Caring For All

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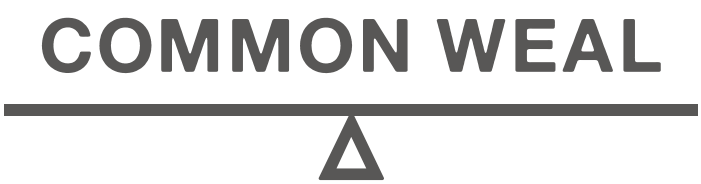
CARING FOR ALL:
A NATIONAL CARE SERVICE FOR SCOTLAND



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We would like to pay particular thanks to former members of the group, who made important contributions to our thinking but are not responsible for the final product: Carmen Simon, Des Loughney and Huw Lloyd Richards.

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KEY POINTS

— Care is the reciprocal, relationship-based underpinning of all of human society. The vast majority of care is informal or social, but sometimes social failure or acute conditions creates caring needs that cannot be met informally. The purpose of a National Care Service (NCS) should be to meet those needs.

— Creating a NCS will require significant investment but will have major social benefits and will, over time, help reduce the cost that the public sector pays to deal with social failures.

— The scale of unmet care is not well measured but it is very large – possibly as many as one in five people need care or support of some kind but about 85% of them receive no formal care at all.

— Care services are currently in a critical state and not fit for purpose – underfunded, rationed, fragmented, centralised, top-down and risk averse. Staff are undertrained and underpaid, morale is low and turnover high.

— The NCS should be built on a firm foundation of effective social work practice, but social work has had its budget slashed and has been broken up and fragmented.

— In Scotland care is driven not by what works but by what politicians think works, with no meaningful response from government to people's experience of the system or the academic study of what really works, and largely disregarding the knowledge and expertise of professionals.

— Care provision works when it is based on sustained, trusting relationships, is focussed on prevention rather than 'protection' and is about supporting people not enforcing rules. The top-down managerialism of the Scottish system means care professionals are not trusted to work together with people to work out what they need.

— Human rights is an important framework for care but is insufficient without adequate resources, a clear line of responsibility for ensuring rights are met and the effective relationships which enable care. Rights, Resources, Responsibilities and Relationships are 'the Four Rs' on which care should be built.

— This enables a set of fundamental guiding principles to be created:

Care must be universal and must always promote welfare;

Care must be easily accessible to prevent problems worsening;

Services should be built on relationships with minimum intervention and minimum bureaucracy;

Care should be based on a shared, collective agreement on needs and outcomes;

Independent living, within a network of interdependent relationships, should normally be the goal;

Provision should be public and free at the point of need;

The workforce must be valued and rewarded; and

Diversity and difference must be recognised – of care needs and of different communities

— Just as we recognise the difference between healthcare and 'public health' (the promotion of a society which reduces the need for medical intervention) so we need the concept of 'public care' – the promotion of what creates a caring society and which reduces the need for formal care.

— The vast majority of care is informal and we must support informal carers – there are about three quarters of a million informal carers in Scotland (not including a million parents with dependent children)

— For care needs not met by a 'public care' approach or through supporting informal carers we need a comprehensive, all-ages NCS 'from womb to tomb'

— The NCS will provide consistent care support from conception (where prospective parents will be given support and training if they want it) through to elderly care at the end of life – and anything in between, from addiction issues to incapacity to housing needs to psychological services

— The NCS must be easy to access. Just as, in most instances, the GP's surgery is the first port of call for people with health needs, so we must establish Local Care Hubs as the first port of call (and the organising centre) for care needs

— A Local Care Hub must be designed to minimise stigma – for example, accessible, there for all, co-located with other community services and facilities. This will be helped by creating the kind of long-term, consistent relationship people have with their GP practice.

— A Local Care Hub should bring together all sorts of care-related services such as Citizens' Advice Bureaux, local authority housing officers and credit union or community banking services

— There should also be a 24-hour national phone line for emergency care issues (like NHS 24) and emergency response services to people's houses

— People with problems which cannot be dealt with on the spot by the Local Care Hub would be referred on to other (specialist) services and those referrals would be primarily local.

— Care provision should be organised locally as local conditions and resources (housing, community infrastructure, childcare provision, schools) are central to successfully achieving good care outcomes – and are the responsibility of local government

— The NCS should therefore be delivered in communities, coordinated by the local authority but funded centrally to ensure accountability, and with a specific government minister at Cabinet level designated to carry responsibility. The responsibilities which would be carried out at the national level would be strategic; data collection, workforce planning, pay and conditions, procurement and so on.

— Staff need to be trusted and empowered, and bureaucracy minimised (such as the example of an English local authority which replaced a mountain of bureaucracy with the single simple sentence "Don't break the law; Don't blow the budget; Do no harm")

— 'Choice' is a badly-flawed means of deciding care provision, every bit as much as if the NHS was expected to deliver precisely what patients wanted without reference to a professional assessment of need. There will inevitably be compromises in care as resources will never be unlimited but the best way to manage this is for local teams to negotiate with local communities and those they deliver care to ('Ethical Commissioning') while recording unmet need to inform future care provision. These negotiations cannot be done centrally

— To make this work the two primary barriers to receiving care must be removed – eligibility criteria (used to 'ration' care) and charging (acting as a 'paywall' to care). It should be left to the judgement of care teams working with those with care needs to identify priorities where resources are limited

— For this to happen staff must be trained and paid at a level which enables them to take ethical decisions where care needs conflict and deliver a consistent, high-quality service. National collective bargaining is required to address pay issues, with trade unions driving negotiations, and proper training put in place for staff, both prior to starting work and then to support continued professional development.

— From there, staff must have sufficient time with each person they are caring for and the power to decide with them the best way to meet their care needs while assured that management is supporting them, not policing them

— A NCS must be a not-for-profit services exactly like the NHS. The profit motive works against all of the above.

— This can be achieved in three steps: letting any low-profit private and voluntary providers come in under the NCS, nationalising any community-based provision which isn't physical asset-based and gradually investing in more localised provision, signalling that for-profit commissioning will cease (this may involve some direct acquisition of property which is already being paid for from public budgets).

— Care and health are closely linked, but one is not a subset of the other – which is why the integration of health and care is failing, driven as it is by managerial interests. Each service has a different focus and different practices and so should be stand-alone; the role of managers is to ensure that frontline staff in each service can effectively 'talk to' the other (for example ensuring consistent IT approaches in both services)

— The regulation of care is a mess and needs serious reform. It must return to a focus on professional enhancement and development and not an assumption it is policing the actions of care workers. The two existing regulatory bodies should be amalgamated and sit inside the NCS at the national level. Much of the regulatory framework is in place to deal with the free market component of current care arrangements and so would become redundant.

— Instead, there should be a process of 'reflective practice' in which workers are supported by their peers and managers to ensure quality provision on a mutual basis – with the power of the regulator to intervene increased in the cases where reflective practice at the individual or service level fails

— While fully funding a new NCS will be challenging, the current level of resources make a real NCS impossible. As well as the additional £800m the Scottish Government has decided to invest in care the £1 billion of 'Barnett Consequentials' which are expected to come to Scotland as a result of the increase in National Insurance contributions is sufficient to make a very good start to the reforms we have outlined.

— This is the minimum of what it should be acceptable to call a 'National Care Service' and Scotland must not accept anything less than this level of ambition

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SCOTLAND - CARE IN NUMBERS

IN NEED OF CARE

43%
Proportion of children on the Child Protection Register involving parental substance misuse

787,000
People with mental health problems

57,300
"Problem" drugs users

90,000
People with dementia

26,349
People with a learning disability

14,200
Children in schools registered as having additional support needs

14,458
Number of looked after children

1,480
Children in residential care

4,697
Children in foster care

11,000
Drugs and alcohol addiction treatments in a three-month period

25,226
Open homelessness cases

27,571
Households classified as homeless

30,345
Homeless adults

11,804
Homeless children

28,400
Criminal justice social work reports in a year

THE DAMAGE OF POVERTY

X 18
Likelihood that the poorest will suffer a drug-related death

X 4
Likelihood that the poorest will suffer an alcohol-related death

X 3
Likelihood that the poorest will commit suicide

X2

Likelihood the poorest will die from Covid

25

Number of years early men in poverty will die

21

Number of years early women in poverty will die

210,000

Children living in absolute poverty

WHO CARES?

2 MILLION

People who give or receive care

1 IN 3

Proportion of adults who have significant caring responsibilities at any one time, not including dependent children

950,000

Number of parents living with dependent children

735,000

Average estimate of the number of informal carers

170,000

People who spend over 35 hours a week caring

155,330

Social care workforce (FTE)

£10.8 BILLION

Value of unpaid care

£2.8 BILLION

Local government net spend on adult social care

160,000

Turnover of carers each year

50 - 65

The peak age for caring

29,000

Young carers in Scotland looking after an adult

1 IN 10

Carer who is a friend or neighbour rather than a family member

1 IN 3

Carers who also have paid employment

85%

Social care workforce who are women

8%

Proportion of total employment which is care work

LIFE AS A CARER

£62

Main carers' benefit for a minimum of 35 hours of care

1 IN 3

Carers struggling to pay utility bills

47%

Carers who have been in debt

8 IN 10

Carers who say their health is worse because of caring

8,290

People who received a Direct Payment to organise their own services

HOME AND AWAY

29,317

Number of long stay residents in care homes for older people

2,567

Number of adults aged 18-65 living in long-stay care homes

48,800

Home care clients aged 65+

10%

Amount of care home fees that go in profits

Full details on all of these numbers can be found throughout the report

INTRODUCTION

The Scottish Government is currently developing proposals for a National Care Service. These are based around a premise that care is a commodity that can be claimed as a right and that it exists as a series of instrumental tasks to be undertaken by paid carers. Common Weal has developed an alternative set of proposals based on care being integral to human existence and that care needs are bound up with and met through relationships.

Our argument is that care matters as much as health and, because of that, needs its own parallel service, from the cradle to the grave (or 'from the womb to the tomb'). After the horrors of the pandemic, we believe Scotland should be creating a National Care Service (NCS) worthy of the name, not re-packaging the current failed system. This means creating an NCS for all, one from which anyone and everyone would have a right to help. *Caring For All* describes the why and how of the way we think such a service should work and the reforms needed to achieve this.

These proposals have been developed by Common Weal's Care Reform Group whose members have been thinking, talking and writing about care since the Covid-19 pandemic revealed the depth of the crisis in our care system last year. This paper is the product of more than 18 months of work – all voluntary – written in a way that we hope anyone can understand.

Caring For All is supported by a number of other papers which set out in more detail the justifications for what we say here and which are designed to give politicians, policy-makers, managers, trade unions, the organisations representing service users and carers and all the other stakeholders in the care system the sort of information they need to turn these proposals into reality. This means consideration of what care in all its complexities should be about; our thoughts about what is wrong with current policy; detailed analyses of how parts of the current system operate and what needs to change – and more. Some of these papers have been published and others will be published in due course. We are still working on some of the detail on the internal workings of the new service, but this report is about how a real National Care Service should look and feel and work with people.

Our hope is our proposals will inspire people across Scotland to start talking publicly about care – about needs, hopes and aspirations – and that they come to realise that, if we have the political will, we could make the NCS one of the pillars of a new welfare state, to sit alongside and complement the NHS.

PART 1

WHAT A NATIONAL CARE SERVICE NEEDS TO DO – AND WHY

THE MEANING OF CARE AND ITS SIGNIFICANCE

Our governments, UK as well as Scottish, have developed screeds of law and policy about the provision of care services[1] and subjected the sector to regular re-organisation* but without ever stepping back and properly considering what care is. The Scottish Government's *Independent Review of Adult Care Review* (IRASC)[2], on whose recommendations their recent proposals for a National Care Service are based, is a case in point. Before we design any National Care Service, we need to be clear what we are talking about[3].

The importance of care in our lives

Care permeates our lives as humans. At one level it's about being concerned and interested in the lives of other people. The common greetings 'how are you?' and 'take care' epitomise that daily concern. At another level it is about going a step further, helping and looking after others, often with the most intimate mental and physical aspects of their lives.

Care is the foundation on which all our lives are built. No baby would ever survive or child develop without it. Caring for children includes meeting physical needs, such as for food, but goes far beyond this, being essential to our mental and emotional development. The strength of the relationship between children and their care givers, particularly the primary care giver (what is called 'attachment' by professionals), is what enables the development of human connection, empathy and cognitive capacity. The nature of those attachments makes a huge difference to our life trajectories with almost all our early learning taking place through caring relationships.

Those relationships are, almost from the start, two-way so that parental care is itself nourished

** Audit Scotland provided a summary of the reforms aimed at integration health and social care 1999-2011. Other reforms affecting social work and social care in that period were the creation of eight Criminal Justice Authorities (2006), Adult Support and Protection Committees (2007) and of Alcohol and Drugs Partnerships (2009). Since 2011 we have seen the creation of statutory Integration Joint Boards for health and social care (2016) and the dissolution of Scotland's eight Criminal Justice Authorities and creation of Community Justice Scotland (2017).*

by the love of the child. It is that reciprocity which makes caring relationships work through all stages of life. Through care, humans learn how to form relationships and in turn, those relationships provide the basis for our ability to relate to and care for others, from opening a door for a stranger to looking after someone with a disability full-time. Care, normally provided through families and predominantly by women, is how society replicates itself. Without it, our society would collapse.

While most children gradually become more independent and learn to live outside the parenting relationship, care often continues to be given and received by parents, grandparents, children, siblings, friends and neighbours throughout life. Moreover, the need to be looked after, whether physically or mentally, can then re-occur at any point in our lives. This is most commonly due to old age but happens for many other reasons, such as recuperation after a serious accident or mental health crisis. Care is what helps people survive periods of incapacity or a bad patch.

At the other end of the spectrum, care in its broadest sense of showing concern for others, plays an important part in the daily life of otherwise 'independent' adults - in reality we are all interdependent. Much of this involves small things, showing others that we are concerned about them, whether this is giving up a seat to an elderly person on a bus or buying a small gift as a token of one's appreciation; or conversely, being shown such concern: the help offered by a neighbour or being thanked for what you have done at work. No-one can live in isolation. Care is therefore more than how society replicates itself, it's the social glue which holds society together on a day-to-day basis.

When care goes awry

But care, being about human relationships, is also complicated and involves tensions and an element of conflict. Everyone has off-days and periods of time when they are more likely to snap at people than treat them with care. How people deal with or avoid frustration, bereavement, boredom, irritating or challenging behaviour, anger, sadness helps determine how relationships evolve. Sometimes people argue most with those who are closest to them. This can have consequences: families squabble, neighbours fall out, relationships end. Caring for dependant people is also often physically and mentally draining. Most people who have been a parent or looked after an older person round the clock will have had feelings that they are about to snap. It is one of the stresses that results in those off-days.

The converse of all the good things about care is that it can also go very wrong. There are abusive relationships – indeed, some people are so damaged by their life experiences that they find it hard to care at all. Abusive relationships or the absence of caring relationships have many consequences and are a major cause of mental health problems, suicide and addiction (from prescribed medication, alcohol and gambling to illicit drugs)[4,5].

Our ability to care is also greatly affected by external factors, such as having sufficient space at home or having to earn an income, which can leave little time for caring or force people to move away from those most important to them.

Implications for a National Care Service

These complexities about caring relationships apply to everyone working in the social care sector and should permeate how staff work and how services are organised.Unless an NCS is based on an understanding of what care is about and how it can go wrong, government will keep driving us down wrong avenues. For example, the Scottish Government has committed to taking a 'human rights' approach to care without considering whose rights – the person in need, their family or the staff working with them – or what happens when those rights conflict or the state's obligations to vulnerable people who are unable to defend their rights. Prior to that, following the Independent Review for Children, the Scottish Government committed to taking a rather different relationship-based approach towards care for children through 'the Promise'. Specificially neither of these approaches considers responsibilities or resources, both of which are also integral to care.

The depiction of a National Care Service that follows is based on our understanding of what care in all its complexity should be about and the approach to 'the four Rs' - rights, responsibilities, relationships and resources - which needs to follow. A National Care Service needs to chime with people's everyday experiences of care, respond when support or practical help is needed and address the failings in our current systems.

