** ***SDS has not been implemented and integrated into the mainstream as imagined.***

The Health & Social Care Standards – developed and published based on the views of people and families who access social care – should always be the starting point for understanding high quality; but we must respect that individual people will have different expectations and definitions of what high quality support looks like to them.

What is high quality social care? Care Inspectorate gradings are inconsistent – both geographically and temporally. There is limited publically available information about what difference exists between a good, a very good and an excellent service. ***The move towards a greater partnership approach to improvement in inspections is welcome, but could be further improved by a transparent framework to support the professional grading judgements made by individual inspectors.***

Has Health & Social Care integration improved the quality of social care for anyone? Our experience is that decisions made in Health generally do not consider how they impact in social care (and vice versa). We see and experience this every day, for example why is the Chief Social Worker never seen alongside the Chief Medical Officer or Chief Nurse at the First Minister's daily COVID briefings? ***The Review should consider the impact of Integration in the lives of people, families and communities, and whether this has been maximised.***

## Needs, rights and preferences of people using social care services and supports

Not-for-profit providers incorporate needs, rights and preferences into their routine operations via policies, procedures, training and supervision of staff. Involvement, person-centred working, a values-based ethos and personal outcomes are embedded and systematised, and hence contribute to the high-quality social care more likely to be experienced in the not-for-profit sector.

In our opinion, many strategic decisions are made because of budgets and the availability of resources, and not as a result of people's needs, rights and preferences. We see lip-service being paid to person-centred approaches and personal outcomes: it is now endemic language in tenders and contracts, but it is not always a routine experience for people experiencing health or social work systems. For example, the large-scale removal of sleepovers was as a direct result of legal clarification regarding a worker's right to be paid an hourly rate of pay resulting in increased costs to providers and hence to commissioning authorities. This large-scale change was not because of people changing their preferences and was not always aligned with people's needs and rights: were people without family, advocates or vocal not-for-profit providers disproportionately impacted?

Many changes in the Scottish Living Wage (SLW), and hence increases in hourly rates of income for providers, are linked to reductions in people's support

packages: this annual, expected, known change in cost risks negatively and disproportionately impacting on those with the smallest voice.

Related to this, not-for-profit providers, like Carr Gomm, are strong advocates of people's rights and determinedly promote independent advocacy. We never experience a commercial conflict as some for-profit providers may do. If people's needs, rights and preferences were truly embedded in 'the system' then perhaps we wouldn't worry about this. ***We would encourage the Review to consider how best to support, expand and strengthen independent advocacy and to consider how best people's rights can be simplified and embedded within the system (perhaps in a Bill of Rights?).***

Is the right to self-directed support embedded in commissioning and a reality for people and families? This is not our experience, and speaks to the reality of power in commissioning of adult social care. ***We would encourage the Review to consider how best to make SDS a practical reality in people's lives.***

The model of shared living services is generally economically viable, but does it align with contemporary needs, rights and preferences? In the era of large-scale hospital closures, many people were accustomed to sharing their living space with others, but nowadays, especially for younger people moving out of a familial home, they will not have had this prior experience. It is challenging to meet everyone's individual preferences in shared settings and resources are limited, but in no other sphere of society do we expect people to move in with strangers with very little or no choice on who they share with or where they live.

For many people with more complex ill-health or impairments, appropriate housing is a key component of life and yet housing is often the departmental outsider not always included within health and social care conversations. ***We would encourage the Review to consider how best to systematically include housing professionals, as their involvement is fundamental to finding good solutions for many people, and these colleagues are currently not within the scope of health and social care integration.***

## The experience of staff working in the social care sector

Staff experience generally begins with a recruitment process. In many communities, providers are competing for staff with other providers and other sectors, including tourism, hospitality and other perceived 'low-skilled' roles. Depending on the candidate, social care can often appear to be a sector in crisis and so the role may not appear attractive; we know from candidates that prior experience of working in the sector or having direct experience of the impact of the sector ensures a more positive view of potential employment in the sector than those only exposed to the skewed crises portrayed by the media and political speakers (and often the sector itself). Providers struggle to recruit in some job markets against other sectors.

