A National Care Service for Scotland – Consultation
SAMH Response

About SAMH
Around since 1923, SAMH is Scotland's national mental health charity. Today, in over 60 communities we work with adults and young people providing mental health social care support, services in primary care, schools and further education, among others. These services, together with our national programme work in See Me, respectme, suicide prevention and active living, inform our policy and campaign work to influence positive social change.

Introduction
SAMH welcomes the opportunity to respond to the Scottish Government's proposals for a National Care Service. We recognise that this is a once in a generation opportunity to radically reform how social care and community health care is organised, prioritised and delivered in Scotland. As the Independent Review of Adult Social Care recognised, the need for change is urgent.

As a large social care provider supporting people with their mental health, we understand the positive life changing impact of high quality, person centred support. Social care and wider community health care must be empowered and resourced to focus on the key principles of supporting recovery and independent living, with people in receipt of care at the heart of decisions about their own lives.

We warmly welcomed the recommendations of the Independent Review of Adult Social Care. We would like to see these recommendations fully implemented through the development of a National Care Service, with minimum national quality guarantees and a focus on ongoing improvements in the system. While there is much to welcome in the Scottish Government proposals, such as the Getting It Right For Everyone (GIRFE) approach, it is not clear that current proposals fully implements the review recommendations or places people at the heart of the design and delivery of their care. It will be important that once the framework for a National Care Service completes its legislative process, people with lived experience and third sector providers are fully involved in co-producing the new system – both at a national and local level.

Many fundamental aspects of the new system require more detail and engagement to realise the aspirations set out in the independent review. For example, we welcome commitments to human rights based ethical commissioning. However, there is little detail in the Government's proposals to reassure us that we will see a fundamental shift in culture from commissioning and procurement based on competition and price, to one based on user involvement and partnership between providers and commissioners.

While the need for change is urgent, it is important that we take the time to ensure that the creation of a National Care Service is not rushed, leading to unintended consequences for people who rely on support to live meaningful lives.

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

OTHER

SAMH recognises that a national approach to improvement, with responsibility sitting with a National Care Service, has the potential to reduce complexity and improve the experience of people supported by the social care system.

In regards to improvement and safety, the National Care Service should be informed by existing successful national programmes of improvement. For example, we support the valuable work done in the mental health work stream of the Scottish Patient Safety Programme (SPSP).[1] The SPSP produces and disseminates evidence-based guidance to improve safety across health and social care, as well as hosting a national learning system to underpin guidance. Crucial to the success of the SPSP has been meaningful patient, carer and frontline staff involvement and a focus on human rights and culture change. For example, their Patient Safety Climate Tool empowers patients in mental health inpatient settings to share their views, experiences and ideas around patient safety to better inform practice.[2] This approach to improvement has seen significant reductions in self-harm in inpatient settings and over a 50% reduction in the use of restraint in mental health wards.[3] The National Care Service must insure a national approach to improvement is underpinned at all stages by genuine and meaningful involvement by people using social care and health services, as well as those working on the frontline of service delivery.

Critically, improvement must be a shared responsibility between the state, regulatory bodies and social care providers. Currently the onus is largely on providers to demonstrate adherence to required regulatory and legal standards through external inspection. As the Independent Review made clear, despite having an array of existing positive standards (for example the national Health and Social Care Standards[4]) external inspection (i.e. undertaken by the Care Inspectorate) is virtually the only tool employed to promote improvement in social care. We agree with the findings in the review that this is not adequate. A collaborative approach – from service design, commissioning and compliance – with providers and people receiving services is needed to drive service improvement.

Access to Care and Support – How it works

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

OTHER

It is common for service users who shared their experiences with us to say that they found accessing social care difficult or very difficult. Many people felt there was a lack of information about what services were available to them locally, and how they can be referred. However, we did find that service users were enthusiastic about self-referral.