THE FUNCTIONS OF A NATIONAL CARE SERVICE

A great deal of thought and research about care, its place in our society and how this should influence the provision of social work and social care services has been undertaken over the last thirty years*. The starting point for designing a National Care Service should be an appreciation that the different levels at which we care for each other interact and affect each other. For example, if a person feels cared for by their employers or receives a respite service, that may help them care for someone who is very dependent. Conversely, stresses at work and never getting a break can result in the breakdown of caring relationships. Because of the way care is interrelated a National Care Service needs to operate at three different levels and which could be expressed as three fundamental (legal) duties:

1. To promote a caring society;

2. To support those who provide care informally through caring relationships;

3. To provide care directly where this is needed.

PROMOTING A CARING SOCIETY

The need for a more caring society

While caring is intrinsic to human society, it needs to be nurtured and in extreme circumstances may be jettisoned in a fight for survival. There are recent instances of whole countries, Yugoslavia in the 1980s for example, where it took just a few months for people who had been formerly neighbours to be killing each other.

While this may be an extreme example, our economic system is constantly evolving in ways that undermine people's ability to care. People are forced to move away from their families or their local communities to look for work, required to work very long hours just to survive or work in conditions which affect their physical and mental health. The state helps reinforce this through our punitive benefits system. Poverty is the single most important factor impacting on people's need for and ability to care. In 2021, people in Scotland's most deprived communities were 18 times more likely to have a drug-related death, four times more likely to have an alcohol related death, three times more likely to commit suicide and twice as likely to die from Covid-19 while 'healthy life expectancy' for men is 25 years less, and for women 21 years less, than in the least deprived areas[6]. We all need care but some need it more than others.

The problem is not just the poverty itself, though the constraints and stresses of living hand-to-mouth are very real, but the impact this has on families and communities, the lack of social infrastructure in deprived areas and people not feeling cared for by society as a whole, as with the homeless person forced to beg on the street. Following the de-industrialisation of the 1980s, many people have now been disempowered to the extent that they no longer believe they can

** Recent examples include: The Care Manifesto - the Politics of Interdependence, the Care Collective, Verso 2020; The Care Crisis, Emma Dowling, Verso 2021.*

do anything to improve their lives*. Poverty and the despair it causes is one of the main reasons people become involved in addictive behaviours and for Scotland's extremely high death rates from alcohol and drugs use[7]. Parental substance misuse was identified as a concern for 43% of children on Child Protection Registers in 2019-20[8].

It is not, however, just those suffering poverty across generations who have been affected. Since the financial collapse in 2008, more and more people have been left without hope and this appears to have played a large part in the epidemic of mental health-related problems and the high suicide rate among young people[9]. Even people who have gone to university, believing this would better their own lives, are being left on the scrap heap while the competition for jobs exerts its own toll.

The need for Public Care

The way society is going at present, we are both creating new care needs and undermining people's ability to care for each other informally. At the same time, the picture that much of the media paints is of an uncaring world full of threats to the most vulnerable, from the sexual abuse of children to the swindling of older people. The message is 'never trust a stranger' and retreat into your social silos. That is increasing the risk of the social bonds that tie people together disintegrating and has fed destructive ideologies, like those associated with the populist right in America, where guns for self-defence replace care. For these reasons we believe that 'Public Care' (that the term has a strange ring tells you how far this has been ignored so far in social policy) should be as integral to the NCS as public health is to the NHS**.

The first element of public care should be to counter the idea that humans are by nature uncaring and promote understanding that care is integral to our lives and our survival as a species.

The second element of public care should be to promote awareness among the public and advise government on the societal factors which affect our ability to care and how we could address these (just as public health researches and provides advice on how to tackle health inequalities). Advocating and assisting with the design of a new welfare state should be a key part of this. For care to work we need: a benefits system that supports people through hard times – as was originally intended in 1948 – rather than punishing people and treating social problems as being a person's individual responsibility as happens at present; social housing provision and rents that don't force people into penury; a legal aid system that enables people to enforce their rights; as well a properly funded NHS.

Besides improving how the state supports people to care, we also need to ensure the private sector contributes to a more caring society: employers that treat people with understanding and respect, as some do, rather than exploiting people and firing them at the first opportunity; consumer services and facilities that are accessible to all, so that people with disabilities can participate fully in everyday life, like anyone else; builders who incorporate community facilities into new housing estates as a matter of course. An NCS cannot deliver care worthy of the name unless government addresses these wider issues that impact on care.

The third element of public care should be to provide and advocate for preventive services, akin to how public health provides smoking cessation services and promotes increased physical activity as the best means to improve the health of the population as a whole. A core part of this work should be about creating services and facilities that help tackle social isolation, as people who are isolated can neither offer nor receive care: they lack the caring relationships that sustain us through life.

** Ken Loach's film "I Daniel Blake" provides a brilliant illustration of how this works.*

*** The relationship between public care and public health is considered further in the section on care and health below*

At one time there was a wide range of such services; day centres, lunch clubs or volunteer visiting schemes for older people, youth clubs for younger people. Much of this community infrastructure has been axed as a result of austerity. But there are also a host of newer care problems we need to address and where research is needed. Examples include: asylum seekers being separated from their families and people who can speak their language and then, just as they start to develop new relationships, getting moved again; the social isolation and stigma associated with addiction problems; the adverse role that social media can have on some relationships between young people.

SUPPORTING INFORMAL CARERS

Informal care* is where a person goes a step beyond being concerned about others and assumes responsibility for looking after someone else. Just as we all need care, the majority of us provide care at points in our lives, most commonly as parents but in many other circumstances and for varying periods of time. People assuming such responsibility form the lynchpin of a caring society and for many providing care is one of the most fulfilling parts of life.

The people who provide informal care

How much care a person provides is, however, to a large extent determined by the way our socio-economic system influences and reinforces gender roles. Where care requires assistance with personal physical tasks, large amounts of time or commitment, such as in bringing up children or caring for frail older people, women are the predominant care-givers and often exploited as such.

Almost a third of Scotland's adult population of c4.5 million have significant caring responsibilities at any one time. The majority of these carers are women. On top of around 950,000 individual parents who live with dependent children, pre-pandemic there were estimated to be between 680,000[10] and 791,000[11] informal carers in Scotland, of whom around 170,000 spend over 35 hours a week caring. This compares with a social care workforce of 206,400 or 155,330 full-time equivalents[12], most of whom are also women and may also be informal carers. The financial value of this unpaid care is estimated to be £10.8 billion which dwarfs the approximately £2.8 billion Scotland's local authorities spend on adult social care[13].

The population of informal carers, like parents with dependent children, is constantly changing as a result of the interplay between those needing care and those who give it. The turnover of carers in Scotland each year is estimated to be 160,000 people. Behind the statistics are real lives. In some cases, people may be thrust into a caring role suddenly, such as where a relative is disabled by an illness or accident. At the other end of the spectrum the caring role may evolve over a number of years as one person in a relationship becomes dependant on another. How friends and family respond to the various situations which gives rise to the need for care then determines the need and demand for service provision.

The carer population is highly diverse, with the needs of carers and the impact of caring varying according to circumstances. Carers range in age from young children, helping to care for a parent with disabilities, to the very old. The peak age for caring is between 50 and 65, a reflection of a change in roles within a caring relationship, with children assuming responsibility for their parent/s as they grow older. Typically for this group, involvement in care may develop over a few years but may be all consuming at times of crisis caused by illness or at end of life. This is quite different to caring for a child with disabilities, which may result in a lifelong caring commitment,

** Various terms apart from informal carers are in use including unpaid carer and care-giver. All have advantages and disadvantages.*

or to one of the estimated 29,000 young carers in Scotland looking after an adult. Although most care is provided between relatives, one in ten carers is a friend or neighbour.

The impacts of providing care informally

About 250,000, or a third of Scotland's carers, try to juggle caring with paid employment. This often puts informal carers under great pressure, left wondering how they will deal with the next crisis, and many decide to stop work to care full-time. The financial consequences for them, and for people who have long-term caring responsibilities for adults with disabilities, are serious. The main carers' benefit is worth just £62.10 for a minimum of 35 hours. Research has found that a third of carers are struggling to pay utility bills, 47% have been in debt and half are struggling to make ends meet, cutting back on food and heating as a result[14]. In addition to the financial consequences, eight in ten carers say their health is worse because of caring and there is evidence that this is getting worse[15].

While the importance of informal care has long been formally acknowledged by government policy*, in practice levels of support provided have been woefully low and, every time services have been cut, carers have been left to pick up the pieces. A prime example was during the Covid crisis[16]. Despite stepping in time and again, carers have been treated with little respect and have very little power, as we have seen during the Covid pandemic when the right of relatives to visit relatives in care homes, for example, was brutally severed.

How to provide meaningful support for informal carers

The challenge for the NCS is to turn this situation around and to convert the plethora of policy statements about informal carers into real support. This means treating informal carers as assets we need to invest in and as full partners in the National Care Service.

We believe there are several major reforms required to make this happen, some of which are about services and others about Public Care:

— First, no-one who decides to provide informal care should be left in poverty as a result. We need to reform the benefits system to support carers and develop ideas like a Universal Basic Income or guaranteed minimum income for all**.

— Second, no-one should be forced to step in and provide care as a result of a lack of social care provision. Universal provision of a range of care services and the abolition of eligibility criteria would enable people to decide themselves when they wish to provide care to someone and enable people who do decide to become informal carers to take a break when they needed it.

— Third, the policies and systems that preclude or make it difficult for informal carers to be involved in taking decisions about care provision need to be reformed so that they can do so. We suggest ways that this should be done at various points in this blueprint.

— Fourth, we need to change our housing and our housing systems so they support care. The idea behind the bedroom tax, that people in rented accommodation should only be entitled to limited space, would have had disastrous consequences for care, not just people being uprooted from the communities but losing the spare room that enabled grandparents to have their grandchildren to stay or for adults

** The first "Strategy for Carers in Scotland" was published in November 1999.*

*** The introduction of the Carers Allowance Supplement in 2018 and the decision by the Scottish Parliament to make a double payment in 2021 as a result of the Covid-pandemic acknowledges the need but does not solve the problem.*

to take in frail parents when they were ill. While the bedroom tax was rightly rejected by the Scottish Government[17], the wider issues about how we redesign housing to support both informal and formal care remain. Having addressed these broader issues, informal care should be able to access a wide range of services/resources like respite, emotional support, training and counselling. Most important of all, however, is the need for an ongoing open dialogue between informal carers and those involved in providing services, so resources can be adapted to any given situation and change of circumstances.

PROVIDING CARE AND SUPPORT

The need for care and support services

The vast majority of care in Scotland is provided as part of everyday life and through social networks, particularly families. But there are circumstances in almost everyone's lives when care needs may not be met or where caring relationships come under stress. There are many examples of where this happens: unexpected or predictable events (a child orphaned or an older person losing their partner); social isolation or a lack of caring networks (homelessness or family members moving away) or a person needing more care than can be provided informally (deteriorating health). All can result in informal carers and the person needing care requiring advice and support to help resolve problems and, in some cases, may result in a need for care services*.

While some stress is inherent in the nature of care and every caring relationship, our socio-economic system often makes that worse, with low pay and long working hours, for example, leaving people with less time to care**.

In contrast with the large amount of health-related data produced by NHS Scotland, information on who needs care in Scotland is very poor[18]. Data on unmet needs has not been recorded for many years (the last attempt to do so in 2010 was incomplete and does not show how many people assessed actually received a service[19]) but services are now focussed almost entirely on providing personal care to those deemed to have 'critical' or 'substantial' needs according to Scottish Government eligibility criteria for services. Neither the IRASC nor the NCS consultation provided any data on care needs or even the number of people qualifying for care services at present.

Data that indicates the potential scale of care needs in Scotland mainly comes from the NHS. For example, compared to Scotland's current population of 5,466,000, there were estimated to be:

— 787,000 people with mental health problems in 2018[20];

— 57,300 'problem' drugs users in 2016/16[21];

— 90,000 people with dementia (based on European prevalence rates)[22];

— 26,349 people with a learning disability according to Scotland's Census, 2011 but 14,200 children in Scotland's schools registered as having additional support needs, suggesting the census is a serious underestimate[23]; and 210,000 children living

** The Dilnott Commission, set up to look at the funding of adult care services and while placing the emphasis on health-related needs, put it like this: "What is care and support? Social care supports people of all ages who find themselves in vulnerable circumstances – as they get older, and if they have a disability or mental health condition. It assists people with certain physical, cognitive or age-related conditions in carrying out personal care or domestic routines. It helps people sustain involvement in paid or unpaid work, education, learning, leisure and other social support systems. It supports people in building social relationships and participating fully in society."*

*** Ken Loach's film, "Sorry We Missed You" (2019), provides a powerful illustration.*

in absolute poverty – a strong indicator of unmet care needs – 2017-20.

Nowhere does the Scottish Government bring together data on likely care needs, something that needs to be urgently rectified. Data about the people who receive services is just as fragmented and out of date, for example:

— **Children and Young People.** At 31 July 2020, there were 14,458 'looked after children' (children required to have a social worker) of whom 1480 were in residential care and 4,697 in foster care. There were over 2000 further children on the Child Protection Register. The number of other children and families being supported is not recorded[24]

— **Direct Payments.** In 2016-17, 8,290 people received a Direct Payment to organise their own services[25].

— **Care Homes.** As at 31 March 2021, "there were an estimated 29,317 long stay residents in care homes for older people" and 2,565 aged 18-65 living in long-stay care homes for adults[26].

— **Home Care.** There were 48,800 Home Care clients aged 65+ in March 2017[27].

— **Addiction Services.** Between January and March 2021 over 11,000 drugs and alcohol treatments commenced of which almost 4,000 include community-based support[28].

— **Homelessness.** There were 25,226 open homelessness cases in Scotland at 31st March 2021 with 27,571 households, containing 30,345 adults and 11,804 children, assessed as homeless in 2020/21 (a decrease on the previous year due to Covid)[29].

— **Criminal Justice.** There were 28,400 criminal justice social work reports (including supplementary reports) and 17,500 social work orders issued in 2019-20[30].

Trend data is as hard to obtain but, apart from Direct Payments, the numbers of people receiving almost every other type of service have reduced in the last ten years. For example, the proportion of the population of older people receiving home care has reduced from over 65 per 1000 in 2008 to 48.9 per 1,000 in 2017. This illustrates the increasing gap between services provided and actual need and changes in eligibility criteria.

There is also other Public Care data that could be used to estimate the scale of need. For example, it is estimated that 17% of the population (900,000 people each year) were living in absolute poverty after housing costs in 2017-20[31]. Then there are the statistics on deaths: the suicides, drug deaths, alcohol deaths and deaths of young people who have been in care.

And this doesn't even begin to capture the lower levels needs, the loneliness and isolation for example that blights lives or how poverty, low incomes and poor housing, contribute to the need for care.

Trying to pull all this data together critically and come up with an estimate of the level of care needed in Scotland would take a volume in itself – it should be a job for government – but a reasonable indication of the number of people needing care and support can be inferred from the estimated 791,000 informal carers in Scotland. If one in four carers look after two people, that would mean informal carers support around a million people; add to that the people who are *mainly* dependent on care services rather than informal carers: around 80,000 older people in care homes and receiving home help services several times a day; 6,000 Looked After Children and perhaps 20,000 from other care groups. That makes 1,100,000 or 20% of Scotland's population. Add to those informal and paid carers and almost two million people in Scotland are either giving or receiving care at any one time. An NCS should have as important a role to play in our lives as the NHS.

Supporting people with care through their lives

The creation of an NCS presents an opportunity to make advice and support about care, in all its complexity, available to everyone and to meet care needs which at present prevent people from

living fulfilled lives. A suite of services, aimed at supporting people and providing care where it is lacking, should cover people from before the cradle to the grave – or from womb to tomb. The emphasis should be on support to all, helping people, rather than targeted intervention aimed at managing risks.