> *"Why should I work in social care when it is easier to work in the supermarket and I can earn more?"*

***We urge the Review to reflect on the reputation of the sector and the often harmful portrayal of a sector in crisis.***

Assuming a candidate is interested in a role in social care, statutory providers recruit in the same job markets and operate alongside other providers doing the same work. Terms and conditions within the statutory sector are significantly better – both wage and benefits – than not-for-profit providers; with providers operating within an income structure that is strongly influenced (by competitive tendering and framework agreements) or stipulated (set within a tender) by the commissioner. Commissioners create and enforce an unequal job market. Providers struggle to recruit given the contractual environment created and managed by statutory commissioners who are also providers.

> *"Why should I work for a provider when I can earn more doing the same job at the council?"*

***The strongly urge the Review to consider the 'two-tier' model of social care in which workers are remunerated very differently depending solely on whether the employer is a statutory body or not.***

Assuming a candidate is interested in a role in social care and chooses to work for a not-for-profit provider, they are committing to registering as a social care professional, gaining a vocational qualification, working alongside and for the most vulnerable citizens in society and making a significant impact in the lives of people, families and communities. It is an excellent role, although sadly has limited career prospects. It is a valuable role that, until COVID, has not been valued by society; and even since COVID is often misunderstood (both by society and politicians).

> *"I'm so glad that I chose to work in social care as I contribute to people living their best life possible."*

In our experience, colleagues enjoy their work and are deeply committed to having a positive impact in people's lives. ***We would encourage the Review to accurately reflect the commitment and impact of social care workers, and consider how best to recognise this in national awareness-raising, status, esteem and reward.***

Beyond recruitment, workers should be receiving a detailed induction prior to supporting anyone. This is a balance of learning theory (values-based approaches, person-centred working, moving and handling, first aid, etc) and shadowing more experienced workers to apply this theory in practice. Induction is a critical time and yet it is not sufficiently valued within hourly rates to ensure that it is systematically delivered (to be considered later), nor does the flexibility exist within contracts to have sufficient time to induct colleagues as we would wish given the demands from commissioners to accept a new referral or expedite someone's hospital discharge. The same principles apply to continual professional development: this is essential but is under-valued in income rates and challenging to deliver given the staff structures imposed by framework contracts.

*"I had arranged training for the worker and she was keenly looking forward to it, but then an urgent referral came in and I was under pressure from the social worker, so I had to pull her off the training. There is no wiggle room in a framework contract."*

For a worker to attend training there must be another worker able to replace them on the rota; the same is true for annual leave or even non-working days. In theory, all income rates are sufficient to cover such normal events but in practice training is cancelled because another colleague is unwell; a worker has sudden caring responsibilities and so another colleague is called in on their day off to cover; the manager works a shift to enable a colleague to provide urgent care for a relative. Life happens but hourly income rates and framework contracts assume perfection. There is no flexibility on a rota because there is no spare income to pay for extra staff. Workers and managers do an incredible job and should be applauded and rewarded, but instead our commissioning approach (via hourly rates and framework agreements) often means that services lose money and become financially unviable. ***We encourage the Review to consider how best to support excellent employers, like Carr Gomm, to continue nurturing and developing our staff to be the best that they can be, and to consider the negative consequences (workforce planning, flexibility and stability) of framework contracts and competitive tendering.***

Not-for-profit providers emphasise culture, values and ethics through recruitment, induction and continual professional development. This should be respected, emphasised and used by the wider Health & Social Care world. This is a skilled profession. Alas, it is often not valued as a skilled profession and this is most evident in the remuneration available for workers, managers and administrators. ***We believe that pay should be linked to the value of the role in society and the skill required (including professional registration and qualification), and not to whether the employer is a public body or not-for-profit provider; and urge the Review to reflect on this inequity.***