When it comes to people who are struggling with their mental health they can find it difficult to access support, which can then increase their sense of distress or hopelessness. It is

---

[1] Health Improvement Scotland Scottish Patient Safety Programme Mental health
[2] Health Improvement Scotland Patient Safety Climate Tool
[3] Health Improvement Scotland Saving lives and reducing harm – how SPSP's Mental Health Programme is reducing harm and improving safety 2018
[4] Scottish Government Health and Social Care Standards 2017

vital that for mental health there is a No Wrong Door policy and that people can safely ask for help regardless of route.

It is also important to remember that people who are struggling with their physical health may also experience mental health issues due to the life changes they are going through, and all presentations for physical health issues should also include an assessment of the individual's mental health.

When people come to access care and support it is vital there are a range of ways in which they can do so, which reflect their individual circumstances. For example, someone may feel more comfortable with a website, others and those who have no internet access at home would not be able to use this, and would need alternatives. Thought also needs to be given to how disability or a low level of fluency in English may put people off using a helpline.

When designing routes to access we must consider the needs of some communities in Scotland who may have social taboos around seeking help outside their community, and for those harder to reach groups.

An area that needs urgent focus by the Scottish Government and National Care Service is the experience of Self-Directed Support (SDS) for people needing support for their mental health. Self-Directed Support (SDS) provides people greater control and agency over the social care they receive, but its uptake amongst people receiving support for their mental health is low. Findings from the ALLIANCE *My Support My Choice* research show that SDS was beneficial to people with mental health problems, but that not enough support or information was provided for many to make an informed choice about their care.[5] Worryingly, people with mental health problems were less likely to have been offered information about all four options available to them within SDS than respondents to *My Support My Choice* more broadly.[6] It is critical that people living with mental health problems have equal access to SDS, including options to control their own care budgets and direct the organisation of their care. This will require the complexities of the SDS system, made more challenging by mental health stigma, to be addressed. Upskilling the social care workforce in mental health and greater access to independent advice and advocacy is needed to reduce barriers to SDS uptake.

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

- **Have a lead professional to coordinate care and support for each individual. The lead professional would co-ordinate all the professionals involved in the adult's care and support.**
- **Have a professional as a clear single point of contact for adults accessing care and support services. The single point of contact would be responsible for communicating with the adult receiving care and support on behalf of all the**

---

[5]The ALLIANCE and Self Directed Support Scotland, *My Support My Choice: People with Mental Health Problems' Experiences of Self-directed Support and Social Care Thematic Report* (December 2020). Available at: https://www.alliance-scotland.org.uk/wp-content/uploads/2020/12/ALLIANCE-SDSS-MSMC-Mental-Health-Report-Dec-2020.pdf.

[6] The ALLIANCE and Self Directed Support Scotland, *My Support My Choice: People with Mental Health Problems' Experiences of Self-directed Support and Social Care Thematic Report* (December 2020), pp. 21-22. Available at: https://www.alliance-scotland.org.uk/wp-content/uploads/2020/12/ALLIANCE-SDSS-MSMC-Mental-Health-Report-Dec-2020.pdf.

professionals involved in their care, but would not have as significant a role in coordinating their care and support.

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

While service users expressed a range of views on the co-ordination of their care. It is worth emphasising the importance of the ability of the co-ordinator to be fully resourced, supported and to have a manageable workload. This would leave the co-ordinator free to give each person the full attention they deserve.

It's well documented that staff within health and social care can often feel overloaded with cases. It is therefore important that high quality wellbeing support is resourced and made available to any potential coordinator role. This should be proactively promoted and easy to access.

Support Planning

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

(a) – **How you tell people about your support needs**

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

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
X				

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

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
X				

(b) – What a support plan should focus on

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

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
	X			

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

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		X		

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

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
X				

(c) - **Whether the support planning process should be different, depending on the level of support you need**

I should get a light-touch conversation if I need a little bit of support; or a more detailed conversation with a qualified social worker if my support needs are more complex.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		X		

If I need a little bit of support, a light-touch conversation could be done by someone in the community such as a support worker or someone from a voluntary sector organisation.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		X		

However much support I need, the conversation should be the same.

