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Submitted to Post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013
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About you

Please read the privacy notice below and tick the box below to show that you understand how the data you provide will be used as set out in the policy.

I have read and understood how the personal data I provide will be used.

What is your name?

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Are you responding as an individual or on behalf of an organisation?

Organisation

Organisation details

Name of organisation

Name of organisation:
Centre for Care - University of Sheffield and University of Birmingham

Information about your organisation

Please add information about your organisation in the box below:

The Centre for Care is a research-focused collaboration between the Universities of Sheffield, Birmingham, Kent and Oxford, the London School of Hygiene & Tropical Medicine, the Office for National Statistics, Carers UK, the National Children's Bureau, and the Social Care Institute for Excellence. Funded by the Economic and Social Research Council (ESRC), with contribution from the National Institute for Health Research (NIHR) and Department of Health and Social Care, as one of its flagship research centres, it works with care sector partners and leading international teams to provide accessible and up-to-date evidence on care – the support needed by people of all ages who need assistance to manage everyday life.

Led at the University of Sheffield by Centre Director Professor Sue Yeandle, our work aims to make a positive difference in how care is experienced and provided in the UK and internationally by producing new evidence and thinking for policymakers, care sector organisations and people who need or provide care. In studying care, we focus on ways of improving wellbeing outcomes and on the networks, communities and systems that support and affect people's daily lives, working closely with external partners.

Contributors to this consultation:
1) Catherine Needham - Professor of Public Policy and Public Management at the Health Services Management Centre, University of Birmingham. Her research focuses on social care, including personalisation, co-production, personal budgets and care markets. She has published a wide range of articles, chapters and books for academic and practitioner audiences. Catherine led the Care in the Four Nations work package within the ESRC (Economic and Social Research Council) Sustainable Care team. She is now leading research on care systems as part of the ESRC Centre for Care and is also a member of IMPACT, the UK centre for evidence implementation in adult social care.

2). Patrick Hall - a social care policy researcher, currently undertaking an ESRC-funded PhD at the University of Birmingham on care commissioning. He was the main researcher on the Care in the Four Nations work package within the ESRC Sustainable Care team. Prior to that he contributed to the European Commission's 2018 peer review of Germany's latest long-term care reforms. Patrick is a former Fellow of the King's Fund, where he co-authored two key publications on social care for older people. Before the King's Fund, he worked with the Department of Health and Social Care, local authorities and NHS organisations on the implementation of the Care Act 2014.

3). Emily Burn - a researcher based at the University of Birmingham where she is focusing on exploring the application of systems thinking to the analysis of social care. Prior to this role, Emily was part of a National Institute for Health Research (NIHR) funded project at the University of Birmingham exploring local authority market-shaping activities in social care and how these facilitate the development and access of personalised care and support.

Demographic questions

1 Are you completing this call for views on behalf of yourself, or someone else?

Someone else

2 Which part of Scotland do you/ the person you represent live in? Please provide the first part of your postcode:

Please use this textbox to provide your answer:

3 Do you/the person you represent have direct experience of self-directed support?

No

If you answered Yes, please use this textbox to provide further detail if you wish:

4 What is your age/the age of the person you represent?

Not Answered

Your views

5 Please tell us what you, or the person you represent, think about the implementation of self-directed support to date.

Please use this textbox to provide your answer:

Key points:
- The Scottish policy of free personal care (FPC) has had unintended consequences for other policy ambitions including self-directed support (SDS). There are tensions between the focus on care as a set of tasks to meet people's assessed needs (represented by FPC), versus the more expansive view of what people need to achieve better outcomes (represented by SDS).
- People are not accessing the full range of SDS options, demonstrating that the legislation has not re-shaped commissioning arrangements as intended. The reasons for this include a lack of advocacy and advice, shortages of Personal Assistants (PAs), and a lack of alternative provision to spend money on.
- There are two contrasting paradigms underpinning reforms - approaches seeking to make care more standardised, and those seeking to make care more differentiated. Opting for a 'best of both worlds' approach contributes to disappointing implementation.
- The National Care Service debate offers an opportunity to explicitly acknowledge these tensions, and clarify which are the primary goals.

1.1 In our book on Social Care in the Four Nations of the UK, we looked at the policy mix in each nation, i.e. the interaction between different social care policies. In Scotland, for example, we considered whether key policies – free personal care, self-directed support, investment in prevention, integration with the NHS – were compatible with each other or not.