All staff working in social care roles should have the opportunity to develop a career in social care, perhaps specialising in dementia care or supporting people with a complex brain injury or the most complex mental illnesses. This is possible for a tiny minority: those that choose to become managers or administrators or those that choose to leave provider organisations to become social workers or health workers. It should be systematically possible for workers to develop and progress (and be appropriately rewarded) in their career as specialist practitioners, skilled to support people with complex support needs, valued for their exceptional personal competencies (as per the SSSC continuous learning framework[2]) and abilities to work as equals alongside partners from the NHS, local authority and beyond. Current commissioning and contracting protocols ensure that workers can only ever be paid close to the Scottish Living Wage and so career progression and planning is systematically impossible. ***We strongly encourage the Review to support the potential for specialist practitioners to be recognised and rewarded.***

[2] https://lms.learn.sssc.uk.com/pluginfile.php/64/mod_resource/content/1/clf.pdf

Support Practitioners are highly regulated professional workers with vocational qualifications and amongst the best personal competencies in society. We should be investing in the sector to make it attractive, investing in workers at the beginning and throughout their career as they develop their skills and expertise. In what other sector – working with the most vulnerable in society – do we consider regulation, professional qualification and registration, and continual professional development to not be worthy of career opportunity and commensurate remuneration.

Health & social care partnerships and local authorities rarely support providers to implement all of the dimensions of Fair Work – particularly pay, terms & conditions – that they implement themselves, as employers of their own staff. This is unjust, inequitable and indefensible in the context of a national approach to Fair Work and to professional registration, qualifications, standards and conduct. ***We would encourage the review to seek to dismantle the "two-tier" workforce and ensure parity of status, esteem and reward across all sectors.***

## Regulation, scrutiny and improvement of social care

Whilst there are excellent (and poor) providers in every sector, not-for-profit providers are consistently awarded the highest proportion of "*very good*" and "*excellent*" Care Inspectorate gradings[3]. ***We would encourage the review to consider how best to capture learning from the not-for-profit sector's record of high quality, and use it to inform improvement initiatives across all sectors.***

In our experience, it can often feel like scrutiny-overload; disproportionate to the quality of care and support provision and with risk assessments of providers. As well as the Care Inspectorate, providers are responsible to different sets of requirements from commissioners, and sometimes the expectations are misaligned or duplicated, leading to significant inefficiency. ***We would encourage the Review to seek to streamline scrutiny by clarifying expectations of different regulatory and commissioning bodies, perhaps by developing a publically-available mapping demonstrating what is being considered by whom and for what reason.***

Similarly, in our experience, inspectors have tended to assume that our services operate (and hence are inspected) in a vacuum rather than as part of a wider adult social care environment: care at home services for older people are a prime example, with inspectors unrealistically comparing these with 24-hr supported living services, when the environment (including commissioning and resourcing) can often be very different. We would support a more robust critical challenge in other areas including assessment processes, resource allocation and commissioning & procurement. ***We would encourage the review to revisit, extend and strengthen both the scope and the powers of scrutiny bodies throughout the whole environment.***

[3] https://bmjopen.bmj.com/content/bmjopen/9/2/e022975.full.pdf

## Human rights and ethics in social care

We would advocate that this should be human rights, ethics and person-centred values. This would speak to how human rights are embedded and put into practice rather than being merely transactional items that can be ticked off a checklist.

There is a significant question here – exacerbated by COVID – about the access people have to everyday services, systems and normal housing, including state benefits and banking services. ***There are fundamental rights issues in people being digitally and financially excluded from the mainstream and we would urge the Review to consider this.***

All social care services operate within communities, therefore there is a wider responsibility on communities to be understanding and inclusive, and community development work plays a key role in ensuring this; community development is often underfunded, or more likely, not funded, and so relies on grant-funding and community fundraising rather than statutory contracted income. ***The Review should consider to what extent community development approaches – aligned to Christie's view of preventative interventions – should be part of the adult social care environment.***

A 'Human Rights Based Approach' is now frequently stated and used, but this is often not explained to people accessing social care and their families by commissioners or social workers. Moreover, there is a key challenge in seeking to balance individual human rights in circumstances of specific orders, capacity challenges, or where respecting one person's human rights will have a negative impact on another's.

The Care Inspectorate has played a positive role in improving the focus on rights, as have the Health and Social Care Standards.