Strongly Agree	Agree	Neither Agree/Disagree	Disagree	Strongly Disagree
		X		

Light touch and/or more detailed support planning should take place in another way – please say how below:

The overriding purpose of both social care and health support should be to promote independent living, recovery and progress towards the person's desired outcomes. As such, meaningful user involvement in support planning is key, both in the setting of desired outcomes when someone is assessed and begins a period of support, and their re-evaluation during periods of care and support. Families, carers and other people close to the person receiving care should be fully involved in support planning and reviews where the person wants this.

Indeed the Scottish Government's Health and Social Care Delivery Plan already states that people, and where appropriate their families, should be at the centre of decisions about what affects them.[7] There is also an existing legal duty on local authorities to take into account the views of the person receiving care and their carers.[8] We know from speaking to people using our and other social care services that this is not happening in all cases.

While in a health care context, our research on the experience of treatment for depression, *Decisions Were Made About Me Not With Me*, found that research participants who were happier with their level of involvement in decision making about their treatment and support were more likely to be satisfied with their treatment.[9] It is essential therefore that a personalised approach to initial planning and regular reviews is taken. We agree with the Scottish Government approach set out in the consultation that this care planning should be strength based and rooted in a human rights framework. It is critical that the needs and wishes of the person receiving care in regards to support planning take precedence over the needs of the system or provider organisations.

As part of the Getting It Right For Everyone approach The National Care Service should coproduce, with people with lived experience, guidance and templates to support social care providers to undertake personalised, outcome focused reviews to aid ongoing support planning. The frequency of these reviews should be determined on an individual basis, according to need, in partnership between providers and the person receiving care.

In line with recommendation 8 of the Independent review,[10] we believe access to independent advocacy and brokerage services must be urgently improved ,including being available during assessment for eligibility for social care, support planning and ongoing review. Independent advocacy is important to realising a human rights approach to care that is centred on the views of the individual.

We are concerned that the Scottish Government proposals, while accepting recommendation 8 of the Independent Review, only discuss advocacy in the context of complaints and raising concerns about care. The Independent review was clear that access to advocacy should be available at all points of someone's social care journey, including support planning. The Mental Health (Care and Treatment) Scotland Act 2003 provides that everyone with mental illness, learning disability, dementia and related conditions has the right to access independent advocacy support.[11] The Act places a legal duty on local authorities and health boards to ensure adequate provision of advocacy services.[12]

We know this right is not being realised in many local areas. The Mental Welfare Commission found in a 2018 review of the implementation of the right to advocacy, that provision and awareness was inconsistent, particularly for people who aren't under a compulsory treatment.[13] The Scottish Government must work with the independent

---

[7] Scottish Government, Health and Social Care Delivery Plan, 2016

[8] Social Work (Scotland) Act 1968

[9] SAMH DECISIONS WERE MADE ABOUT ME NOT WITH ME 2020

[10] Recommendation 8: More independent advocacy and brokerage services, including peer services, must be made available to people to ensure that their voices are heard, and to help prepare for participation in planning and organising their support.

[11] Mental Health (Care and Treatment) (Scotland) Act 2003

[12] Mental Health (Care and Treatment) (Scotland) Act 2003

[13] MWC The Right to Advocacy March 2018 A review of how local authorities and NHS Boards are discharging their responsibilities under the Mental Health (Care and Treatment) (Scotland) Act 2003 2018

advocacy sector to ensure as a matter of urgency that there is adequate funding and provision of independent advocacy services to support people engaging with the social care system, and that existing legal duties to people with mental health problems are complied with.

Part (b) of the question asks if, *"Decisions about the support I get should be focused on the tasks I need to carry out each day to be able to take care of myself and live a full life"*. Independent living should be the fundamental goal of social care support and as such support, in part, should include help with daily tasks that can support independent living. This fundamentally goes beyond "taking care of myself" and includes support to live a full fulfilling life, beyond basic personal health needs. As such we have some caveats about the use of 'task based' language in support planning. We are concerned that a focus on tasks does not embrace a social model of disability and can result in support being provided at a minimum level to achieve daily functions. In contrast, we strongly believe that support should be designed around individual outcomes and focus on the aspirations of individuals rather than perceived deficits in ability.