The NCS needs to start by helping people prepare for and then supporting them through parenthood, the single most important way we are brought up to care. This needs to be underpinned by much improved parental rights at work. At present some help is provided from the NHS to prospective parents, mainly to women and mainly in the form of health checks, but the NHS is geared to health, not care. Little support is then offered for when care gets challenging: a baby cries and doesn't go to sleep, not just once just but for days, or a toddler has tantrum after tantrum. We have lost sight of how hard parenting can be. That may not matter where parents have someone else to show them the ropes, their own parents for example, but a lot of people don't have such support and Health Visitors, who were trained to meet that demand, have been severely under-resourced for years[32]. While parent education can be valuable, and does have a place, relying on that alone in combination with the child protection system doesn't work. For example, it's a good thing that more people with learning disabilities are having children and getting the opportunity to care for others, but they receive little support to do so and the consequence is their children are overrepresented in the Child Protection system. Common Weal have set out our proposals for ante-natal care and a comprehensive Early Years' Service, which would form part of the NCS, in *Childcare or Caring about Children*[33].

That paper also describes how a universal service should provide extra support where needed. Families with disabled children provide a good example. Caring for such children can bring great rewards but generally it is even more demanding than most parenting because the child/children require more support for longer periods of time. Recent research[34] has shown that families with disabled children are some of the most disadvantaged in England and face serious barriers to participation in society, not least from attitudes in social services. While there has been extensive policy development around the needs of families with disabled children in Scotland[35], so the areas where help is required are well known, but resources are still needed to turn policy into reality so that families feel supported[36].

Once children go to school, that normally becomes the first point of call for children needing care or support. Common Weal would like to see services associated with schools like breakfast clubs and after-school care, which provide important supports for parents, becoming universal. Schools have a key role in supporting children to cope with difficulties that arise from going to school. For example, as children get older, they face challenges in developing their own identity and in developing relationships with their peers. This is a stressful process, which is made worse for many by the ways schools operate (large classes, pressures to succeed etc). Schools also have an important role to play in educating adolescents about the transition from childhood to adulthood and steering teenagers through the guidance system.

Children, at both home and school, are also affected by the problems faced by parents, including poverty and working hours, addiction and relationships. These affect how children are cared for and their ability to participate in school. While it is important that teachers view part of their role as supporting children and engaging with families, some children and young people at school need support over and above what the education system can offer. The NCS therefore needs to provide further on-site professional support to school children and support to parents who are finding it difficult to care for their children. This should be done through social workers, and include the provision of practical help where needed, rather than leaving this to teachers as often happens at present. The emphasis of social work should change from interventions based on assessment of 'risk', treatment and protection, to supporting children and their families to address problems.

When children reach 16 or 18, they and their families are faced at present with an abrupt and artificially-contrived transition to adult services in both the health system and the care system, with services for children generally being better resourced. This does not reflect reality where

young people mature at different rates and many of those with special needs carry these into adulthood. The difficulties that these dividing lines create has been well researched[37] and partially recognised for care leavers, where local authorities now have responsibilities to provide care until 21. A relationship-based NCS should be based on promoting continuity of care and support, particularly for children and young people and their parents, recognising that for most people in their lives there may come a time to move on. This is one of the most important reasons why the NCS should be universally provided for all age groups and across all so-called client groups.

An NCS though is particularly important for those who, because of disability or their health needs, may need support to live independently as adults. This includes a wide range of people including those born with disabilities or life limiting illnesses and those acquiring them. Any of us could have a car accident while a combination of climate and genes has resulted in Scotland having the highest levels of MS in the world. Independent living, however, should not be seen as living without support. We are all interdependent but too often now the outcome is seen as 'independence', rehabilitating someone so they can stand on their own two feet without public services, a cost cutting measure. As the Scottish Government's consultation states, care should be about helping people not just to survive – a focus on meeting basic physical needs – but on enabling people to thrive, i.e., to form a range of caring relationships from interactions with local shopkeepers or strangers (which requires a person to be able to leave their house) to conjugal relationships.

We can also, at any stage in our lives, run into difficulties and need support and sometimes, where we don't get this, this can have tragic consequences or result in longer-term problems. Homelessness provides a good example. As Jess Turtle, founder of the Museum of Homelessness put it in an article in The Ferret on Scotland's record number of drug deaths:

> "A roof is not enough. People need meaning, purpose, care and genuinely supportive relationships in their lives too, especially those of us who are trauma survivors."[38]

Many other difficulties have a very large care component, from domestic abuse (the opposite of a caring relationship) to refugees (people forced to uproot and abandon their care networks), from feeling suicidal to being addicted (both of which reflect an alienation from society, a belief that society no longer cares sufficiently to make life worth living). Everyone in these circumstances needs support but at present whether such people receive support is haphazard and existing support is very fragmented. The NCS needs to pull the supports for all these issues together and fill the gaps to create a coherent whole.

And finally, if you are lucky enough to live your adult life without ever needing support from outside your own social circle, the likelihood is you may need care in your old age, whether because of the deterioration in health associated with ageing or because you have outlived your contemporaries and lost your circle of support. The largest proportion of the population needing care services are older people but at present the system is almost entirely focussed on providing for 'priority health needs', which results in people being looked after rather than cared for, and insufficient to enable most older people to thrive. The NCS needs to turn that around.

Our National Health Service cannot be defined by a list of illnesses and treatments. It has been driven by health needs and evolved as health needs change to be there for people whatever happens. The Covid pandemic provides a striking example. The NCS should be the same. Just like health, we can need care at any stage in life, and our aspiration should be that the NCS is always there when we need it. To be comprehensive, it needs to keep evolving to meet changing care needs.

SUPPORT ON YOUR DOORSTEP

The first thing the NCS needs to do is provide people with advice and support on the full range of care issues, rather like a GP is there to provide people with advice about health issues. That support needs to be available in person, not through a call centre or only available on-line.

Turning social work back into a helping service

Social Work is the profession that is trained to undertake that work, but over the last thirty years the role of the social worker has changed from supporting people to safeguarding those deemed vulnerable under child and adult protection procedures and from arranging help to acting as the gatekeepers to scarce resources. These changes mean social workers spend endless time assessing risks and form-filling rather actually helping people. They mean most people never get to see a social worker even though there are significantly more social workers than GPs in Scotland. In September 2020 there were 5,100 GPs in Scotland including part-time staff. While Scottish Government data is inconsistent, with it claiming there were 5,900 frontline social workers in Scotland in 2016 compared to the Audit Scotland report into Social Work which said there are 10,000, both figures are higher than for GPs[39]. Most importantly the changes made to social work have impacted on the public's perception of social workers: the feeling of being watched, not supported, and of decisions being driven by cost, not need, undermines trust which is key to any successful supportive relationship. Arguably the current system in which social workers are forced to operate is contrary to the codes of practice which require staff to maintain the trust of people using services and wider public trust.

Common Weal believes we need to fundamentally change that and re-orient social workers to supporting individuals and families, whatever their circumstances, within local communities. We have set out our reasons for this and what we think social workers should do in our paper *Struggling to Care*[40]. But in short, social workers should be the first port of call in the NCS for people seeking help.

That will require a change from the roles that social workers are currently required to fulfil: a shift from filling in assessment forms and trying to manage the behaviour of individuals, to working with people and their families to resolve problems and identifying what infrastructure and services are needed locally to enable them to live fulfilled lives. There are models for how to do this. In Leeds, they replaced a mass of procedures governing what social workers were supposed to do by three rules – "Don't break the law; Don't blow the budget; Do no harm" – and a 27-page tick-box assessment form with a two-sided 'Conversation Record'[41]. As part of this change process, we will need to see how far a reduction in bureaucracy can free up social workers to provide support to the public and to build supportive relationships with those most in need of care. We could then review how many new social workers are required.

Help within walking distance

The Scottish Government in their NCS consultation ask a number of questions about how to make care services more accessible and how they should join up with other services when the answer was staring them in the face. People should be able to go and see a Social Worker just like they can go and see a GP. That is why we have proposed the establishment of Local Care Hubs[42]. Just like the GP, the social worker should be responsible for referring people on to other services where appropriate. And, just like the GP, if those referrals don't address the problems, the Social Worker should always be there as a backstop.

This would end any confusion about where to go to get support with care issues*. That confusion has in large part been created by the fragmentation of the care system and of social work into different specialisms, with some functions now carried out by voluntary organisations. The consequence has been that a single family may have to approach different offices/organisations for support with different aspects of the same care problem. The best thing about the Scottish Government's proposals about the NCS is they provide the potential to bring all this together and consider problems faced by families as a whole. It would cut out lots of waste and duplication.

** The Scottish Consultation about a National Care Service contained five questions about how to make services easier to access without considering the obvious answer, a single-entry point.*

Having a social work service like that would relieve many of the current pressures on GPs, whom people end up visiting because there is nowhere else to get help.

Many care difficulties arise because of issues such as poverty and housing. Advice services, like those provided by the Citizens Advice Service, need to be seen as an essential accompaniment to the NCS. They should be funded through it, ending the multiplicity of funding streams that exist at present[43] and professionally staffed rather than having to rely on volunteers.

For this to work Social Work and allied services, such as Citizens Advice, need to be accessible to people and on their doorstep – just like GP surgeries generally are. That means changing the current set-up where social work offices have been shut down and access to services is restricted through call centres and waiting lists for appointments and replacing this with social work services embedded in local communities[44].

Just as with health, normally people should be under no obligation to seek advice – sadly men often don't seek advice from their GP early enough – but where they need to do so, the old, the young, families or single people should be able to walk in through a door near them and get help. And those who are likely to need help regularly because they face complex care issues should have a named worker, who they can get to know and trust and from who they can receive consistent support.

Professional support with care needs works best when the relationship between the person needing support and the person providing it is itself based on care. What turns around people's lives is that despite perhaps having had many crises, they will still be supported without being judged. This has been recognised by the Promise, the Scottish Government's reform programme for 'Looked after Children'*, a primary focus of which is about re-engaging social workers and other care staff in 'relationship-based practice'. But not so far for adult services. Care needs to be integral to all social work practice functions within the NCS and perhaps most of all for those outcast from society, the homeless, people with addiction problems or mental illnesses and those subject to the criminal justice system.

Our aim should be to grow public confidence in social workers and the NCS so that the many people who are currently excluded from or fail to seek support – often with disastrous consequences like suicide or addiction related deaths – feel able to ask for help when they need it. This will take more than the ten-minute appointments most GPs are allowed to offer. It will also require social workers to re-build trust with the public and to start advocating for those they work with. Unless we get to the position of people being comfortable with the idea of seeking help and feeling confident that they will receive proper support when they do so, the whole idea of prevention, of providing support early to prevent problems getting worse, can never be achieved.

However open and welcoming a Local Care Hub, it is important that the NCS is also embedded in other places where it might be needed, like schools and GP surgeries, and reaches out to groups such as refugees, immigrant communities and other people who might not attend any of these places. We need to grow such community outreach capacity.

While the focus should be on prevention, it is also important that help is available at the end of a phone, 24 hours a day, seven days to respond to emergencies. One reason why some older people are admitted to hospital unnecessarily is that people use the NHS as the service of last resort. Getting support at home in an emergency – for example to sort out the caring consequences of one member of an elderly couple falling and hurting themselves – is very difficult across much

** Looked After Children is the term for children for whom local authorities have caring responsibilities, either in their own homes or "accommodated".*

of the country. The NCS needs the equivalent of an ambulance service but for care*.

While the primary focus of Social Work should be support not policing of behaviour, there would be occasions when, like the NHS and communicable diseases, the social work service within the NCS would need to take action to protect others. This is best done not by blaming people for problems that are often outwith their control – like poverty – but to support such people to achieve changes including how they develop sustaining caring relationships in their lives. Social workers are, again, trained to do this but have increasingly in recent years been forced to adopt a policing role.

LOCAL SERVICE PROVISION

Where people need care services, our vision is that these should also wherever possible be based and managed locally through the Local Care Hub. Apart from some specialised services, which may need to cover a wider geographical area, we believe this is the best way to ensure that services are fit for purpose.

Locally-based services make it far easier for care services to work with other services like health and housing, a long-held government aspiration**. They enable managers and staff to get to know the area, their neighbourhood, what facilities are available and the organisations working there. But instead of trying to make this happen from the top down, organised by all-knowing managers in remote offices (as the Scottish Government wants to do) we believe this should happen from the bottom up. Two key ingredients are that staff should have the time (and technology) to work with other services where a person needing care requires this and that they have sufficient status to be trusted and respected by people working in other services.

While this will require management to be re-organised, it will require more leadership, not least to ensure that reforms are understood, owned by all the stakeholders and operational models developed by frontline staff, informal carers and service users.

It follows from the meaning of care that good services will enable care staff to have the time to develop the skills to form valued relationships with service users and their informal carers while also providing the practical care when it is needed. Our contention is that locally-based services enable managers and the care workforce to deploy resources – which is all about the time available to care staff – in a way that benefits the maximum number of people for the maximum time. They do this by knowing their neighbourhood and who needs what at any one time within it and which worker is best suited/placed to provide the care.

For example, if a person normally receives a home care visit only in the mornings but one afternoon is feeling unwell, if there is one care worker or team working on the street, it should be possible for them to pop back in and see them later in the day. But this also requires the workforce to have dynamic communication and assessment skills. This would make it feasible to manage services for everyone's benefit, a contrast to the current situation where there may be several providers operating on one street and much of the time of care staff is wasted travelling.

Locally-based teams can also strengthen more informal local care networks, for example, supporting isolated people to use local facilities or even to put lonely people in touch with each other for the company.

The key change needed here is for frontline staff to be empowered and have the discretion to agree with the people they are caring for what help they receive on a day-to-day basis based

** It is generally much easier to receive a service to get out of hospital than to get a service to prevent a hospital admission which is why people ring for an ambulance. The Regional Councils, which used to be responsible for social work services, used to operate fairly comprehensive standby or out of hours services which have been cut back.*

*** Community Planning was enshrined in Part 2 of the Community Empowerment (Scotland) Act 2015*

on their needs and preferences. For example, where someone is feeling unwell one day and needs more support, their neighbour is unlikely to begrudge receiving less care if the carer explains the reason: the quid pro quo is that they know that if they are feeling unwell, the carer will ensure they get more help. Conversely, if someone has a family member visiting one day and does not need their normal care provision, the carer should be able to spend that time with another person: an opportunity perhaps for an extended cup of tea and a chat, to go out for a walk or to do a 'spring clean'. Some people might prefer additional company, others practical help.

The point here is that, like all caring relationships, those between the care workforce and the people they support require an element of compromise. If 50% of the older people needing support to get to bed would like to do so at 10pm, the only way to deliver that efficiently would be to employ a large percentage of the workforce for half an hour at that time which would have major implications for staff well-being. This is not an excuse for those 'tuck-in' services that have been known put people to bed at 4pm. Instead, what a good service should do is allow its staff to negotiate with the people they are supporting to come up with arrangements that provide the maximum benefit to all. Organising provision for the welfare of all is much easier where the staff member is supporting people who live in close proximity and requires good relationships with the people needing care, their informal carers and local service managers. This would also be good for the workforce. They would spend less time travelling and a local base would enable them to have a break or use the toilet, feel part of a team and support each other.

This vision conflicts with the ideology of choice which has driven reform of the care system for the last 20 years and was embedded in the Self-Directed Support (Scotland) Act 2013. This has combined the consumerist idea that choice drives markets, and is therefore the way to improve care, with the idea that an approach based on individual rights is the way to people get the care they need. Neither idea is correct.

By far the most important factor in the quality of care provision is the person/persons caring for a person, whether they can relate to them and have the necessary knowledge and skills to do so, and *not* the provider. While some providers are better than others, there are great carers working for poor providers and poor carers working for better providers. Moreover, the turnover of the social care workforce is such – between 25-30% a year over the last 10 years – that even where people use their rights of choice to select a provider and a worker who is good for them, there is no guarantee that situation will last.

Rather than improving care, choice has actually played an important role in lowering the quality of care provision. First, the tender processes designed to give people a choice of services have driven down the price of care and, along with that, staff wages, terms and conditions and training, the very things that are key to care quality. Second, it has resulted in duplication (management, travel time etc) meaning that as resources have become scarcer, ever less has been spent on providing care at the front line.