If the right exists for everyone to have "*the highest attainable standard of physical and mental health*", there is a risk that limited social care funding denies this right. Social care support is a human rights issue: without social care, people with support needs may be unable to access or exercise their human rights (e.g. to work, to family life, to freedom of movement, to democracy). ***We would encourage the Review to ensure that any future social care system is aligned with relevant UN Conventions (including UNCRC and UNCRPD).***

## Commissioning and procurement

There is no consistent approach to commissioning and procurement within a Health and Social Care Partnership, let alone between them. Despite the clarity and helpfulness of social care commissioning legislation and guidance, the implementation in reality remains determinedly fixed on competitive tendering. There are negative consequences for people supported, families, communities, workers and providers as a result of routine and cyclical competitive tendering and re-tendering.

Generally speaking, services are commissioned individually and according to that person's "*life and limb*" requirements in line with local eligibility criteria. Commissioners are required to attain "*best value*" and are expected to administer a "*market*". Carr Gomm is not aware of any body of evidence that documents the benefits or positive outcomes of competitive tendering and re-tendering, or any evidence that "*best value*" is achieved through these processes. ***We would encourage the Review to consider the evidence underpinning these standard approaches, and potentially consider a radical overhaul of existing assumptions.***

In theory, commissioning services individually speaks to the importance of person-centred approaches and personal outcomes. In our experience, too few contemporary referrals' systems embed person-centred approaches or seek to understand what really matters to each person.

Surprisingly, individual commissioning assumes that everyone's domestic arrangement is geographically equivalent (that is, there are no distinguishing barriers or costs to living in different households in different parts of a community) and agnostic to community assets and services. When people's individual assets are considered, this can often be in an attempt to reduce or minimise any commissioned service.

Framework agreements are now the contemporary contractual mechanism for administering individual services: these are thought to deliver "*best value*" for the purchaser through a competitive tender process. Commissioning via framework agreements is non-optimal and in many circumstances is failing for all stakeholders. (We are not aware of examples in which framework contracts are operating optimally.) In our view, many procurement teams don't understand or choose not to understand the actual cost of providing support within a framework contract, assuming instead that the 'market' will set the price: this is often worst within care at home services for older people. Within other models of service, including block-funded mental health outreach, commissioners clearly understand the opportunities, risks and costs of operation and offer positive support. ***The Review should consider whether all adult social care services are commissioned, procured and resourced equally.***

Carr Gomm has repeatedly attempted to engage and explain the nuances and complexities of the costs of operation but have thus far failed to pique sufficient interest; instead hearing comments such as "*paying workers for travel time is an employer's choice and not a commissioner's responsibility*". This is factually incorrect; employment law is clear that travel time must be paid. But it is also morally vacuous as no purchaser would ever consider not paying its own staff to travel to business appointments: can we imagine the outcry if we advise community midwives or district nurses that they will only be paid when they are in someone's home and not in-between times? As noted above, there is a significant disconnection between the operational reality of framework contracts for providers and operational terms for in-house services. ***We would strongly urge the Review to consider the two-tier contractual arrangements between commissioned and in-house services, and the complex nuance***

***involved in providing different models of service in different locations to different people.***

**Worked Example**

Our experience is that adults living in their own home will generally be assessed as requiring multiple supports per day or week for periods of time (from 15 minutes to a couple of hours), with a total of 10hrs/person/wk being reasonably typical. Using the UK Homecare Association Minimum Price for Homecare[4] as a benchmark (and stressing that no commissioner uses this as it is considered an excessive and unrealistically high price), consider what that support money pays for each hour (£21.99):

- 1hr of direct support with the worker earning SLW (£9.30/hr)
- Statutory minimum employment benefits, including minimum pension contribution of 3%
- 1.73% contribution to paying a day's training time
- 2.90% contribution to paying a day's sick pay
- £2.92 towards management time
- £0.11 towards paying for PPE
- £0.24 towards overhead costs
- £0.24 contribution to recruiting new workers
- £0.21 contribution towards paying for statutory regulation fees

Before going on, consider the assumptions within this model in COVID times: £0.11 income per hour of work for PPE costs, and that hour of work could include visits to multiple people. This starkly illustrates the flaws in pricing per hour and assuming that on average the costs will work out.