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

AGREE

As found in the Independent Review and from our own experience as a social care provider, navigating the social care system can be complex, time consuming and often distressing for all involved. This includes social care staff, providers and most importantly people and their families in receipt of or trying to access care. In part this is down to a lack of consistency in language and terminology used throughout the social care and health systems, including in assessments.

We agree that the GIRFE should be adopted and a shared, clearly understood language should be developed across all services and professionals in regards to support assessments. If implemented well, this has potential to significantly reduce the confusion of navigating the social care and community health system, both from the perspective of those using the system and those working within it.

It is important to highlight that any improvements to the assessment process for social care will only be successful if assessments are easy to access and undertaken by practitioners with relevant expertise: something which is not currently the case. As we said in evidence to the independent review, people with mental health problems engaging with the social care service have too often been assessed by practitioners without professional experience or expertise in mental health.[14] As we also set out, this is compounded by assessments focused on physical functionality and rigid, inconsistent eligibility criteria for access to support.

We believe that the National Care Service should ensure that the social care service workforce, specifically staff who conduct assessments, are upskilled in mental health so people with mental health problems are not disadvantaged when trying to access support. In part this this could be achieved by exploration of a duty on the National Care Service (or

---

[14] SAMH Independent Review of Adult Social Care – SAMH Submission

assessment body e.g.) to provide a suitably qualified assessor. This would align social care with positive developments in assessments for entitlement under Scottish Social Security system where there is a legal duty for assessments considering disability (mental or physical) to be undertaken by someone with relevant experience of mental health where the applicant has a mental health condition.[15]

In determining consistent language and terminology to be used in the proposed approach, the NCS must be coproduced with people with lived experience of a wide range of disabilities, as well as social care providers. Again, the development of the Scottish Social Security system provides a good exemplar with the use of Experience Panels to support the design (including application forms etc.) of the new system. We believe a similar model should be introduced as a matter of urgency to support the development and implementation of the National Care Service. Good practice from providers such as SAMH's 'My Life, My Way' strength based planning tool used in our Glasgow Supported Living Services should be used to inform the development of consistent language.

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

YES.

SAMH strongly welcomes the Scottish Government's proposals to introduce both a single planning model and an integrated health and social care record. As outlined in previous answers, navigating the social care system is often challenging and confusing. A single portable Adult Support Plan embedded in the desired outcomes for the individual receiving care has potential to radically simplify the experience of navigating the social care system.

We spoke to people supported by SAMH services to inform this consultation. They echoed concerns raised by those we spoke to ahead of the Independent Review. A recurrent theme was the distress and frustration caused by having to frequently retell their story to various medical and social care practitioners and services whenever their support changed:

> *"[a single social care record] would make it clearer, like an overview of your history so when you go to the GP [or anything] … [currently] you end up having to repeat everything every time, you spend most of the 10 minutes explaining your previous history and everything. It's not really aimed for mental health, that's fine if it's like a physical thing. Of course you're going to have to go into detail and explain it all properly and everything like that but it's like…You don't really want to go into [everything] every time you go into a GP, to say how bad you are and [everything like that]. You want them to be able to just click on a screen and see…"* (SAMH Focus Group Participant October 2021)

This is an unmissable opportunity to improve the experience for people who are in receipt of care and support from a variety of agencies across the health and social care system. We have been told that multi agency communication can be poor, leading to frustration and

---

[15] Scottish Government Disability Benefits Policy: Position Papers: Paper 4: How does a decision get made on my disability benefit application? October 2020

distress. This is a particular concern for people living with co-morbidities who may be seeking (or receiving) support for various aspects of their health, such as addictions and mental health. People using SAMH services told us that too often it felt that the onus for ensuring communication between agencies was placed on them:

> *"And it's up to yourself, it's up to you, you need to keep saying, "Oh, I'm in touch with these. I'm getting help for this." There's no communication, so you kind of find yourself repeating yourself quite a bit and stuff like that, but it is what it is."* (SAMH Focus Group Participant October 2021)

Another focus group participant who is engaged with a variety of services including mental health, addictions and housing services added:

> *"It's all individuals who, I don't think they even communicate at all with each other. I don't think they even know that I'm involved with the other thing [addictions, mental health and homelessness services]. Well, they do know but they don't know who to speak to or anything.*
>
> *We need, I'm saying that they're like a consortium that does actually have a spider's web of, you know, I'll be in the middle and people know where I am, so it would be easier doing it that way rather than such a splintered effect of how it's getting dealt with just now"* {SAMH Focus Group Participant October 2021)

Central to the success of implementing a single adult support plan and the GIRFE model is the need for radical cultural change, with agencies, commissioners and providers moving towards a truly person centred and integrated way of working. Rather than the persistent siloed approach experienced today, despite limited progress made following integration in wake of the Public Bodies (Joint working) (Scotland) Act 2014.

While we are very supportive of an integrated health and social care record, the use and sharing of personal data must be accompanied by adequate legal safeguards. These safeguards would ensure potentially distressing personal information is only shared with consent of the individual where it will benefit their care and support.

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

AGREE

While we agree a National Practice Model has exciting potential to reduce complexity and ensure a greater person centred approach to the access and delivery of social care (and community health care), the Scottish Government proposals do not provide adequate detail of how we will move from the current approach of the delivery of social care to the GIRFE approach.

This will require fundamental change in culture, leadership, practice and structure to achieve. The SAMH survey we undertook ahead of the 2019 Health and Sports Committee Inquiry into social care found that only 46% of respondents felt their views were listened to and acted on.[16] When asked about what they would like to see change in social care, the most common answer was more choice in the type of support they receive (48%), with 31%

---

[16] SAMH Health and Sports Committee Social Care Inquiry – SAMH Response

stating they wanted more involvement in planning their support.[17] These findings highlight that there is a significant distance to travel, particularly from the point of view of people using the existing system.

We accept that the Scottish Government proposals are intended to be the first step in creating the legal infrastructure for the National Care Service. However to ensure improved outcomes for people, and their choice and agency, is at the heart of the new system, work must begin urgently to ensure proposals such as the GIRFE approach are more fully developed. Lived experience views and the views of frontline staff and providers must be at the heart of this development process.

As the GIRFE approach develops, existing good practice must be captured and used to inform the national approach. For example, the focus on service user outcomes is embedded in the work of SAMH. A number of our community services use the outcomes-focused planning tool "My Life My Way". This is a strength-based tool which allows the person being assessed to identify their strengths and set personalised goals for their support. The tool is used throughout the person's time with the service to check progress and re-evaluate goals and desired outcomes, putting them at the heart of decisions about their care.[18] A national approach must build on this and similar good practice, while also ensuring providers such as SAMH retain flexibility to go beyond minimum criteria in regards to support planning.

Using Data to Support Care

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

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

STRONGLY AGREE

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

STRONGLY AGREE

Q12. Should legislation be used to require all care services and other relevant parties to provide data as specified by a National Care Service, and include the requirement to meet common data standards and definitions for that data collection? Yes No Please say why.

YES

Data collection which is robust, full and intersectional will greatly aid in the development and delivery of services for users. However, some thought needs to be given to the extent to which services will be required to gather data, and the amount of time this will take, as their primary focus should be their service users.

---

[17] SAMH Health and Sports Committee Social Care Inquiry – SAMH Response
[18] SAMH Health and Sports Committee Social Care Inquiry – SAMH Response

On the matter of what data should be collected, we agree with the proposals that this should be set out in guidance to the forthcoming legislation rather than primary legislation itself. This provides flexibility to amend requirements in this complex area as need arises. The Scottish Government must work in partnership with care providers, statutory bodies (such as Local Authorities, Health Boards and Public Health Scotland) and regulators to inform what gaps in data exist and much should be collected ahead of any legal duty coming into place.