1.2 For the book, we interviewed 65 key policy stakeholders across national and local care systems (politicians, civil servants, care providers, NHS, third sector (i.e. advocacy groups), regulatory and oversight bodies, Directors of Adult Social Services, commissioners, social workers).

1.3 Many of our Scottish interviewees were supportive of the policy of free personal care (FPC), but noted that there had been unintended consequences for other policy ambitions within the system. In particular, the policy had increased the focus on categorising people according to their needs, rather than incentivising preventative or holistic approaches such as self-directed support (SDS):

'[FPC] has made a major difference. What it negatively has done, however, has been to take our eye off a prevention orientation.' (Scotland, Provider representative)

1.4 Given the focus on meeting assessed care needs – i.e. on care as a set of tasks – this functional approach to care creates tensions with the self-directed support policy which is about taking a more expansive view of what people need to support better outcomes.

'So, whereas "up, washed, dressed, fed and bed" is not chargeable, all the other services that people receive are chargeable. Therefore we had to start categorising what it is we're doing to people…which then becomes a huge bureaucracy…And personal care is just one aspect of care for the whole person.' (Scotland, civil servant)

1.5 Another interviewee set out broader frustrations with the implementation of SDS to date:

'The narrative in Scotland is, you know, well, you all must innovate, we need to find the solution, whether it's more family care, whether it's reducing paid support, whatever the hell it is and I keep saying to them, "Well you legislated for it, it's called SDS, why not try it?" Why not try and implement that first, see if it works. Really push the implementation of it and then that might be the answer to your problems. You've legislated for that and you're kind of just leaving it to rot.' (Scotland, third sector)

1.6 The Feeley report cited evidence showing that 50 per cent of people had not been offered the full range of self-directed support options. Low rates of implementation of options 1 and 2 (direct payments and Individual Service Funds) are the most visible evidence that commissioning arrangements have not been reshaped in the way that the SDS legislation envisaged. Data from Public Health Scotland indicate that the proportion of people accessing options 1 and 2 continues to be low. In 2021/22, 1.8 per 1,000 of the population accessed option 1 and 1.7 per 1,000 of the population accessed option 2. By way of comparison, this rate is 16.2 per 1,000 of the population for option 3 (the local authority arranges support). (see https://publichealthscotland.scot/publications/insights-in-social-care-statistics-for-scotland/insights-in-social-care-statistics-for-scotland-support-provided-or-funde
).

1.7 There are a number of reasons why direct payments and Individual Service Funds are failing to increase in most parts of the UK. These include a lack of advocacy and advice to enable people to take up options 1 and 2, as well as shortages of personal assistants and lack of alternative services to spend

money on.

1.8 A further factor, which came out of our four nations study, is that self-directed support clashes with other policies weakening the policy commitment to implementation. There are two contrasting paradigms underpinning care reforms in Scotland:

Standardisation - approaches which seek to make care standardised and consistent, with a more professionalised workforce and a closer integration with health.
Differentiation - approaches which seek to make care more local, more differentiated, more co-produced and more strengths-based.

1.9 Free personal care, nationalised commissioning, more regulation, Integrated Joint Boards and a register of care workers aim to make care more standardised and consistent. Self-directed support, the prevention agenda and the commitment to co-production are part of the differentiation narrative. The failure to address the tensions between these two paradigms and instead to opt for a 'best of both worlds' approach, has contributed to disappointing implementation.

1.10 If SDS were to be given primary focus as an over-arching goal, rather than only one of several contending priorities, this would send an important signal. For example if health and care integration were to be a secondary goal, with self-directed support as the primary goal, it is likely that the structural approaches to integration which have been favoured to date would be reconsidered in favour of those that facilitate cultural shifts towards choice and control. Reforms falling within the standardisation paradigm (like the much-needed improvement in the pay and conditions of care workers) would be done with a clear eye on how to avoid compromising self-directed support.

1.11 The National Care Service debate offers an opportunity to be more explicit about these tensions and how to manage them. Proposals on a National Care Service are still evolving. However, the stated aim of the reforms is to improve the consistency of services. There is the potential for the aim of consistency to conflict with the person-centred approach of SDS. Continuing to prioritise standardisation and consistency means that focus is taken off the development of more relational commissioning approaches. Local government needs to maintain the ability to develop community-based services, particularly given the geographic context of Scotland and the needs of rural and island communities. However, if care continues to be commissioned in chunks of time, with little dialogue with the people and families being supported, and no opportunities to build and sustain relationships, it will not contribute to wellbeing.