While the idea of human rights is very important, it has serious limitation when it comes to care as we have explained in more detail elsewhere[45,46]. Simply put, it's very difficult to take a rights approach to care because it involves a mutual relationship, two parties who both have moral rights within that relationship, and for it to work well both need to negotiate how that works. Some compromise is integral to good care. The idea, therefore, that the answer to current problems in the care system – most of which come down to lack of resources – is to make rights stronger is in our view misguided.

Care provision is by its nature both demanding – on all parties – and tricky. A large part of the challenge is how to resolve disagreements. Our view is that this is best done at the frontline. If a person is not happy with the service they are receiving, the first point of call for sorting this out is with the people who are providing the care to them. That has implications; the workforce needs to be both empowered, so that they can adjust the care they provide with the person's agreement, but if that is not possible, they then also need the time to work out or negotiate other solutions with the person they are caring for. If that doesn't resolve the issues, the person or their informal carer should then be able to talk to

the manager of the service, again on the basis that problems are best resolved face to face.

For example, there are people who, due to their personalities and interests, do not get on and, since relationships are crucial to effective care, mechanisms that enable the users of services and carers to change the member of staff working with them should be built into every service. It may be reasonable to ask people to tolerate seeing professionals they don't particularly like occasionally, but people should never be asked to tolerate people they dislike coming into their houses each day, let alone helping them with the most intimate aspects of personal care. Such issues are best sorted out in locally-based services.

There will always, of course, be problems that cannot be sorted in this way, workers and managers who are mot working as they should. Sometimes this will be for understandable reasons like they are going through bad times in their own lives, but there will be some people who shouldn't be working in social care (however much we improve current recruitment processes) and sometimes whole services can go awry through poor management.

These issues are considered further in the section on regulation, but if local services were, as we propose, accountable to local management committees which included people needing care, informal carers, frontline trade union representatives and professional social workers, problems with services would not be left to individuals to sort out but would become a matter for the local community.

REMOVING BARRIERS TO SUPPORT AND SERVICES

Two main barriers have been used in Scotland to restrict access to social care services and manage budgets: eligibility criteria and charging. These have served to alienate people, particularly adults with longer-term care needs, from social workers and local authorities whom they perceive as the source of the problems but actually they administer the current system on behalf of the Scottish Government[47].

The effect of removing eligibility criteria

As budgets for social care services have been cut, so eligibility criteria for services have been raised and are now determined almost entirely by the likelihood of immediate risks of physical harm. Unless a person needing care is deemed to be sufficiently high risk, they won't even get to see a social worker, even though local authorities still have a statutory duty to assess needs and if problems were sorted at an early stage that could prevent care needs escalating. If the person gets over these initial hurdles, they are then faced with a social worker whose job is to act as a gatekeeper, rather than a gateway, to services (though some, wanting to help, still try to circumvent the rules). The fundamental problem dates back to 1948 when Aneurin Bevan committed central government to fund health but decided that expenditure on care would depend on what local authorities could afford. Resources have been put before needs ever since and the issue has become particularly acute since the onset of austerity[48]. We need to reverse the priorities, put need before resources and as a first step to doing so abolish eligibility criteria for services as was suggested in the IRASC[49].

This does not mean that anyone asking for help would then receive a care service. First wants are not the same as care needs and, just as the NHS does not pay for certain types of cosmetic surgery, the NCS would not provide unlimited care. Part of the job of the professional social worker is, through listening and discussion over time, to help people understand the difference: where it is reasonable to provide care services and where a person has the power – with support – to find other solutions to their perceived needs. This in not unlike the role that GPs play in the NHS.

Second, there will always be some gap between assessed need and the services available. As we have shown, just as with demand for health care, levels and types of care needs evolve over time and sometimes the demand for new services – for example those associated with asylum seekers and refugees – can emerge quite suddenly. The

way to manage this is not to pretend those needs don't exist by using risk-based eligibility criteria to exclude people from services but to operate waiting lists like the NHS. Waiting lists provide transparency, help hold politicians to account and drive investment in services.

Eligibility criteria are also sometimes justified by those managing services as a means of preventing services from being swamped. There are reasons to doubt that would happen. Where they have a choice, most people don't want services in their lives. That is because while people appreciate help in a crisis, few enjoy being dependant on others for care. Most people want to stand on their own two feet first, will go to friends and family second and only call for help from services as a last resort. That is why local community infrastructure such as clubs and meeting places is so important, it is what would make it possible for people to 'self-direct' their own support[50]. The best solution to older people feeling lonely is not to pay someone to sit with them – it lies in having places in the community where they can go. Investment in community infrastructure, not eligibility criteria, is the best way to manage demand but we won't know where we need to invest unless we start collecting information on unmet care needs.

The effect of abolishing charges

The second barrier to support is charging. Abolishing this is a matter of principle. When you need not just advice or support from a social worker but a care service, just as with the NHS, you should not have to put your hand in your pocket.

Ending means testing and the requirement for financial assessments, which is a humiliating ordeal for many, would also free up social workers to spend their time helping people once again. Although well-intentioned, the introduction of Free Personal and Nursing Care (FPNC) in 2002 has distorted the entire care system. Instead of making all care free, it made personal care, defined by a list composed almost entirely of physical tasks (such as eating, washing and dressing) free. All the essential relational elements of care were excluded. This has had a number of serious consequences:

- It has resulted in money, not need, determining service provision. Short of resources, councils have increasingly restricted service provision to FPNC tasks, a trend that has been reinforced because any person who asks for other help faces significant charges.

- It has seriously constrained choice because if a person needs help with both personal care and housework but would prefer a family member to do the former, they face being charged.

- It lies behind the time and task approach to care, where staff are forced to pack as many tasks into as short a time as possible but with no time to talk to people, resulting in the notorious 15-minute home care visit.

In short, FPNC has served to focus services more and more on physical care tasks and has undermined what should be the most important element of care provision, caring relationships. The focus on the physical has also contributed to the political narrative that the real purpose of care provision should be to support the NHS to manage physical illness and frailty. Even that is now collapsing as a result of the current staffing crisis with social care workers being instructed not to stay with people requiring urgent medical attention until an ambulance arrives[51].

CORE PRINCIPLES OF A COMPREHENSIVE NATIONAL CARE SERVICE – MAKING CARE WORK FOR EVERYONE

Drawing this all together, we believe that a National Care Service should be underpinned by a set of Core Principles. All of the Core Principles are built upon Rights guaranteed by appropriate Resource allocation, the Responsibility of government and public sector agencies to deliver them, and the Relationships that underpin Care – The Four Rs:

1. **Universality of Care and Promotion of Welfare:** care should be on offer to people throughout the whole course of their lives. At times when our own resources are insufficient to give us the support we might need, public care should be available. This includes necessary support to those who care formally and informally within families and kinship groups – whether parents, kinship carers, or other carers. The promotion of welfare is a fundamental public duty.

2. **Accessibility and Prevention:** care services, however provided and including publicly provided social work services, should be easily accessible within local communities and available at the earliest opportunity to those who require them.

3. **Services Built on Relationships, with Minimum Intervention and Minimum Bureaucracy:** care is most effectively delivered when it is provided by those whom we trust and know, or who are trusted and known within our communities. This might involve the maintenance of long-term relationships based on an open-door policy between workers and users of services. There should be no accusations of over-dependency – relationships between citizens and professionals should always be based on minimum interventions, not determined by pre-determined protocols or eligibility criteria. Elaborate bureaucracy should only be in place where of proven necessity e.g., in complex care situations.

4. **Service Provision Based on Individual and Collective Agreement on Need and Outcomes for Services Provided:** workers tasked with offering care services within communities should agree need and desired outcomes with those they are supporting, whether collectively or individually. The Four Rs.

5. **Independent Living:** people with disabilities should be supported so that they can fulfil their potential and live their lives like all other citizens. This involves choice and the right to determine services required through agreement over assessed need.

6. **Public Provision Free at the Point of Need:** all care, from briefly-given advice on a particular issue to full time residential or nursing home care, should be free and publicly provided. This recognises the place of Third Sector (not-for-profit) provision to meet very specialised need.

7. **A Valued Workforce:** the days of care being the role of unpaid or low paid women belong in history not in a modern care service. Care and care work are fundamental to a progressive society that values all its citizens, and the recognition of its importance should be reflected in the training and pay given to a workforce who are the subject of sectoral collective bargaining. Social care is a highly skilled job and should be remunerated accordingly and all should have access to levels of qualification and training appropriate to their role; career pathways should be clear and open to all. Health and Safety should be accorded priority.

8. **Recognition of Diversity and Difference:** services must recognise that our communities are based on very different kinds of identity and culture, and their delivery must be sensitive to, and address issues that create barriers and potentially further discrimination and inequality.

SUMMARY OF WHAT A NATIONAL CARE SERVICE NEEDS TO DO

To summarise, the NCS, needs:

— To be comprehensive and flexible enough to adapt to changing needs over time;

— To do everything possible to ensure the maximum welfare of citizens;

— To have a special focus on prevention by offering support early and again whenever needed to make sure problems don't get worse;

— To alleviate the responsibility for welfare from the families of those who are in need so that it never becomes a burden;

— To meet the social need for remedial activity when human welfare goes wrong;

— To treat people with real respect, which means engaging and negotiating with them about care needs rather than applying rules about the use of resources;

— To put care first by devolving control over services to the people who need them, their informal carers and the frontline workforce; and

— To record unmet need and distribute the resources that are available to it equitably across Scotland according to need.

PART 2

HOW SCOTLAND'S NATIONAL CARE SERVICE SHOULD BE ORGANISED – AND WHY

CREATING THE NEW NATIONAL CARE SERVICE

While, currently, care and support services are in a critical state, not fit for purpose and require radical reform, we should not re-invent the wheel but instead take account of what does and doesn't work. That requires a degree of analysis which is almost completely absent from the IRASC and the Scottish Government's proposals for an NCS. Based on such an analysis it is possible then to work out what to keep, what to restore, what to change and where to innovate.

To illustrate our overall approach:

— There are still things that are done well in Scotland, most notably by the social work and care staff who provide high quality and effective care and support against all odds, without whom the system would collapse, but also many examples of the creative use of scarce resources. We need to ***keep*** that experience to inform the development of a better National Care Service.

— While it would be wrong to present the past as some sort of nirvana, there are things that used to be done well in Scotland, such as the Children's Hearing system recommended by the Kilbrandon Report, the Social Work (Scotland) Act 1968* or the recording of unmet need, things that have been degraded over the years and which we should ***restore***.

— On the other hand, there are examples of practice, services and whole systems, like those that ration access to care and support, which are not fit for purpose. These we need to ***change***.

— There are also longstanding issues, such as the very high number of people living in institutional care in Scotland (from care homes to prisons), where we need to ***innovate*** if we are to help people improve their lives.

** The Social Work (Scotland) Act 1968, which brought all social work together under local authorities had many merits including the emphasis on care needs, the wide duty to promote social welfare, working with families, support not blaming.*

Instead of looking at what works and what doesn't, the Scottish Government has put its emphasis on the 'lived experience' of people with care needs and their carers and linked this to a rights-based approach to care. While we believe the views of people needing care are very important, this approach risks confusing wants with care, fails to appreciate that there will be as many views as there are individuals, neglects responsibilities, discounts the views and professional experience of those working in the care system and ignores the research from numerous studies and pilots in Scotland and abroad, not least that which is concerned with the 'lived experiences' of people in receipt of care services.

THE SOCIAL CARE WORKFORCE

It follows from care being all about relationships that, if we really want to improve care provision, we need to focus on the workforce rather than trying to improve care from above, as the Scottish Government is proposing in its plans to create a centralised National Care Service.

The largest section of the social care workforce comprises those who provide care directly on a day-to-day basis: childminders, personal assistants (employed directly by people with disabilities), home care, day care and care home staff. They are supplemented by a small number of more specialist staff.

In 2020 the social care workforce, 85% of whom are women, officially increased to 209,690 or approximately 159,260 whole time equivalents, about 8% of all employment in Scotland[52]. The figure is an underestimate as it excludes Personal Assistants, childcare assistants (estimated 500), commissioning and procurement staff, private and voluntary sector headquarter staff and council managers working in centralised teams.

Pay, conditions and training – current position

Most of the problems faced by the social care workforce are well documented and concentrated in the private and voluntary sector. Examples of these are precarious contracts, poverty pay, unpaid overtime, unpaid travelling time, split shifts, lack of support and supervision and staff paying for their own work equipment[53]. This has resulted in the very high turnover of staff in the workforce and high levels of vacancies in services, double the national average[54] both of which have had a serious impact on the quality of care offered.

High turnover has also helped to undermine the current system for training the workforce where new care staff are required to register with the SSSC when they start work and are then allowed, as a condition of that registration, three years to gain a Scottish Vocational Qualification. Where workers stay that long, they are often forced to gain the qualification in their own time and sometimes at their own expense.

That employers can recruit people who have no qualifications or training, even in the public sector, to provide care to vulnerable people, some of whom have challenging health conditions and complex care needs, is a national scandal. The Scottish Government announced in 2021 that it had set up a working group to look at induction – not training – for people wanting to work in care services. However, in other European countries care staff are supported to gain professional qualifications. In Scotland, staff who are untrained through no fault of their own, are being referred by employers to the Scottish Social Services Council to have their 'fitness to practice' investigated in ever increasing numbers; 4,122 staff in 2019/20 which resulted in 151 hearings[55,56]. Far from the workforce being respected, they are being intimidated and bullied.

Outside the public sector there are few opportunities for social care career development. There is a massive gulf between professionally-qualified workers and the rest of the care workforce with almost no career pathways between the two.

While the Scottish Government has frequently iterated its desire to improve the position of the social care workforce, the only substantive change has been the policy commitment to pay the Scottish Living Wage. Although this has now been built in to the funding of services and

providers, there are no provisions to enforce this or monitor whether the funding is passed on to staff. There has been little recognition that procurement has driven the downward spiral in workforce pay and conditions or that the social care workforce is poorly unionised, particularly in the third and private sectors. The consultation on creating a National Care Service contained few concrete proposals for addressing current problems while the IRASC's proposal for 'workforce representatives' appeared a deliberate attempt to undermine the role of Trade Unions.

Pay, conditions and training – our proposals for the NCS

The creation of the NCS needs to be accompanied by a package of measures to improve the pay and conditions of those working in it, with a levelling up of those currently working across the public, private and voluntary sectors. These should be developed and negotiated through a system of national collective bargaining, which is not dependent on the creation of the NCS but is the key to workforce empowerment. At present national collective bargaining only exists in the public sector but could be extended with immediate effect to cover the private and voluntary sector.

The starting points for this should be:

— Policy support for the unionisation of all social care workplaces to underpin national collective bargaining. While the NCS needs to be designed to ensure input of trade unions at all levels of the organisation, trade unions have a responsibility to invest resources in recruitment and to work together;

— As an immediate first step the basic wage for the social care workforce should be increased from the Scottish Living Wage in line with the demands of the representative Trade Unions* in recognition of the demands of care work and the anti-social hours involved. The rise should be accompanied by a commitment to further increases to bring all staff up to rates currently paid by the public sector;

— Alongside this, a system of salary scales should be introduced with spinal points allowing annual increments for the first five years and covering a paid induction period. This would recognise that staff develop knowledge and skills over time, would reward them for doing so and help stabilise the workforce;

— To improve skills and knowledge in sector, the number of paid days training annually should be increased from four to 10 for all staff, over the course of six years as training capacity increased;

— To support good practice, the entire workforce should have time dedicated for support, supervision and attendance at staff meetings;

— Occupational sick pay and occupational pensions should be extended to the entire social care workforce;

— Travel time, apart from arrival and departure from work once a day, and travelling expenses at a nationally agreed rate should be paid with immediate effect. This would mean people working split shifts were paid to travel to work after the first shift each day;

— All work-related equipment should be of a good standard and paid for by employers, including mobile phones and Personal Protective Equipment;

— Systems to ensure the 'Health, Safety and Welfare of Social Care Workers' should be set up across the sector as explained in more detail in our paper of the same name[57]; and

— Secure contracts of employment, incorporating these recommendations,

** The GMB has been calling for a basic wage of £15 an hour.*

should be required across the sector, replacing exploitative and precarious (zero hour or no specified hour) contracts.

This should be accompanied by a national programme for induction and training and reforms aimed at empowering the workforce and freeing them up to spend time caring (as outlined below).