Complaints and putting things right

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

OTHER

The ability to seek and access redress in regards to the standard of care someone receives is fundamental to a human rights approach. We agree with the Independent Review that existing avenues for complaint and redress are confusing at a local and national level. Progress has been made in recent years, for example though the Duty of Candour legislation and introduction of new Health and Social Care Standards (my support my life). However, more needs to be done to increase awareness of expected standards and how to seek support when someone receiving care (or their family) believe standards have not been met.

Indeed, people using SAMH services told us ahead of the consultation that they had little awareness of the existing complaint mechanisms, representing a significant impediment to them realising their rights.

We believe there is merit in all the proposals set out by the Scottish Government and do not feel it is possible to rank them. All are mutually beneficial and needed to radically improve the complaints process.

In regards to a Charter of rights and responsibilities, we believe this would be a positive move, but only if its development was informed by people with lived experience of the social care system, including people living with mental health problems, and adequately promoted. In Scotland, we have mixed experience in regards to the effectiveness and visibility of charters. For example the NHS Charter of Patient Rights and Responsibilities, while a positive document, has little public awareness and so is under used as a tool to secure people's rights in health care. In contrast, the Social Security Scotland Charter – Our Charter[19] has strong statutory underpinnings informed by intensive stakeholder engagement and co-produced by people with lived experience of social security. We believe this model should be used when developing a charter for rights and responsibilities in social care.

People supported by our services welcomed the idea of a single point of access for complaints and feedback, which would cover the whole social care and community health system:

> *"I think it would be better. It would simplify if it's one place like and anything like that because it would be stressful enough…So I do think that as long as it's independent and there aren't many [things] that you might complain about, it's definitely better to*

---

[19] Social Security Scotland Our-Charter

have someone that is just one person or anything like that, especially for all the ones that have multiple care, like different places or anything like that." (SAMH Focus Group October 2021)

Awareness levels of how to raise a concern were very limited and a clearly promoted single point of access has potential to significantly increase awareness of the complaints process.

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

YES

SAMH is broadly in favour of the appointment of a commissioner for community health care, though more detail on their exact role and function is required. A commissioner has potential to provide clarity and act as a single focal point for advocating for the rights of people receiving care and treatment and their families. It is crucial that if a commissioner is appointed they have the powers to ensure any recommendations they make are acted upon.

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

YES

Measuring ongoing feedback in regards to someone's experience of care, and that of their families', should be a fundamental aspect of assessing quality and improvement across the system. It is crucial this data is collected in a meaningful, standardised way to measure progress in improving the social care system. We accept that this is a complex area with multiple social care providers currently using bespoke and varying tools to measure experience, with these varying significantly in terminology and outcomes assessed.

At SAMH, we welcomed the production and introduction of the national Health and Social care Standards, My Support, My Life, which are applicable to both NHS services and services registered with the Care Inspectorate.[20] Importantly, these standards are taken into account during inspection of services. In creating a national set of experience outcomes and associated data sets to be collected across the system, we believe the My Support, My Life standards have potential to provide a basis for these, as they already encompass important aspects of a person's experience (e.g. to be treated with compassion; and to be included in decisions about care and treatment).

Residential Care Charges

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

OTHER

---

[20] Scottish Government Health and Social Care Standards: my support, my life 2017

While this consultation does not discuss non-residential social care charges we would like to reiterate our position that non-residential social care charges should be abolished at the earliest opportunity. We very strongly welcome commitments in the Scottish Government Programme for Government that options for abolishing non-residential social care charges will be brought forward.[21]

Non-residential charges can be applied to services such as housing support, supported accommodation, laundry, shopping and cleaning, as well as self-directed support services.[22] The amount people pay, and the level of income they need to have before they become liable for charges, varies a great deal between different local authorities.[23]

 As social care is essential to people realising their human rights and supports independent living we see no justification for charges being retained and welcome their removal. This is particularly the case as we move to further integrate health and social care. There is no legal need for the Government to wait for a National Care Service to remove non-residential care charges. The Scottish Government has powers from the Community Care and Health (Scotland) Act 2002 to set national limits to the amount people can be charged, which could be used to abolish charges in practice. This power has not been used to date, with local authorities able to set their own charging rates.