All framework agreements pay on an individual basis and hence do not financially facilitate any flexibility: no provider can afford to have 'extra' staff to respond to urgent referrals; no provider can afford to deviate from strict shift patterns minimising travel time and cost; no provider can afford to pay the financial penalties that arise for being late (having stayed longer with the last person because they were unwell and awaiting an ambulance, say); no provider can afford to develop a staffing structure that provides back-up to the manager. No provider can afford to reasonably mitigate the known risks of operating a high-quality service in a dynamic environment. Providers cannot sufficiently mitigate the financial costs of any of these scenarios as a direct result of the structure of a framework contract.

By definition, framework agreements are volatile because individual people's lives are complex: new people are referred in to the service, people stop receiving a service, and people want to change their service for many reasons. Such volatility is expected in life; flexibility is expected of every provider by every commissioner, but framework contracts systematically remove the means to be flexible from providers.

[4] https://www.ukhca.co.uk/downloads.aspx?ID=434

A new referral is received but the provider has no excess staff, as to do so means losing significant money prior to the referral: using the UKHCA algorithm, a provider would incur losses of at least £12.62/hr (SLW wage plus minimum on-costs) each hour from income of £21.99.

If someone stops receiving support – perhaps someone passes away or recovers from mental ill health – then the income for their individual service stops and immediately the provider is incurring a staff cost for the worker that had previously provided that service without commensurate income.

If someone has family visiting and so cancels their support in advance then no income is received and the provider incurs a financial loss; or if the person requests to change their support time to align with their personal circumstances, for example a medical appointment, then the provider faces asking other people to change their support times to fit someone else, and potentially incurring a financial loss, because support visits and travel distances/times must then be moved away from the most efficient plan.

No commissioner pays a rate based on the UKHCA's £21.99 to cater for the *minimum* price of a homecare service, therefore the examples provided here are overly optimistic.

***We would strongly encourage the Review to consider the structural competence of framework contracts and whether they contribute to delivering positive outcomes for people, providers and commissioners.***

Framework agreements do not facilitate flexibility. People are not islands within a community but part of that community. Purchasers should be commissioning person-centred services for individuals and communities that deliver personal outcomes. If there was a team of workers embedded in a community with the flexibility to respond to the complexities and dynamism of life, then everyone would be better off; this is especially true for care at home services for older people. With flexibility being systematically purchased for a community, the provider could respond and react immediately but could also reach out and deliver preventative supports when that flexibility is not required: flexible and preventative by design.

**Case Example of what is possible**
Hypothetical analysis demonstrates that a community requires an average of 500 hours of support per week, although this varies from about 475 to 550hrs/wk. The commissioner chooses to buy 600 hours of community supports per week (regardless of individual demand) and this ensures a sufficient staff presence such that all referrals are accepted; all hospital discharges are accommodated (and there is scope for hospital in-reach and practical support home from hospital); there is flexibility to support people when they want their support, even if this changes; there is proactive preventative outreach to keep community members considered

'at-risk' by their GP healthy and well, and to prevent crises as far as possible.

By moving away from a framework contract, this example has created a systematically flexible community service that can provide a far better service to each individual.

Moreover, framework agreements mandate multiple providers regardless of local environmental limitations: it seems futile to insist on having multiple providers in a small town to create the illusion of 'choice' when none of those providers are viable as a direct result of the framework mechanism: this is a false choice. Carr Gomm has historically withdrawn from contracts in which statutory market management has prevented provider viability, for example in Pitlochry: a small rural town with an ageing population, a small and reducing workforce, and a seasonal tourist trade that offers far higher wages. This would seem to be the ideal environment to create a flexible community-based service rather than continually enforcing the ideology of a 'market' when the overwhelming evidence is that this does not work: Pitlochry had multiple providers and none of them were viable!

Finally, framework contracts shifts risk from purchasers to providers (and thereafter from unscrupulous providers to employees, for example via zero hour contracts, unpaid training or travel time, or asking workers to buy their own uniforms). This risk-shifting is unfair, inequitable and again highlights the fundamental mismatch between commissioned and in-house services.