Induction should not be confused with education and training; it is what should follow training and is about enabling staff to learn enough about the job and working environment to work effectively and safely. For some social care settings that might be as little as one or two weeks but for others it might be more and that time should be paid.

Our vision is that education and training should be central to the developing of a fit-for-purpose National Care Service and a forthcoming paper will describe how a new system for training within the NCS might operate. The new system should borrow from the well-tested experience of other sectors and involve giving young people some input and experience, for example through placements as part of the secondary school curriculum, courses, qualifications delivered through accredited further and higher education establishments and provision of apprenticeships. The system should provide well-prepared and well-supervised placements pre-work; good on the job support and supervision, including mentoring in the early stages; and then lifelong learning with further training designed to fit with career progression.

Once such a system is in place – we should aim to do this within three years – everyone entering the workforce should have some level of education and placement experience before starting work and then be supported to develop further skills through ongoing training and education. The system also needs to be designed to enable and support informal carers to access the parts of training and education programmes that are relevant to them

Empowering the workforce

The Scottish Government has given even less consideration to other workforce factors that are critical to make care provision work. First, care workers need to have the time to build relationships with the people they are caring for and others, such as informal carers, who are involved. This means increasing staffing levels in accommodation-based services, such as day centres and care homes, and expanding the time that workers in the community are currently allowed to spend while providing care at home.

Second, the only way that care will ever be flexible enough to meet people's needs is if care workers are empowered to decide how the care they provide is delivered on a day-to-day basis. This needs to be done with service users and informal carers and in ways that respect the rights and wishes of all involved. To devolve day-to-day decision-making to the frontline successfully will require all staff to be trained in ethical decision making and to have access to good support and supervision.

Third, because caring can be such a complex and demanding job, social care workers need regular support from managers – who should have the experience and qualifications to do so – and their colleagues. Many community staff now work out of a car – if they have one – when what they need is to see managers regularly, have somewhere to meet with others and get advice, laugh or cry as circumstances dictate. Local Care Hubs would provide a base for providing this essential support to staff.

Investment in and empowerment of the social care workforce is the key to improving care services and care provision but for this to be achieved private for-profit involvement in the provision of care needs to be phased out.

Ending the market in care

The ideas that you can buy a relationship or that businesses should be able to exploit others to provide care, should be seen for what they are – as undermining the very purpose of care. It should therefore be a fundamental principle of the NCS that care is not-for-profit. Our argument is not that all private care provision has been bad or that all public and voluntary sector has been good but that if Scotland is to have good care provision, those providing it need to be 100% focussed on

care and not thinking about how to make money or conversely, in the case of local authorities, obsessed with how to restrict expenditure. We need the NCS to be driven by care, just as the NHS, for all its faults, is still driven by health.

In Scotland politicians of all parties have accepted that health provision should be 'not-for-profit' and, to their credit, have generally resisted the ongoing attempts to privatise the NHS that have been promoted in England, although there have been notable recent exceptions[58]. However, within social care, this attitude is far less prevalent and Scottish politicians have generally applied totally contradictory principles to care, allowing it to be outsourced for profit with disastrous consequences[59].

There are already precedents for moving to a not-for-profit care system in Scotland. The law in theory requires foster care services to be not-for-profit although this is laxly enforced and there is nothing to stop companies transferring profits through intra-group charges, loans etc*. And the Scottish Government in their response to the Independent Care Review for Children, the Promise, accepted that all children's services should be not-for-profit, while accepting the opposite for adult services[60]. That unresolved contradiction helps explain why many in children's services are now so concerned about being included in the proposed NCS[61].

At the same time, the Scottish Government plans to integrate health and social care create a real risk that the not-for-profit ethos of the NHS will be undermined and private companies are allowed into the NHS by the backdoor. If private companies run care services, why not new 'integrated' health and care services? There are very strong political reasons therefore for enshrining the not-for-profit principle into the NCS from the start. Doing so would resolve a number of issues that are currently undermining the care system and enable a new National Care Service to be built on firm foundations:

— A not-for-profit service would prevent money being extracted out of the care system, often to tax havens, as profit and enable it to be reinvested in care. While there are no accurate figures for how much money is lost from Scotland at present, UK estimates are that up to 10% of care home fees go in profits. With Scotland spending more than £800m a year on private care home places[62] that is £80m lost from the system which could be much better spent.

— The drive for profit is the primary reason why the social care workforce has been treated so badly. It has been responsible for driving down wages, employment conditions and levels of training in the sector. Moreover, it has dragged the voluntary sector, which has been forced to compete for contracts through the procurement system, in its wake. While the Scottish Government has tried to rectify some of this, it has itself admitted that it has no power to force providers to reward their workforce properly[63].

— Valuing money before care results in constant pressure to take short-cuts and cut standards. While contracts could be used better than they are** enforcing contractual clauses is fraught with difficulty. Moreover, there is always a price for any quality improvements, with providers expecting a cut from every £1 they are handed. Rather than trying to use carrot-and-stick to get private businesses to do the right thing, it would be much simpler and more efficient to have services focussed entirely on care.

— This would enable the current arrangements for commissioning and regulation, neither of which have worked, to be fundamentally re-thought and reformed (see below), making far better use of resources.

** For example, the accounts of Foster Care Associates Scotland show that as of December 2019 they had made an interest free loan of £9,163,000 to their parent company.*

*** See section on Ethical Commissioning below.*

— Abolishing the private sector would also bring the workforce together, as in the NHS. That would make it possible to create a single national structure for pay and conditions, facilitate national collective bargaining and enable the development of a national training programme and career pathways, just like in the NHS, as instead of changing employer staff would move to other jobs within the NCS.

— The price of not acting now is likely to be very high. The financialisation of the care sector is continuing apace. Care is now an international industry that uses a number of financial instruments to extract profit[64] and in which the power of organisations like equity funds and real estate investment trusts is increasing.

The private sector serves to transfer money from ordinary people and the public sector to the rich, increasing inequality. It is incompatible with care provision but its power has been such that it has blinded politicians to the truth. It is only in the last ten years that people have begun to question the sector and there is now lots of excellent research to substantiate those concerns. There is no longer any excuse not to act.

The place of the voluntary sector

Historically, the voluntary sector has played a very important role in both social work and social care. After Beveridge's Voluntary Services Inquiry in 1947 the sector accepted the need for state welfare provision and formed what has been called a 'pragmatic partnership' with the welfare state[65]. That relationship was changed by the Community Care Act 1991 which initiated a drive to outsource services. Increasingly the voluntary sector, which had focussed on specialist provision and campaigning, become involved in direct care provision and, partly because of the procurement regime, started to compete with and often act like the private sector.

For example, the largest care provider in Scotland is now the Richmond Fellowship, which had its origins as a small specialist mental health provider but now has a budget larger than some council social work departments, pays its frontline staff the minimum wage, has very poor working conditions, resisted recognition of trade unions and reports profits in its accounts just like any private business*.

Many of the support functions that used to be undertaken by local government have also been transferred to the voluntary sector. Instead of professional social workers speaking up for people in need, that function is now performed by low paid and often poorly trained advocacy services whose role is limited to supporting people through the hoops and hurdles of the care 'system'. Instead of local authorities promoting social welfare through Section 12 of the Social Work (Scotland) Act 1968, the Scottish Government hands £500,000 to the Corra Foundation to administer the Winter Support Small Grants Fund which disburses small grants to people in need through local voluntary organisations. It's a cheap way of both the Scottish Government and voluntary sector getting media publicity but does nothing to reverse the cuts in public welfare.

While similar processes have taken place in England, in other respects the role of the voluntary sector in Scotland has taken a divergent course. In England there has been significant criticism of the direction of state policy by the voluntary sector and the UK Government has responded with legal restrictions as to what the voluntary sector can do[66]. In Scotland, however, a significant section of the voluntary sector is now funded directly by the Scottish Government, is used to disburse funds on its behalf and has far more power, when it comes to policy making, than local authorities.

As larger centrally-funded voluntary organisations have grown, either as providers or as a conduit for central government small

** Richmond Fellowship, made a financial surplus of £4,418,000 in the year to March 2020 on turnover of £83,241,000, has cash reserves of £32,004,000 (almost all of which derives from fees paid for by local authorities) and invests other surplus in private markets.*

grants which have mushroomed in scope and number, the nature of smaller local community organisations which used to provide so much community infrastructure in Scotland have withered and their position become ever more precarious through lack of local authority funding[67]. These organisations often fulfil roles that used to be performed within local councils – by community workers and others, who enjoyed trade union negotiated salaries and effective administrative back-up at one end, and professional governance at the other – both of which are now often done by 'volunteers'. Sometimes such small local groups are running services that should have stayed in the public sector but were 'asset transferred' in the name of 'community empowerment' including vital infrastructure like public toilets and libraries.

Most local charities now live from hand-to-mouth and exploit volunteers who are not trained to do so in the bureaucracy of governance; applying for grants and accounting for expenditure, managing staff, where they exist, minuting meetings. Instead of addressing the failures of the system, volunteers are dragged into the minutiae of mitigating its worst excesses. The system currently relies on the well-intentioned baby boomers who have been able to retire at 60 and will, like the care of the very old which relies on this same cohort, collapse as retirement age increases. Such volunteers are actually depriving younger people of job opportunities in the provision of essential services and the growth of the sector is in inverse proportion to the loss of secure jobs in local authorities.

Voluntary sector care providers have not been neutral in these changes. Instead of being allied with the welfare state against the private sector, it has sometimes felt that parts of the voluntary sector are leading the charge to dismember the welfare state. They have generally accepted, indeed sometimes promoted, the justification for outsourcing, the idea that public service provision is too expensive and best done by others. They have then used procurement processes to grow their own businesses in a race to the bottom. In the last few years, however, the voluntary sector has started to challenge the whole system, both procurement and self-directed support[68].

There are similar issues at local level, with paid managers of organisations that are little more than conduits for passing responsibilities onto volunteers, describing themselves with grand titles like 'CEO'. Such posts are so dependent on pleasing funders that the 'partnerships' and other bodies they inhabit can become little more than exercises at camouflage over the shrinkage of the public sector. Outside of children's services, the voluntary sector has been fairly silent about the Scottish Government's proposals to create a for-profit care service and it's difficult to avoid the conclusion that there are senior managers in the sector who have replaced principle with self-interest.

And yet, potentially, the voluntary sector could play a crucial role within a not-for-profit care service. It could have a key role in representing services users and carers, just like the trade unions represent the workforce. National providers could play an important part in the provision of specialist care. Small local voluntary organisations provide an opportunity to develop community-controlled services. It could play an important role in raising awareness of new issues as they arise and in campaigning.

For this to happen, however, firstly we need to abolish the private sector element of provision so that the voluntary sector can start to work in partnership with local authorities. Secondly, we need to initiate a public debate about what has gone wrong in the sector and how it should be reformed as part of the wider reforms needed to create the NCS. Thirdly voluntary organisations need to be securely funded so that workforce pay, conditions and training mirrors the public sector. In our view the NCS should then shift attention and resources from supporting large voluntary sector providers to smaller locally-based and community-controlled voluntary sector providers who are signed up, complementing the public sector, not shrinking it. The next section explains further how this could be done.

ETHICAL COMMISSIONING

Why has commissioning gone wrong?

Commissioning has several meanings. In the NHS it is used to refer to the planning, designing and costing of services that are mainly operated in-house, from new hospitals to public health screening programmes. In social care it is the term used to describe how public authorities plan and manage the market in private and voluntary services and has become increasingly associated with the European Union's procurement regime.

Ethical commissioning should be about putting people, not resources or profit, at the centre of how we plan and develop services:

— the people who need care

— informal carers

— the workforce

The fundamental problem with the commissioning system for the last thirty years is that it has not been driven by the needs of people but rather by our profit-driven capitalist system and more specifically:

— constraints on public expenditure, which date back to the 1980s, in the face of growing need and demand;

— the requirement for local authorities to balance reduced budgets, which has resulted in pressure to outsource services to reduce costs;

— the EU-derived procurement/tendering regime which has been the means for achieving this; and

— the market, where it can make money and where it can't.

The result has been insufficient and poor quality services that fail to support informal carers and people's needs and one of the most exploited sections of Scotland's workforce.

By contrast, built into every new NHS service are the costs of providing that service, from staff wages (based on the nationally agreed pay rates and terms and conditions) to the provision of equipment sourced from private providers. Procurement has a vital role in delivering the facilities and goods necessary to deliver quality services (for example buildings*, equipment, energy supplies, PPE, drugs, food etc), but should not be part of the fundamental service design, which is about patients and staff. We should adopt a similar model for a NCS but that requires an end to the market in social care.

The importance of getting costs right

If care was not-for-profit, social care commissioning could change from procuring services from markets to planning services with local communities. That would be revolutionary and enable many of the aspirations behind the various attempts to improve commissioning over the last 20 years to be realised.

However, contrary to current policy, attention to inputs is as important as considering desired outcomes. Indeed, without the right inputs (appropriately trained staff with sufficient time to care) we will never improve outcomes which explains why, despite all the talk, the epidemic of people dying before their time continues to grow.

Based on the experience of developing the National Care Home Contract care cost calculator, we know it would not be difficult to build in the recommendations of the Fair Work Convention, and to price services based on cost, not on what the market will offer. That requires some further development nationally, including:

— working with staff to establish how much time is reasonably required to provide care tasks holistically;

** How important is demonstrated by the problems at the Queen Elizabeth University Hospital in Glasgow.*

— looking at the impact of shift length and patterns on staff's ability to provide quality care;

— developing methodologies to build the cost of travel time and miles into what is paid for services.

— considering how best to provide or cost other infrastructure that supports service delivery, from training to smartphone provision

Commissioning in the NCS would have a key role in ensuing services are properly resourced while at the same time making sure money is well spent.

The purpose of ethical commissioning

But, having established parameters for core costs, the really skilled job would then begin: assisting the primary stakeholders, those needing care, carers and the workforce, to redesign services collectively so they meet need. The intention would be that commissioners and commissioning became far more like the centres for independent living, which help people with disabilities design and manage their care packages, but for communities and within the context of care being provided publicly or on a not-for-profit basis. Provision could be through local authorities, community interest companies, voluntary organisations, social enterprises with employee ownership such as Highland Home Carers or Buurtzorg-type models of self-managed staff teams*.

For this to happen the right to choose one's provider, as enshrined in the Self-Directed Support (Scotland) Act should cease to be the *primary* factor driving commissioning. The right to choose providers would remain important for particular groups and circumstances, including:

— people with disabilities needing long term care who are in a position to and want to control their care packages (using the same costing principles as apply to other services);

— residential services for adults.

Alongside this the role of the Social Worker would need to change: from acting as a gatekeeper, who then advises eligible people about their right to choose a service, to introducing the person needing care to their local service provider and helping to negotiate how their care needs should be met (with all the complexities and compromises that that involves).

As opposed to the current market system, ethical commissioning would aim to:

— create accessible services, with local offices and bases for staff, so anyone can speak to staff and managers of the service if required;

— empower service users, carers and front-line staff to take day-to-day decisions about how the workforce uses its time, allowing staff to spend more time with a person when needed, less time when not;

— develop mechanisms, such as elected service management committees, to empower service users, carers and front-line staff to control how both public and voluntary services are managed;

— replace duplicate competing services with one locally accountable service;

— invest in local community infrastructure in order to allow people with care needs and their carers to participate in ordinary life; and

— put health and safety first, which in the current pandemic would include retrofitting building-based services to enable high

** The Buurtzorg model has been trialled in Scotland, with mixed success in Aberdeen due to nurses being swamped with social care work and by the voluntary sector provider Cornerstone who tried to apply the model to teams without professional training.*

standards of infection control in a manner that is as unobtrusive as possible; proper ventilation, changing areas for staff etc.

Models of service provision

Neither the IRASC nor the Scottish Government's consultation on the NCS gives any consideration to what types or models of service the NCS should provide. Government has shifted from trying to commission particular types of service, such as specialist dementia units, to leaving that to the market and individual choice. In doing so it has abdicated responsibility and one of the first priorities for commissioning within the new National Care Service, at both local and national level, should be to work with the relevant communities to decide and plan what types of service are required, informed by research.

