Carr Gomm's response to the Scottish Parliament Post Legislative Scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013- December 2023

Carr Gomm is a leading social care charity supporting people and communities across Scotland. Our approaches are delivered by people who share Carr Gomm's values and are well-trained and supported to fulfill their roles.

The Social Care (Self-directed Support) (Scotland) Act 2013 (the SDS legislation), has failed for several key reasons. For example, the changes desired by the Act to bring about transformation to how people access social care and support and the application of the rights, Values and Principles of SDS have not materialised. Carr Gomm senior leaders reflected on the reasons and these have been summarised under the following key areas:

1. Our voice and position as a third sector provider.
2. A whole system view and the importance of key policy areas and legislation linking up.
3. Ethical, strategic commissioning as a method of ensuring appropriate social care is in place for people and communities.
4. The need for social work colleagues, commissioners and social care workers to be properly resourced to make wise decisions.

1. Our voice and position as a third sector provider.

We take our ability to influence change seriously; to help improve the lives of the people we support and the communities we are invited to work with. In addition, we collaborate with partners to share our experiences and to influence both local and national policy and legislative direction.

As a professional, well-established organisation, our desire is to work as equals with partners. This is not always our experience in practice, especially around procurement mechanisms, which will be explored further in the paper. Our significant experience of supporting people and families *should* be actively sought out by commissioners and SDS Leads within HSCPs. Alas, it feels increasingly common that HSCPs and public bodies *talk* about collaborative working and co-production, but then *act* in isolation by choosing not to engage with provider organisations. The experienced voices of good providers should be part of finding good solutions as an equal partner.

2. A whole system view and the importance of key policy areas and legislation linking up.

The SDS legislation, underpinned by human rights approaches, was meant to be a significant 'game-changer' in improving access to quality social care and support. However, our experience is that the legislation has not achieved the transformation supported people and those helping them desired. Our reflections are:

- The success of SDS has fallen short because we have not had an effective national leadership approach to ensure consistency across Scotland. Implementation of the SDS legislation has been piecemeal and inconsistent. We currently have at least thirty-two different approaches to implementation, as each local authority has taken its own course.
- People were able to access person-centred approaches; the assistance to be involved in decisions about their support, to shape their plans and to direct payments prior to the SDS legislation. It is our opinion that the legislation has not enhanced these approaches and that we do not see material change to approaches of good support provision because of the legislation.
- It is our experience that people often do not get a choice of Option but are 'shoe-horned' into an arrangement that fits the availability of services locally: oftentimes people are given Option 1 or Option 3, not because it is their choice, but because it is the commissioner's choice.

For example, when people want to choose or accept Option 3, there is not then a concomitant choice of provider- people must accept what they are given. In rural, remote and island communities and, increasingly in our urban areas, access to support via a registered support provider is not adequate or available to everyone and people therefore have no choice but to accept Option 1. We have concerns over the large-scale application of Option 1 for people who do not choose it and/or do not have capability or resources to manage the responsibilities.

- The significant change in the SDS legislation was the addition of Option 2. This development has been poorly implemented and very few people across Scotland access their support via Option 2. In our experience, there is evidence that Option 2 has been used to suit local authorities to fill gaps when commissioned services have not been available- these arrangements are not in place as a direct result of choice exercised by the supported person. How the finances associated with Option 2 are managed is also inconsistent and is not transparent across the country.
- Partners and in particular, local authorities need to get better at how we record information about SDS. We question the current accuracy of SDS information from local authorities and this limits our collective ability to make accurate plans and subsequent improvements.
- SDS has been described by Scottish Government as 'the way we do social care in Scotland.' However, in terms of whole system change effort, training on the rights, principles, and mechanisms of SDS has been inconsistent and is limited for social work students, those new to social care careers and established workers.
- Time needs to be taken to learn about the barriers to successful delivery of Scottish policy by stopping, noticing, learning and adjusting practice accordingly. Adding new policy and legislation does not bring about change in practice without a robust and workable implementation plan. For example, the Christie Report (2011) has not realised its ambitions for health and social care. This was followed by the SDS legislation - have we taken time to explore why each of these key policy changes have failed before adding further layers of new law, for example the National Care Service Bill?

- The SDS legislation has not been updated to consider the implications of changes in society, for example austerity and the reduction in the availability of public services, including social care coupled with local authorities' requirements to balance their finances.

3. The need for ethical, strategic commissioning as a method of ensuring appropriate social care for people and communities

Good results are in place when ethical, strategic commissioning approaches are used. For example, the work coordinated by Dundee City Council and registered social care providers has resulted in increased and honest collaboration between partners. The culture that has developed has enabled all partners to work equally and honestly about the successes and challenges faced and to find solutions as a collective. This contrasts with competitive tendering where organisations are put up against each other, damaging the possibilities of future trusting relationships: sadly, the principles social care policies are routinely trumped by the market priorities of social care procurement.

At Carr Gomm, we would like to see ethical commissioning principles being adopted by all local authorities and their social care partners to enable strategic planning and delivery of social care and allied services based on the needs of any given community. This is contrary to current common practice whereby the majority of local authorities continue to procure based on the seriously flawed neo-liberal assumptions that the market will produce optimal results. In turn, this also has the potential of improving partnership working as trust is developed between parties as they are working together rather than against each other through competitive mechanisms to secure services.

4. The need for social work colleagues, commissioners, and social care workers to be properly resourced to make wise decisions.

Public sector workers, with a responsibility for delivering SDS, in addition to adequate training, need the resources and relationships to conduct their functions. The SDS Standards, have provided a good framework to support,

for example, ‘worker autonomy’ and ‘transparency of budgets.’ These standards are yet to be effectively implemented and for their ambition to become a reality. A good starting point would be to see improvements in the connections between commissioners, social workers, and finance teams alongside improvements in collaborative approaches with provider and community partners. Trusting and respectful relationships are at the heart of good collaboration and these need to be established between cross-sector partners to ensure that SDS can bring about the transformative change people were and, continue to be promised.

Conclusion

The changes desired by supported people have not been fully realised by the SDS legislation and Carr Gomm would welcome further opportunities to share our evidence and suggestions for improvement.

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