There is nothing that creates more of an uneven 'market' than when the purchaser is also a provider. No provider can compete against an in-house service: in terms of recruiting staff to worse terms and conditions; in terms of operating within a budget set by the purchaser; in terms of having equal access to referrals; in terms of having any influence over minimising travel times and distances? This is not a market, but a skewed monopsony. ***We strongly urge the Review to consider whether society benefits from this skewed two-tier system.***

SDS is a form of individual commissioning and many commissioners use the same or equivalent, contractual frameworks or approved provider lists, and hence achieve many of the same adverse results. The person assessed as requiring 100hrs/wk can have their choice of provider whereas the person assessed as requiring daily visits totalling 3hrs/wk will struggle to find any provider financially able to deliver this service; this issue is significantly worse in rural areas. In such cases, SDS does not offer choice and control; instead it peddles a falsehood inevitably leading to disappointment, frustration and despair. This may initially have been an unforeseeable and unintended consequence of SDS but it is now routine and normalised, and a direct result of the contractual mechanisms in place creating financial risk, uncertainty and inflexibility.

Competitive tendering and re-tendering is the norm, despite Scottish Government guidance and any notion of what people and families want. Carr Gomm was involved in a collaborative 'test-of-change' initiative with Dundee

Health & Social Care Partnership and all incumbent providers in Dundee: we worked together to commission about 20 services supporting over one hundred people to move out of long-stay hospital and into new build housing with support. Existing contractual mechanisms were adapted and extended, so there was no tendering and no competition; instead, we focussed on values-based principles, collaboration, relationships, and a single-minded focus to have an optimal impact in the lives of individual people and families. ***We would urge the Review to use this Dundee experience as an example of collaborative commissioning in action.***

## Finance

As noted above, the way money is spent through framework contracts actively ensures inflexibility. Moreover, it actively excludes creativity, development and innovation because there is no time for anyone to invest in research, testing and redesign. We are literally at the financial bottom of what is possible!

Moreover, one local authority that we work with continues to clawback any savings that any provider has made at year-end, thereby removing any incentive from providers to be efficient. This is an active step to remove provider sustainability and stability, and then potentially also creativity, innovation and community development, adding value to the lives of people, families and communities.

The cost of in-house social care services delivered by Health and Social Care Partnerships is not well known, but is significantly more than the price paid to not-for profit providers. ***To facilitate real choice for people – and indeed to generate public debate – we urge the Review to publish and share widely a cost comparison across all services in Scotland, including an analysis of spend in terms of volume, efficiency and outcomes achieved, by sector, as well as addressing the matter of overall funding levels.***

At the beginning of November every year, the Living Wage Foundation announces the new Scottish Living Wage. Every year since the Scottish Government announced that social care professionals would be paid at least the SLW, it has taken Carr Gomm at least twelve months to agree settlements with purchasers and receive backdated payments. SLW is no longer a surprise; this is now normal. And yet every year, without fail – even this year, with 3.3% announced by the Scottish Government in early April – there has been a significant time delay, administrative complexity, uncertainty and debate surrounding SLW agreements. ***We would encourage the Review to consider whether this uplift process could systematically occur between November (SLW uplift announcement by the Living Wage Foundation) and March – as commissioners in Falkirk and Glasgow manage to do – rather than between April and October as many others do.***

In some scenarios, commissioners have concluded that reducing people's support package is the only way they can "*afford*" to provide a SLW uplift. This is not done secretly: it is expressed in public briefings about how framework contracts will operate, and how providers are expected to deliver "*efficiency savings*" across people's packages of care and support. There is a clear

mismatch here between responsibilities of commissioners, expectations of providers and the human rights of individuals receiving support.