Here we consider briefly some of the options:

— **Purpose built housing-based services.** Ironically, the state's abandonment of sheltered housing in favour of individualised care services for the old has been accompanied by a boom in private retirement villages for the rich who recognise the value of being able to have your own private space along with access to communal facilities and support. While such housing won't suit everyone, being barrier-free it can make a real difference to those with physical disabilities, enables those who might otherwise be isolated to form new friendships and can improve access to health and other services. Increasing the number of purpose-built housing-based services is part of the key to reducing the number of people who have to live in care homes*, including adults with disabilities.

— **Housing based services in the community.** In areas where there are higher populations of people with care needs there is significant potential to invest in communal facilities which could be used by people living nearby in the same sorts of way as the best sheltered housing complexes operate – a Local Care Hub out of which home care and housing staff can operate but also where people can come for a meal (lunch club) etc.

— **Care centres linked to Local Care Hubs.** Large care homes, divorced from local communities, have become the norm in the name of efficiency/profit while over the last ten years day centre provision has reduced by almost 25%69. Smaller care homes, which also provided respite and day care, would enable people to build caring relationship with staff and other users over time and continuity of care where needs increased. It would help address some of the concerns that make many people reluctant to accept a short break.

— **Communal food provision/eating.** There is a considerable difference in the experience of being handed a re-heated meal by a home help and being left alone to eat it and getting out the house to enjoy a meal with others. And yet the trend has been to stop supporting (preventive) services like lunch clubs and replace them with far more expensive provision at home. And for frailer people who find eating or communication difficult, there is masses of potential for staff to sit down and eat meals with them as part of the care they offer, akin to the teachers who used to sit down with pupils for school lunches and 'steer the ship'.

— **Support for looked after children.** Although relationships have been recognised as key to getting care for looked after children right, the way social work and care services are currently organised undermines this. Changes of social worker are thrust upon young people for organisational reasons, such as they reach a certain age or move area. Where young people having trouble do form positive attachments with adults,

** Borders Council was reported in November 2021 to be considering the development of a care village at Tweedbank in place of two care homes.*

whether at a school, youth club or in a residential home, when the young person moves, we do nothing to support that relationship to continue whereas what we need to do is pay/organise the work of that staff member so that they can continue to have contact and support the young person where needed.

— **Foster care.** The Scottish Government has rightly extended the responsibilities of 'corporate' parents to care and support young people up to the age of 25, without changing the model of foster care or supporting foster carers to make this possible. For example, where foster carers take on new children, the provision of larger housing or an extension, would enable young people who have left home to return when they wanted to do so or needed support (as happens in other families).

— **Community-driven support services.** While community-based social work teams will often become aware of unmet needs in communities and a service gap, that won't always be the case and groups of people in a community may identify a need. Community Social Work has a key role to play in responding to this and, where they cannot meet the gap from existing services, facilitating the involvement of commissioners and more specialist staff able to engage with and support people with complex and multiple needs.

How to change from private market to ethical care provision

The IRASC rejected nationalisation of care on grounds of cost but included no analysis to support this contention, apart from a reference to the £900,000 it cost the Scottish Government to take Home Farm Care Home on Skye into public ownership*. While statistics are no longer collected on spend between the public, voluntary and private sectors, workforce data from the SSSC[70] shows of the total social work and social care workforce around 80,000 are employed in the private sector, around 70,000 in the voluntary sector and around 56,000 in the public sector.

Given assurances about the future, we believe the vast majority of the voluntary sector would want to align itself to the NCS and sign up to the same values and standards, the same workforce pay and conditions and the not-for-profit principle. Exactly how they would fit with the NCS would need to be negotiated over time as part of a general transformation from top-down centrally-managed to locally-based and locally-controlled services, but we see no fundamental reason why most of the voluntary sector would object to this. It is possible too that some private sector operators might be prepared to transfer voluntarily to the NCS, for example by swapping a private sector franchise in home care for a secure job in the NCS with an appropriate price being paid for any capital assets.

For those that don't wish to join the NCS there are several options. The first is simply for local authorities within the NCS to terminate contracts when they reach their term and to transfer staff to the NCS under the TUPE regulations. While this can be a complex process, it would be a one-off and would minimise disruption to services users and allow workforce pay and conditions in these services to be aligned with the public sector.

The second option would be to nationalise services. The costs or threat of disruption from this would not be great, for community-based services, especially if spread over time. Services provided to people in their own homes are human-resource-intensive and the capital assets required to provide such services mainly consist of office buildings, associated equipment and IT systems and vehicles. For example, in the case of Richmond Fellowship Scotland, the largest care provider in Scotland, it had fixed assets of just £15,066,000 in March 2020 almost £2 million of which was in land[71].

The main challenge for nationalisation is with building-based care provision because of the capital assets involved. While voluntary sector

** Nowhere in the IRASC is there any analysis of the balance of spend on private and voluntary sector services.*

providers might be prepared to join the NCS, so long as they were able to retain their assets and were fairly paid for maintaining them, it seems unlikely that most private sector businesses, whose assets were valued at the end of 2020 as being worth £2 billion[72] would agree to them being used for the public good and a fair price*. In the scheme of things, however, £2bn would be a relatively small amount which could be paid for in two years if the recent increase in revenue resulting from the increase in National Insurance was handed over to the Scottish Government.

Contrary to the IRASC, however, bringing the assets of the care home industry into public ownership would cost far less than this and in the medium term pay for itself**. For 30 years the aspiration has been to maintain more older people in the community but still far too many end their lives in care homes. With proper investment in housing and community services, it is not unreasonable over time to plan for the care home sector for older people in Scotland to reduce from around 32,000 to 16,000 places. In other words, a NCS wouldn't need to acquire the whole sector but could terminate contracts with suitable notice over time. Moreover, valuation of care homes is a complex business, with lots of variables, but for poorly performing care homes, the value of the assets would likely to be less.

Further still, if the Scottish Government followed the precedent of foster care services and required all providers over time to be not-for-profit, that would destroy the speculation in care home buildings that results in current market valuations. It would then be possible to buy out providers not on the basis of the value of the business but the value of the land and building – and important to remember that the public already pays for the land and buildings in the fees paid to private providers.

If phased in over a period of years – and many small private providers might be happy to operate until their owners wished to retire and sell up – nationalising the care home industry would be quite affordable.

For the last thirty years the state has turned to the private sector as the main source of capital for investment in care assets but that should not be used as an excuse not to develop alternative mechanisms to fund capital investment in future. In 2020 the Scottish National Investment Bank (SNIB) launched after a long campaign headed by Common Weal. The bank is set to be directly capitalised by the Scottish Government granting it approximately £200 million per year for ten years until it reaches a total capitalisation of £2 billion. The bank is required to loan money on a 'patient finance' model and its investments guided by a series of 'missions'[73] from the Scottish Government including targets to transition to net zero carbon emissions, invest in innovation and, crucially for the purposes of social care reform, to reduce inequality and improve opportunities and outcomes for people in Scotland. This last mission opens the possibility of expanding and harnessing SNIB funding to help with the capital investments required to reform social care. Another option, to issue care bonds to help pay for the nationalisation of the private sector and investment in care infrastructure, could be particularly attractive as it would be for the common good and would give people an opportunity to earn some interest on their savings, unlike at present.

With the increased financialisation of the private care sector the real question is whether we can afford not to nationalise it?

** It is important to note here that in the private residential services sector premises tend to be small and leased, not owned, which would make it possible to nationalise or exit from these services without incurring large capital costs.*

*** If, as estimated, about 10% of care home fees is, in the case of larger providers, extracted in profit that is a significant sum of money that could be used to pay interest on any care homes that were acquired on the open market.*

CARE AND HEALTH, THE NCS AND THE NHS

Care and health are both key to the quality of our lives but, while interconnected, are very different concepts. This has important consequences and implications for how we meet health needs and how we meet care needs.

The relationship between care and health

While there is an inevitable crossover and it is unhelpful to impose false dichotomies, there are some fundamental differences between health and care that go largely unrecognised in the drive to integrate the two fields.

Care is primarily about human relationships whereas health is primarily about how our minds and bodies function. The one is social; the other is about the human organism. They involve very different knowledge practices with care being more of an art, health more of a science. This means the way that professional care staff and professional health practitioners go about their work is fundamentally different. You cannot 'treat' care problems whereas science-based treatment is central to much health service provision. While health can be subject to interventions to do so better, the practice of care is essentially practical and moral.

There is of course considerable overlap. To provide care for people with complex needs, carers may need to acquire health-related knowledge; to be a good doctor you need to be both caring and to acquire some understanding of people's care needs. But the distinction between care and health gets blurred as we have no verb 'to health' someone and as a consequence we talk about doctors 'caring' for their patients and of health-*care* services.

The primary purpose of healthcare services and the NHS, however, is very different to what care services should do. The core function of health services is to treat bodily illnesses, whether physical or mental, although since prevention is far better than cure, the NHS is also concerned about the environmental and social factors that cause illness. The core function of care services, by contrast, is about providing care when this cannot be done through people's network of caring relationship. But again, because prevention is better than provision, social work is concerned about the economic and social care factors that influence this.

That creates further overlap between health and care because, just as poverty and inequality affect care, they also affect health. Indeed, where people lack close caring relationships or are subject to abusive relationships that in themselves can cause ill-health, both mental and physical, with good care playing an important role in the physical development of children. Care therefore has a vitally important contribution to make to good health, while physical and mental illnesses affect people's ability to care.

Public Health has, to its credit, recognised much of this and, in the absence of a Public Care Service, stepped in to fill the gap. That has, however, had the unfortunate consequence that issues like poverty are now almost invariably seen through a health lens and reinforced the tendency of politicians to fund the NHS before other services like local government. The connections and overlaps don't change the fact that health and care are different and there is a discussion to be had on whether some of the functions currently carried out through Public Health would be better delivered by a Public Care Service with the power to invest in care infrastructure.

Caring relationships, while central to care, also have an important role in health service provision. There is a difference between a doctor who cares and one who doesn't. But then you could say that of lawyers or architects and anyone who provides services. Care is the social cement that binds health practitioners and their patients. Sometimes it is more than that, particularly in nursing: care assists recovery from illness, while palliative care is both health-care and care.

Understanding the differences, the interrelationship and the overlaps between health and care is in our view essential if we are to improve how we meet health and care needs and in any consideration of the NCS. Health

and care both need to be recognised in their own right, which is why the creation of the NCS independent of the NHS is so important, it will give care the status it deserves. We first need to sort out how best to meet health and care needs and then we can look at the overlaps and interrelationships and how health and care services should work together.

Instead, over the last twenty years, thinking about health and care has been conflated and driven by the resource crisis in the NHS.

The crisis in the NHS and health and social care integration

Caught between the neoliberal consensus that public spending is bad and public support for the NHS, politicians have tried to mitigate increasing demand, primarily the growing number of older people, and the costs of new and ever more high-tech medical treatments by divesting the NHS of responsibility for anything other than treatment. Long-term beds have been closed and provision effectively outsourced to private providers. Meanwhile, day-to-day operation of hospitals has become focussed on throughput, just in time medical treatment, with little regard to whether people's home circumstances will allow them to recuperate or manage at home*. Under this system, anyone who is unable to leave hospital the moment they are pronounced medically fit to do so, is classed as a problem, a 'delayed discharge'. Responsibility is then passed to social services to fix this by getting people out of hospital as quickly as possible.

This has helped enable the significant reduction in the number of NHS beds over the last ten years[74] but the system has been plagued by 'blocked bed crises' even before it was exposed by the Covid pandemic. Instead of taking a critical look at the underlying problems, the response up until now has been to try and make care services work for the NHS, hence health and social care integration. That is manifested in the performance indicators for the Integration Joint Boards that are based on data; since 2015, nine out of 13 have been about keeping people out of hospital, hospital admissions or speed of discharge[75]. While the failure to meet those targets is well documented[76] the response of both Audit Scotland and the IRASC was to urge further integration. The Covid pandemic should have made it obvious to all that the lack of capacity in the NHS cannot be addressed by shunting people recovering from illnesses over to social care.

The focus on integration has distorted the whole relationship between care and health and had adverse consequences for both:

— First, it has served to disguise the underfunding of both health and care, with the health and social care partnerships caught in the middle;

— Second, local authorities have been forced into directing inadequate resources on meeting the high priority physical care needs of individuals to keep them out of hospital rather than on providing the lower-level services, such as lunch clubs and youth clubs, which enable and support people to enjoy caring relationships. This has been a significant contributory factor to the increase in mental illness and addiction problems which is now threatening to overwhelm mental health services. To compound the disaster, instead of viewing it from a care perspective – what do we need to do to support families and local communities to combat social isolation and despair and feel cared for – the loudest voices are medicalising the problems, calling for teachers to be trained in mental health[77], more mental health workers for example to be employed in schools[78]; and

— Third, while it is in the interests of many people to return home once treatment

** While the focus of delayed discharge is on older people, mother and their new babies now spend an extremely short time in hospital. That is fine for some but for others it contributes to the lack of support in early parenting discussed above.*

is ended, for others hospital admission comes at a crisis point in their lives and should be an opportunity to support and care for them in a way that enables them to change. That used to an important function of hospital social work and other hospital-based services such as occupational therapy and physiotherapy. People with alcohol and addiction problems, for example, need time to get their lives together. But instead of supporting people to do this while in hospital, the system encourages people to return home or discharge themselves* back into the same surroundings and milieu which contributed to the hospital admission. Hence, in part, the revolving door in hospital admissions. In 2018-19, 92,000 people in 2018-19 had three or more hospital admissions[79].

Towards a new model for health and care

To address these and wider issues, both health and care need to be valued and considered in their own right. The almost exclusive focus on one part of the relationship between care and health has shifted attention from all the things that support good care and which we have described earlier. If we could get that right, it would not just be good for people, it would be good for their health and help reduce demand on the NHS. We therefore believe that unlike Adult Care Services at present, the NCS should be focussed on care. For that to happen it needs to be independent from the NHS. Both services should then be funded to do the jobs they were primarily set up to do. That would help relieve services like General Practice, which are currently overwhelmed because they have become the service of last resort for social problems.

This should not preclude, however, the NHS including 'care' as well as treatment in its provision and the NCS including 'treatment' in its care provision. It makes sense to care for some people in hospital for a time after they are medically fit for discharge and plan the NHS estate accordingly. If care was properly funded and care staff properly remunerated, it would be no more expensive to care for people under the NHS where this made sense. Instead of bouncing older people into care homes, as the only way to get them out of hospital quickly, giving them time to recover after their treatment had ended would respect their human rights. Conversely, it would make sense for the NCS to provide certain health treatment but that requires care staff to be properly trained to do this and appropriately remunerated. The opportunities for the NHS and NCS to work in partnership and mutually assist each other where health needs and care needs coincide and overlap should be obvious.

We should abandon, however, the current managerialist approach to 'integration' which has attempted to make inadequate resources go further by making health staff do care jobs and vice versa. This has ignored the distinct differences between health and care and the different knowledge and skills required by the two workforces. Instead, the co-ordination of health and care services for individuals is best left to the professionals concerned in consultation with the person who has health and care needs. The focus of management should be on ensuring that the organisational structure and infrastructure of the two services (including IT systems) facilitates such co-ordination and that the workload of professionals allows them time to work on a multi-disciplinary basis across health and care where appropriate.

Underpinning all these considerations the operation of the NHS and the NCS should be bound by a common set of values and principles: a commitment to the welfare state; respect for the rights of individuals to take decisions about services; services being free at the point of need and not-for-profit; a focus on workforce training and support etc. The creation of a NCS founded on a clear set of principles should be an opportunity to do the same for the NHS.

** Hospital doctors are proscribed from prescribing methadone or providing patients with alcohol with the result that many discharge themselves even before they are medically fit to be discharged.*

THE STRUCTURE AND ORGANISATION OF THE NATIONAL CARE SERVICE

Currently, local authorities have primary responsibility for care, in legal statute, financially and in terms of service provision, whether they do this directly or commission other services. But since integration with health has become the policy mantra, the NHS and local authorities have been forced into new structures, the latest incarnation of which are the Integrated Joint Boards. These haven't delivered what they promised[80] but despite that evidence the Scottish Government wants to operate the new NCS through enhanced Health and Social Care Boards rather than local government. By contrast our proposal is that the NCS should be financed by the Scottish Government but delivered through local authorities.