Accountability, transparency and equity are key financial issues for not-for-profit providers. As noted, there are significant problems with the current 'two-tier' system in which 'in-house' care & support is routinely funded more generously than commissioned support; and there are major problems with the absence of any effective ring-fencing of resources or monitoring of spend. This is very starkly revealed by the huge difficulties that Carr Gomm – and other not-for-profit providers – have experienced in accessing the money allocated by Government to public bodies to support additional social care spend arising from Covid-19. In general, third sector finances are minutely scrutinised whilst comparatively little independent scrutiny is applied to public expenditure on social care. ***We would encourage the review to address these issues as a matter of urgency: every citizen, regardless of who provides their care & support, ought to be confident that the same financial rules and standards apply to all organisations in all sectors.***

Similar to the processes of SLW uplifts and Covid-19 reimbursement, the process for purchasers paying invoices can often be administratively complex leading to significant risk for providers, and again this does not contribute to a feeling of partnership working or even joined-up systems. It is common for a social worker to agree to a change in someone's service, for the provider to make appropriate operational changes and adapt invoicing accordingly, only for the purchaser's finance team to refuse to pay the new invoice as their system has not been updated. No payment is made for a service that has been delivered – often preventing a crisis in someone's life – and the provider must then seek to tread a safe path through a bureaucratic minefield to try and recoup their rightful income. As noted above, this is a particularly acute problem within framework contracts. Similar challenges arise regarding new referrals, admissions or discharges from hospital, variations in services as people's lives change, and services ending: all thoroughly expected and predictable scenarios within adult social care and yet seemingly always a surprise and complication for commissioners' finance teams. ***We would urge the Review to consider ways that standard operating systems between partners can be simplified and streamlined to be maximally efficient and resource light.***

## Potential national aspects of a social care system

Given the mixed economy of service provision and the Integration agenda, should this be entitled potential national aspects of a health and social care system? Immediately, Carr Gomm would then propose that the Review considers a review of the roles, responsibilities and remuneration across the wider health and social care environment, including social work assistants, nurses and adult social care workers, and similarly of managers of these teams of workers. Such a wide-ranging exercise may lead to greater regard and respect being paid to social care workers, and to the promotion of professionalism of the role and sector. ***We would urge the Review to undertake this comparison of roles, responsibilities and remuneration.***

Given that the highest quality social care is more likely to be experienced in the not-for-profit sector, than in the for-profit or public sectors, it would seem wise to invest more in learning how this set of values-based providers consistently delivers better whilst being paid less (than the public sector). And as a result of this learning, invest greater focus and more resources in utilising this sector, whilst removing profit and reducing inefficiency from the sector.

Social workers are key drivers of people's experience of social care but SDS input to their training is negligible. ***If SDS is the new normal in social care, then the Review should consider whether this becomes the cornerstone of all social work training. Moreover, all social work trainees would benefit from spending extended periods of time working alongside provider organisations as a requirement of their qualification.***

A significant progressive step would be to increase the transparency in the whole system, especially the costs of in-house services, the costs of commissioning and procurement, and the costs of regulation and inspection.

Further aspects of a National Care Service that have the potential to make a positive impact, include:

- The development of a Bill of Rights to simplify and rationalise the rights that people accessing social care support have, and related to this, stronger involvement of independent advocacy (especially relating to long-standing changes to support, for example the removal of sleepovers);
- Leadership from Government and COSLA to operationalise the existing social care commissioning and procurement guidance and hence move away from framework contracts, competitive tendering and re-tendering, and the requirement for all stakeholders to invest scarce resources in the contractual administration of these processes;
- National guidance on payment for travel time and consideration of how this is commissioned within diverse communities (rather than based on an average time/cost per person);
- National expectations regarding Fair Work, regardless of employer;
- A training bursary for new workers recruited into social care;
- The systematic inclusion of housing teams and housing planners within Integrated Joint Boards to facilitate appropriate options for people with specific accommodation requirements relating to their support;
- A simple national process for awarding and administering Scottish Living Wage uplifts;
- A flexible mechanism that facilitates community commissioning (rather than individual commissioning);
- Leadership from Government, NHS and COSLA to consider hospital capacity and short-notice discharge as whole system challenges requiring coordination and teamwork (and potentially community commissioning) rather than simplistically as a health problem that social work must 'fix'.

Thank you for reading this submission. Carr Gomm would be pleased to discuss any aspect of this submission with the Review Chair, panel and secretariat, in whatever way would be most convenient.