Why the NCS needs to be delivered through local government

Many people's experience of local authority care is not good, whether this is the support offered by social workers, care services which take little account of their views or wishes or ancillary services like housing[81,82]. Significant elements of the disability movement now support a centralised NCS, like the NHS, because of these experiences. We believe that is a mistake.

First, it fails to acknowledge that most of local authority funding comes from central government and that funding, which was squeezed before the financial crash, has been relentlessly cut since then[83]. That accounts for many, but not all, of people's bad experiences with local authorities and the services they have outsourced. While local councillors could have done far more and earlier to highlight the consequences of these funding cuts, ultimately they provide a democratic check to central government which would not exist in a centralised NCS.

Second, it fails to recognise the differences between care and health and that local communities are crucial to the success of care provision. With their wider responsibilities for housing, certain benefits, education and community infrastructure, local authorities are far better placed to make care work than boards dominated by the requirements of the NHS.

Third, a matter of principle is at stake. As Winston Churchill once said: "*No one pretends that democracy is perfect or all-wise. Indeed, it has been said that democracy is the worst form of Government except for all those other forms that have been tried from time to time....*". Local government may have serious faults at present and have a lot to answer for, but the alternative, boards under the patronage of Scottish Ministers, will be far worse. The challenge is to make local authorities work. Our proposals for a standalone NCS delivered by local authorities provide an opportunity to reinvigorate local democracy.

Financing local authorities to deliver care services

Resources are crucial to the success of the NCS. Centralised funding would free up local authorities from having to set care budgets and end the post-code lottery, where different amounts are spent on care across the country because different councils afford it a different political priority. Care is too important for that. While the care budget would be ring-fenced and local authorities would be expected to distribute it fairly according to need across their area, how to make best use of it would be their decision, working together with local communities.

Local authorities would, however, have a vital new role in helping to hold central government to account for the amount that was invested in care and ensuring this becomes as much a political priority as funding the NHS. Just as in the NHS, waiting lists and new treatments drives investment, so in social care a legal duty on local authorities to record and publish data on all unmet social care needs, the outcome of consultation about the services required to meet them and their proposals for responding to that should fulfil a similar function. Scottish Ministers should then be under a legal obligation to take this into account when determining the annual care budget for Scotland. This would put local authorities in a powerful position politically if it fell short.

In return for proper funding, local authorities would be expected to undertake extensive reforms of the social work and social care systems as they operate at present, with the aim of decentralising services to local communities and empowering service users, informal carers and staff who work on the frontline (as described above). Our forthcoming paper on the Structure and Organisation of the NCS will set out in more detail how to do this but, because every local community is different, we don't believe there is any merit in prescribing this centrally, either by the Scottish Government or councils.

The basic legal framework for devolving services already exists and local authorities should be given the opportunity to foster that, rather than block it as at present.

National NCS functions and governance

A small number of functions would require to be delivered centrally and, in our view, to ensure that central and local functions work together this should be under a Board of Councillors chaired by a new Cabinet Secretary for Care (with equal status to the Cabinet Secretary for Health).

These functions should include:

— data collection, including unmet need, carers, local authorities' views as to services required and statistics;

— research, bringing together a number of organisations that are funded to do this at present, and funding of research in Scotland's universities;

— workforce planning;

— national professional leadership (e.g., social workers, occupational therapists);

— a national training framework and training programmes;

— workforce pay and conditions and sectoral collective bargaining;

— finance, budget setting and allocations to local authorities based on need;

— national commissioning, including agreeing cost calculators for service provision and commissioning of cross-boundary and nationwide, including specialist, services;

— national procurement e.g., PPE, community (occupational therapy) equipment, equipment for building based services; and

— interface at national level with other public policy and services: health, housing, environment etc.

REGULATION AND IMPROVEMENT

One of the first pieces of legislation passed by the Scottish Parliament was the Regulation of Care (Scotland) Act 2001. This set up two separate regulatory bodies for social care, the Scottish Social Services Council (SSSC), which regulates the workforce, and the Care Inspectorate (CI) which regulates care services across the public, private and voluntary sectors. There is almost no evidence* that shows this system has made any difference, either to the quality of the workforce or to the quality of services. The creation of a not-for-profit NCS provides an opportunity for fundamental reform.

** There has been no review of the Care Inspectorate and SSSC to establish what they have achieved. The Crerar Review 2007, which looked at regulation across the public sector, found little evidence of its impact in the Report of the Independent Review of Regulation, Audit, Inspection and Complaints Handling of Public Services in Scotland. The merging of the Social Work Inspection Agency and Care Commission in the Public Services Reform (Scotland) Act 2010 was done on grounds of cost and did not consider the impact of either agency*

The Scottish Social Services Council

The SSSC's primary role is to ensure those working in social work and social care are fit to do so. It maintains registers of staff working in social work services, sets out qualification requirements and investigates concerns about workers fitness to practise. It also undertakes various initiatives to promote the development of good practice.

The SSSC was intended to help professionalise the workforce and, as new groups of staff were registered and then trained, one might have expected fitness to practice cases to drop over time. The opposite has happened; training for many groups of staff has collapsed while, as was mentioned earlier, disciplinary investigations and actions have increased over time and there is now a huge backlog of fitness to practise cases, with some staff having to wait four years for their case to be heard[84]. While there is little formal research into the impact this has had in Scotland, anecdotally[85] it can shatter the careers of people where cases are not proved while generally the whole system appears to cause huge emotional scars, made worse because many employers now use the threat of referral to the SSSC as a means to intimidate workers.

The central flaw in the current system is that responsibility for learning is placed on the individual worker. This may be appropriate for social workers and managers, who have undertaken extensive training as part of acquiring professional qualifications, but is not appropriate for front line care workers with limited or no experience of higher education and who may be entering the workforce for the first time. The system almost certainly contributes to the high turnover in the workforce* and our feedback has been that many workers live in fear of whether they will meet SSSC requirements or not.

While devoting considerable effort to policing the Employees Codes of Practice, the SSSC takes no account of whether providers are carrying out the responsibilities set out in the Employers Code of Practice. The Care Inspectorate is supposed to take account of this Code while inspecting services** but because its powers relate to services, not providers, it has no means of taking action. With training usually the first thing to be cut by employers, most social care workers now receive little or none. That provides an opportunity for fundamental reform.

How to reform the SSSC and support the workforce

Rather than try and create a new system to force employers to provide training, it would be simpler, cheaper and more effective to create a national social care training/workforce development section within the NCS. The NCS would then be responsible for developing a national qualifications framework through collective bargaining with the workforce. That would leave the SSSC responsible for the registration of the workforce and serious fitness to practise cases and these functions could form part of the remit of a new regulator for the NCS.

As part of this reform, further groups of staff working within social care should be required to register with the new regulator. Neither personal assistants, employed through direct payments, nor social work assistants are currently required to register, despite working directly with people who need support or care. In addition, there are some associated staff, working in commissioning and regulation, who should be brought within the regulatory remit.

Personal assistants should be required to undertake the same training as other staff and direct payments should include an allowance to enable them to attend training in work time. A new national training programme should be developed for social work assistants, commissioning and regulatory staff.

** Despite the high turnover, there appears to have been no research in this area.*

*** The Employers Code of Practice is generally never referred to in Inspection Reports.*

The Care Inspectorate

While regulatory control by the SSSC over the workforce has increased, regulatory control over services by the Care Inspectorate has generally decreased. Since its creation the frequency of inspections has reduced, controls over staffing in services relaxed, allowing for example qualified nurses to be stripped out of care homes and there has been a failure to take enforcement action or close services, even when poor standards have been evidenced on multiple occasions. Moreover, despite its powers to decide whether a provider is fit to operate a service, the Care Inspectorate has stood by while the pay and conditions of the workforce have been undermined and it has watched money being leached out of the system. While inspection grades have gradually risen since it was created, this appears a consequence of grade inflation rather than a real improvement in standards.

After years of concealing the failures in the current system, it all came to head with the outbreak of the Covid pandemic when the Care Inspectorate stood aside while services were ravaged or collapsed. While eventually forced by the Scottish Parliament to inspect how care homes were managing infection control, by March 2021 only 332 of Scotland's 1068 Care Homes had been inspected[86], and only one in 20 complaints about care homes submitted during the pandemic were investigated[87]. Other types of service were almost completely abandoned at the hour of their users' greatest need. Belatedly over the last year the Care Inspectorate has taken more enforcement action than ever before, with 23 out of 12,054 registered services having been served Improvement Notices, still a tiny proportion of the total[88].

While the legal framework for regulating services is weak and cumbersome, making it very difficult to take effective regulatory action, the wider assumption that there can be an effective partnership between the public sector and the private sector is the root problem. There are many good staff in the Care Inspectorate who are committed to high quality care provision but they are expected to work with services which are owned by people and organisations whose primary motivation is not care but profit. Staff have no powers to force providers to invest what is needed to deliver good quality care. To reform the current system to ensure that public funding and private fees were spent on care and invested in staff would require significant resources (e.g., accountants to track where money is going) and there is no evidence it would work*.

A new system for regulation and improvement

If care became not-for-profit and properly funded, the Care Inspectorate and the SSSC could be slimmed down, merged and their staff put to better use. The reason for this is that the overwhelming majority of front-line staff and managers in the care system care about what they do but because of the way the current system is operated, they are constantly prevented from delivering the sort of care they might wish through lack of money, training etc. That does not mean there should be no regulation, but it does mean that those elements of the Care Inspectorate and SSSC's work that are about supporting services and people to improve, might be better deployed in a new training section within the NCS.

A new regulatory system could then be built on a recognition that the nature of care does not lend itself to auditing which is how regulation currently operates. Care is a moral/practical endeavour rather than a technical/rational one, whereas regulatory regimes are invariably technical/rational. Care is hard to count 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.

** For example, despite the Office of Fair Trading first issuing guidance on unfair terms in care home contracts in 1998, its successor the Competition and Markets Authority found a similar range of problems in its Care Home Markets Study Final Report 2017.*

Arising out of the nature of care, the way to encourage improvement and achieve excellence is not to rely on dozens of standards, which no-one can reasonably remember, or audit or a performance target culture, but to develop reflective practice in which workers are supported by their peers and managers. Instead of relying on an occasional inspection to pick up when things are going wrong, the system needs to be designed to get it right on a day-to-day basis. That implies that responsibility for questions about fitness to practise should lie through line-managers with employers and when things go wrong, as they will, responsibility for this should lie with the employer as much as the employee. With a proper training and induction system, for example, people who are not suited to caring jobs should not be employed in the first place but where they are, issues should be addressed at an early stage by a no-blame approach and the onus should then be on employers to ensure staff are supported to do the job well.

With a not-for-profit care service, the focus could shift from inspecting individual services within it to inspecting the commissioning and management functions within local authorities to ensure they are supporting frontline staff to do the job properly. Primary responsibility for ensuring care services (including those in the voluntary sector) were of sufficient quality and met people's needs could return to local authorities *but* their performance in delivering this would then be subject to inspection. That could involve random or selective inspection of services within an area, (akin to how schools are currently inspected) to ensure they were of a proper standard and what the local authority was reporting was true.

It would be important, however, that the new regulator retained – indeed increased – its powers to take regulatory action when a service was not of an acceptable standard. But those powers should be primarily directed at local authorities/national commissioners, not individual services. The expectation should be that if a local authority commissioned a service, whether in-house or from the voluntary sector, and it was failing, the local authority would then step in (and in the case of the voluntary sector have the power to do so through their contracts). It is essential that the public retain the right to complain to the regulator where local authorities or national commissioners fail to address complaints about individual staff or services.

To facilitate all of this happening we would suggest that the local authority should have a duty to:

— produce its own reports on services and share these with the regulator;

— copy all complaints that could not be dealt with at the service level to the regulator; and

— inform the regulator of all disciplinary action against staff that calls into question their fitness to practice.

Such a system would require fewer staff to be employed in regulation but more in commissioning. It would also enable the separate complaints services operated by the SSSC and Care Inspectorate to be combined. This would enable a new single slimmed down regulator to focus on ensuring that the NCS was doing the job it was set up to do and addressing serious problems where they occurred.

FUNDING AND FINANCE

Our starting point is that care provision by the NCS should be collectively and fully funded by central government, like the NHS, instead of partially and inadequately funded as at present It should also be free. Revenue to fund this should be raised in a progressive way so that the wealthier contribute more. In the medium term the costs of care provision should not fall on those individuals who need it or on the groups most likely to need care, as the UK Government has done by increasing National Insurance contributions to fund care.

A universal care service, free at the point of use, would help liberate people from fear and stress: from the concerns that the parent/s of a child born with a disability faces about that child's future, to the fear of ending up isolated and alone

in one's final years. A universal service would, by getting in early, prevent some care needs increasing and in doing so reduce some financial costs. It would, through rewarding, treating and training the workforce properly, greatly improve the well-being of the care workforce and reduce gender pay inequality. What is more, every penny spent on care staff, is money invested in the local communities where they work.

Instead of regarding care as an intractable funding problem, we need to change our assumptions and treat care provision as an investment that, like the NHS, benefits everyone in society and is part of a wider caring economy[89]. With the ongoing attrition of employment in many areas of the economy (outsourcing manufacturing to other countries, reduction in administrative jobs through Information Technology, increasing automation) health and care services continue to provide opportunities for meaningful employment. Moreover, while health is in some aspects becoming increasingly automated – it's possible to envisage the time when most surgery might be carried out by robots – care by its nature depends on interaction with other humans*.

The general economic benefits from investing in care have been increasingly recognised and were acknowledged in the IRASC[90]. For example, the Women's Budget Group[91] found that investing 1% of GDP in care would create 2.7 times as many jobs as the same investment in construction and that even if wages were increased to the levels of those in construction, still 60% more jobs would be created, while governments would recover more income from tax and national insurance. Those benefits would continue "If training was also provided and pay increased accordingly to reach Denmark's levels, where care workers are paid about 73% of qualified nurses and teachers"**. In Scotland around 210,000 people or 8% of the workforce are employed in care compared to 10% in Sweden and 11% in Denmark.

Investing in care would also arguably be the single most important action government could take to address inequality in general and gender pay equality in particular. The need for care is experienced disproportionately in more deprived local communities (children, disability, illness, social isolation, homelessness, addiction, care needs resulting from ill-health) and creating better paid jobs in those communities would make a significant contribution to reducing poverty. As many commentators have observed, with women making up the vast majority of the social care workforce, any raising of pay in the care sector makes a significant contribution to reducing the gender pay gap.

These economic benefits would be even higher if so much public money was not currently extracted out of the care system by private providers, often to tax havens where it benefits very few. Care provision generally also has low carbon emissions and would be relative straightforward to make carbon neutral, particularly if services were embedded in local communities.

Seen from this perspective, the failure of social care expenditure to keep up with demand for over a decade and the market economy in care has been a lost opportunity to create meaningful sustainable jobs that benefit everyone in the face of the global climate and environmental crises. This contrasts with the impact of public funding in other areas of the economy, where state supported investment can destroy jobs through greater efficiency/use of capital or supports things that are harmful (whether producing weapons or exploiting people in other countries).

With the capitalist world system in crisis, we shouldn't be worrying about whether we can afford to fund care but rather what will happen if we don't as automation continues to make thousands of jobs redundant. Care, because it depends on human relationships, offers hope for fulfilling jobs into the future and is an area

** This has not prevented the European Union from funding a programme to see if care could be replaced by robots, a programme promoted in the UK by Advinia Health Care.*

*** In Denmark there is a unified health and care service in which there is a single unified career ladder including both homecare and nursing staff.*

where we need to resist the onward march of robots. The wellbeing of the entire population of Scotland depends on there being a larger care workforce in future: care jobs are part of the solution to a just transition from a fossil fuel-based economy to a green economy.

The creation of the NCS therefore has to be seen as part of a wider response to the current crisis and it is up to us to use government to channel the necessary resources into it. While the Scottish Government, with their limited powers, faces significant challenges in how to do this*, it has an opportunity to use the additional revenues arising from the increase the National Insurance contributions. According to GERS, over the past five years Scotland's National Insurance Contributions have been about 7.95% of the UK's total (compared to our 'population share' of about 8.3% of the UK – reflecting generally lower incomes in Scotland compared to the UK average). According to the Office of Budget Responsibility's forecast, the Health and Social Care Levy is due to come in in 2023-24 and to raise about £18-£20 bn per year. If we follow that GERS share then Scotland should expect to see about £1.45bn per year[92].

Even £1bn extra, while not enough to fully fund the NCS we propose, if added to the £800m increase in social care expenditure the Scottish Government had already committed to spend by 2025 in response to the IRASC, would be sufficient to make a radical start and fund the transition to a not-for-profit care system like the NHS. The main challenge with nationalising services is buying out the assets of the care home sector valued at around £2bn**. In theory, the Scottish Government could therefore take over all those assets in two years. But, with the better investment in community services we have argued for, we might need only half those assets and could take those over in a five-year period for £200m a year. That would leave £800m to spend elsewhere.

But each investment of £200m would immediately stop money being leached out of the system in profit[93] – something the IRASC was uneasy about – and save around £8m a year that could be reinvested in care. It would also enable the reform of commissioning and the regulators, which again would free up resources that could be better used elsewhere.

Similarly, while the IRASC's estimate that "every pound beyond the Real Living Wage will increase the national social care support wage bill by about £100m per annum" was far too low[94], even investing just half the extra £1bn, would enable a significant pay increase. Coupled with the immediate instigation of a training programme, that would help reduce workforce turnover and reduce staff shortages. That, in turn, would save costs elsewhere in the system and improve the caring capacity of the workforce. Instead of spending time and money on recruitment, employing agency staff and trying to fill gaps in rotas, managers would be freed up to support staff.

Meanwhile, as the members of the workforce grew more experienced, they would become better at their jobs and could take on more, including frontline decision-making. That in turn would in turn free up managers but also start to relieve pressure on the NHS as better care is the best way to keep people out of hospital.

The cuts to social care over the decade of austerity*** have created a vicious circle or downward spiral where, for all the talk of

** In the Scottish Government's budget for 2022-23, there was no mention of the additional monies and no additional allocation to care beyond commitments that had been made in the Programme for Government.*

*** The IRASC did not attempt to value the sector but argued that the purchase of Home Farm Care Home on Skye for £900k showed nationalisation was unaffordable. Actually, at that price, just under £26k a place, the 31,757 private sector care home places for adults in Scotland could be bought for less than £1 billion.*

**** Government financial data that would enable the extent of the cuts in social care to be properly assessed is lacking but Social Work Scotland in their submission to the IRASC estimated that social care expenditure in 2018-19 was "over £700m less than what would have been required to maintain services at their pre-austerity levels compared to the needs of Scotland's adult population"*

efficiency, less and less is delivered for every £1 invested. By contrast investment will create a virtuous circle where more is achieved for every £1 invested.

£200m to buy out care homes plus £500m to fund an immediate wage rise would still leave an extra £300m a year to finance the IRASC's underestimate of the costs necessary to fund its other recommendations[95], including abolition of charges, some of the other reforms we have recommended here and to start to develop new services. While all this was being done, there would be time to look at how we could put resources to better use and develop new mechanisms for capital funding.

Once the general population and businesses started to realise that investing had positive returns – improvements in mental health, for example, would have positive consequences for businesses – that would make the idea of progressive taxation for care more acceptable.

There is clearly a need to develop a detailed financial plan for how we set up the NCS and a requirement for much better financial information. That should be the responsibility of the Scottish Government working alongside local authorities, the voluntary sector and those in the private sector who are prepared to co-operate. Common Weal's Care Reform Group has been working on the figures and intends to publish its own finance paper in due course to show just what could be done.

SUMMARY OF HOW THE NATIONAL CARE SERVICE SHOULD BE ORGANISED AND WHY

— The NCS needs to be founded, like the NHS, on its frontline staff who need to be properly paid, trained and supported because only that will make care provision work.

— Frontline staff with the users of services and their informal carers should be empowered to take day to day decisions about care provision, because they are in the best position to do so

— Staff, service user and carers should be involved in the management of all services in order to restore the legitimacy and good sense of collective care provision. This provision would allow for people to manage their own services as they do under Direct Payments.

— The private market must be abolished, because it puts money and the exploitation of staff before care and leaches money out of the system (and country).

— Care provision, whether through the public or voluntary sector, should be embedded in local communities and designed to meet needs which would otherwise be unmet.

— Adult care should be separated from health because they are different and all care re-integrated into a single NCS delivered by local councils because local democracy matters and all other options are worse.

— The focus of commissioning should shift from selecting providers to assisting local communities and organisations to design or redesign services, according to agreed cost inputs, so that they work.

— With the workforce supported and the private market abolished, the primary focus of regulation can shift to inspecting how local authorities are delivering their commissioning functions (i.e., services designed with local communities and to empower those who need them) while retaining some residual responsibilities to investigate serious complaints and failures in the care system.

— The NCS should be centrally financed and the Scottish Government should have responsibility for ensuring that resources are sufficient to meet needs through dialogue with local authorities.

— The main role of the NCS nationally should be to support, rather than manage, the delivery of care locally, e.g., through collecting data on unmet need, research and training, but with some agreed exceptions, e.g., procurement of goods.

FROM HERE TO THERE

In order to transform our current poorly resourced, fragmented system of care into a properly resourced, co-ordinated National Care Service fit to stand alongside the NHS there will need to be a transitional plan that enables the changes to be implemented over a number of years. This should include a number of key strands:

1. **The National Care Service (Scotland) Act.** The new legislation that the Scottish Government has promised to introduce next June needs to be comprehensive. It must be founded on a definition of care and its importance in our society and set out the vision and principles for how the NCS should operate, including its responsibilities, the rights of people needing care, informal carers and staff within that and how resources will be determined and distributed. But we also need to take the opportunity to simplify and rationalise current legislation as happened in England and Wales with their respective Care Acts (in terms of form if not necessarily of content). In Scotland we have moved from one easy to understand and unifying law in 1968 (the Social Work Scotland Act) to dozens of separate laws* which even professionals find hard to understand. The law that directly concerns social work and social care, including regulation, should be rationalised and all be in one place. The National Care Service (Scotland) Act should also contain provisions for transitional arrangements.

2. **Phasing out the market in care.** While the requirement to move to not-to-profit services is a matter of principle, any transitional plan should be built on the recognition that there are clear differences between providers and that good private providers should be involved in designing transitional arrangements and have their contribution recognised. The initial focus of the transitional plan should be to reduce the amount of profit that is extracted from the system and to close/take over providers who fail to provide good standards of care. Those private providers who provide good services should be given certainty that their staff will be able to transfer to the NCS and their owners will receive fair compensation for the transfer of their assets.

3. **Devolving design and control of services.** There are two main aspects to this, creating a new framework for the democratic control of services and involving the people who depend on them. This needs to include users of services, their informal carers and staff, in their design and operation. The first can be done through legislation, requiring all services for example to have a Board that represents staff, informal carers and the people who use them. The second is a greater challenge but is the one that is most crucial if care provision is to enable people to thrive. There is no single solution because every community is different but we have to reverse the centralisation and financialisation of services that have both disempowered and disillusioned local communities. To empower communities to reform services will require support, in the form of community development and community social work but also from commissioning staff. This will take time and mistakes will be made along the way. The crucial thing is that structural reforms, as outlined in our organisation section, facilitate the development of local conversations about how best to meet care

** We have counted at least twenty-six.*

needs and that there is then support to translate these into action/care services.

4. **Empowerment of the workforce.** If social care workers are to be properly rewarded and given the time to care and the ability to take decisions on how best to do this, they need to be empowered. A suite of changes will be required to do this, from abolition of the fixed-length home care visit to creating structures for national collective bargaining. That process needs to involve the trade unions, frontline workers and managers, service users and informal carers, and people with relevant expertise in training, workforce planning and other human resources related issues.

5. **Care practice.** Currently practice is mainly driven by managing and making do with inadequate resources but, as that is fixed, if we are to maximise the potential of the workforce, as we explained above, we need to shift from a rights approach to an approach based on the ethics of care. That needs to be embedded in training, everyday management of services and regulation and will require its own change programme.

6. **Reform of local authorities.** We believe, contrary to the Scottish Government, that the NCS should be managed by local authorities. But councils need to recognise the damaging impacts of centralisation and a managerialist culture and reform how they operate by both democratising and devolving control over services. Our hope is that every local authority in Scotland would commit to create a five-year change programme, without the need for more legislation. The Community Empowerment (Scotland) Act 2015, for example, already in theory gives every community a right to a say over services, but polices resulting from it such as Participatory Budgeting amount to only a tiny fraction of Local Authority spending and – as with all other areas of Local Authority finance – have seen much greater pressure on demand than there has been in funding supply, making meaningful decision-making difficult to practically impossible. Any further attempts to move responsibilities – particularly in care – to Local Authorities without also devolving the powers and resources required to make good those responsibilities must be resisted.

7. **Reform of commissioning and regulation.** Our proposals to end the private market in services would allow the current roles and organisational structures for commissioning and the regulators to be fundamentally reformed as we have outlined above. That will require a significant change programme. Legislation will be needed to merge and change the remits of the Care Inspectorate and SSSC. Staff re-organisation would be required to transfer some staff supporting workforce development into a new training body within the NCS and to transfer some regulatory staff to commissioning. And along with this a significant change in skillsets and culture will be needed, for example from knowing about the EU procurement regulations to an ability to engage with service users, informal carers and staff on how best to design services. That in might in turn require commissioning staff to be devolved down to work in local areas.

8. **National infrastructure.** Many of the functions which we have proposed should be carried out centrally already exist in embryonic form in other places: workforce development at the SSSC, national commissioning at Scotland Excel*, professional leadership in the office of the Chief Social Work Officer and data collection in the Scottish Government. These need to be brought together and the gaps filled in another change programme.

9. **The role of central government.** Our proposal that central government assumes responsibility for funding while

** Scotland Excel is the body that is democratically controlled by local authorities and conducts procurement on their behalf.*

relinquishing power over delivery, is a reversal of current roles. The Scottish Government has increasingly tried to control delivery through legislation, standards and guidance while dumping financial responsibility onto inadequately-funded local authorities. Changing that will pose a major political challenge to our civil servants and national politicians whose thinking is embedded and driven by the current system. It will only happen if there is sufficient pressure from the public based on the simple demand that we need the National Care Service to match the NHS.

10. **The financial plan.** How to pay for care has always been the greatest challenge faced by the Scottish Government and partly explains the lack of ambition in their reform proposals. Now that they will receive significant additional monies through the UK Government's decision to increase National Insurance, they have far more resources than ever anticipated. They should seize the opportunity, commit to spend that additional resource on care, and develop a phased plan about how it will spend the additional money over the next five years.

CONCLUSION – A NATIONAL CARE SERVICE WON'T JUST HAPPEN

The proposals we have set out for a real National Care Service will not be achieved in isolation and will only be delivered as part of much wider, radical reform of the state in Scotland. It would make no sense for government to create an NCS on the lines we suggest while continuing to push other public services, including education and health, along the same trajectory that care services have been forced down for the last forty years: top-down management; outsourcing; de-professionalisation and de-skilling; deterioration of pay and working conditions; and ever-increasing reliance on the voluntary sector and volunteer labour.

While care and care provision are different to health or education and requires a service in its own right, many of the principles and proposals we have outlined could and should be applied to other services: the NHS needs to be democratised and power devolved; rigid policy control over teaching needs to be relaxed; all public services should be funded according to need rather than the latest economic dogma.

In our view the Scottish Government and civil service in Scotland is unlikely to agree to any of these changes willingly. That would require both to abandon their neoliberal assumptions about the role of the state, relinquish power and empower those on the frontline. These changes and our proposals for an NCS, therefore, will only happen through people power.

We hope, therefore, that Caring for All inspires people to realise another future is possible and helps prompt a ferment of thought, debate and activity about care across Scotland as an alternative to the proposal in the IRASC and the official consultation on an NCS which were designed to perpetuate the current system.

A real NCS will require far more thought and organisation than we have proposed in this Blueprint. The social care workforce needs to collectivise through the trade unions who represent them – and they in turn need to work together to establish a way forward. Pay and conditions are important and pressing issues, but so is the advance of services based on a strong public sector, and the devolvement of power to front line staff. Service users and carers dissatisfied with the current system need to unite with other forces and develop new mediums through which their voices can be heard. Social work and social care managers need to be treated as the experts they are, and not be sidelined in favour of private consultants. All of us need to work together in a spirit of unity, social justice and purpose.

Caring for All is only a starting point: and we hope those with an interest in the care system, from the bottom up, will take the ideas, develop them further and then campaign together for the radical reforms that will be required to create a National Care Service worthy of the name.

APPENDIX

A BRIEF ACCOUNT OF WHAT'S GONE WRONG WITH THE CARE SYSTEM

Our current care system cannot deliver the type of care we really need, support carers or help develop a more caring society as a consequence of a number of deep-seated flaws which can only be addressed through fundamental reform.

— The problems date back to 1948, when responsibility for care, which had been governed by the Poor Laws was given to local authorities – a good thing – but without the resources to deliver care effectively, unlike the NHS which was set up at the same time.

— The attempt to put the system on a firmer footing following the Kilbrandon Report (1964) through the Social Work Scotland Act (1968), was not properly resourced either but made progress for a few years due to expansion of local government at the time.

— Thatcher put an end to that, with the Community Care Act (1990) turning social workers into gatekeepers and initiating the systematic outsourcing for the delivery of care to the private sector.

— Starting in the care home sector, which helps explain why that is the most financialised section of the market, profit rather than caring about people has become the driving force behind care provision.

— The result has been de-professionalisation of care provision and a downward spiral in pay and conditions.

— New Labour's response to a system already in crisis was to put increased emphasis on greater efficiency and managerial solutions – the public sector was expected to do more for less in the face of growing demand, particularly from increasing numbers of older people.

— The New Labour response to the failings of the market was to put greater emphasis on regulation but with a light touch in which the shift from caring for people to profit making could never be challenged.

— The Scottish Parliament responded to the outsourcing of NHS long-stay provision that had previously been provided for free to the private and voluntary sector by adopting the recommendations of the Sutherland report and introducing Free Personal and Nursing Care (FPNC), initially mainly for older people. Almost the entire emphasis of this, however, was on provision of help with physical care tasks, not care in the sense set out in this report, and has diverted us from the importance of 'just' being with someone, for instance sharing a pot of tea.

— FPNC, together with the policy emphasis on Delayed Discharge and Health and Care Integration (all about getting people sufficiently on their feet to be able to leave hospital) and Eligibility Criteria (which again prioritised physical needs over mental well-being) has focused the system on physical care needs. Efficiency drives have then been able to reduce meeting those needs to a series of tasks.

— Alongside this, driven by neoliberal ideology, the focus of the system has changed from tackling poverty and working through community and family, to treating the need for care and support as problem pertaining to individuals.

— As part of this Scottish Government policy has pushed concepts of individual service user rights and choice as a solution to issues, rather than more collective solutions. This has driven a consumerist approach to care provision, which supports the continuation of the private market, and has meant that public community

infrastructure, necessary for preventive approaches to work, has been steadily cut.

— The onset of austerity following the financial crisis of 2008 made all these issues worse but the Scottish Government's response, including in the IRASC, has been to continue pushing the same direction of travel.

— Since then, increasing emphasis has been put on integration with health, in the mistaken belief that by merging the two system you could solve the problems of both. It hasn't worked, not just because of the lack of resources or because the promised 'efficiencies' have never materialised but because care and health and fundamentally two different systems.

— Subjugating care to the needs of acute hospitals has created a care vacuum elsewhere and been partly responsible for the epidemic of untimely deaths from homelessness, drugs, suicide etc., which the NHS is now having to respond to.

— In response to the obvious failings, the Scottish Government has tried to control the sector ever more closely from the top down through legislation, standards and guidance. Like integration, it hasn't worked.

— While some of our politicians recognise some of these failures and almost all understand the value of prevention, for example, even after the Covid crisis the political will to analyse what has gone wrong and commit to radical reform remains weak.

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