We would like to highlight the particular issue of people who are obliged to receive social care through a Compulsory Community Treatment Order. While COSLA guidance states people receiving compulsory treatment should not be charged, legally they can be, and are in a number of local authority areas.[24] This is in direct conflict with the Milan Principles, which guide the Mental Health (Care and Treatment) (Scotland) Act 2003. In particular, the principle of reciprocity, which imposed an obligation on the state to provide safe and appropriate care and treatment where a person is receiving compulsory treatment. It is totally unacceptable that it is at the discretion of local authorities to decide if people should be charged for the care they are under obligation to receive.

In regards to residential care charges, we believe a fundamental debate needs to occur to determine the fairness and framework for residential charges. This must be explored in a human rights context and recognise that people cared for in residential settings do not have equal agency over fundamental decisions about, for example, where to live and what to eat compared to people living independently in the community. Residential charges must not deter people from accessing social care and therefore not realising their rights to independent living, dignity and respect.

National Care Service The case for change

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

YES

---

[21] Scottish Government Programme For Government 2021/21
[22] CCPS Extending Free Personal Care to people under 65 years of age – Briefing 2019
[23] Citizens Advice Scotland Social care and support
[24] COSLA: National Strategy & Guidance Charges Applying to Non-residential Social Care Services 2019/20

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

The introduction of a National Care Service represents significant structural change (nationally and locally) to the way social care will be designed, commissioned and delivered. As such, we broadly agree with the approach outlined in this chapter in regards to proposed services and functions to be included in the National Care Service. As Integrated Joint Boards are proposed to become Community Health and Social Care Boards, acting as the local arm of the National Care Service, it is prudent that services to be included are aligned to those currently integrated under the current IJB (Public Bodies (Joint Working) Scotland Act) arrangements. Any additional services/functions to be included should only be added after careful consideration and engagement with providers, existing accountable bodies (for example Local Authorities in regards to children's social work etc) and people with lived experience.

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

No

Children's Services

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

As an organisation who works in the field of mental health we would be predominantly concerned with children being able to access the support they need for their mental health whatever part of the National Care Service system they are in, or systems outside of National Care Service. We know that currently there is not enough support for children and many are slipping through the cracks with one in five children referred to CAMHs being rejected outright.[25] SAMH's priority is to make sure that all children get the mental health support they need without threat of rejection.

It is possible that including children's social work and social care services may be able to help children and their families access better support. However, a lot of this is dependent on the finer detail of the design and culture of the National Care Service, the training that staff get, and if mental health is treated as importantly as physical health. At this moment in time, we are unable to answer this question without more detail and time to consider the implications.

It is important to note that significant and meaningful engagement was undertaken with the adult social care sector as part of the independent review. If children's services are to be included in the National Care Service a similar level of engagement is needed with people working in and supported by children's social care and social work services. This to ensure any changes, structurally and in practice, will have a positive impact on children, their families and people who work in the sector.

---

[25] Public Health Scotland Child and Adolescent Mental Health Services (CAMHS) waiting times – Quarter ending 30 June 2021

It is also important that any proposals to include children's services, including mental health services, in the National Care Service take account of existing work being undertaken by the Children and Young People's Mental Health and Wellbeing Joint Delivery Board and findings from the 2018 audit of rejected referrals.[26],[27]

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

When considering this point, it's important to acknowledge the differing needs of children and families across Scotland.

For children with disabilities, this may reduce complexity, but so far there is not enough detail on the proposed changes for a definitive answer to be reached. We would like to see the mental health of children with disabilities considered in the design of the National Care Service, as physical and neurological disabilities can have a significant impact on mental health. We would suggest that all National Care Service staff should have appropriate mental health training, and that clear pathways of support for all children's mental health are in place.

For young people transitioning to adulthood, there are different challenges. We know that young people in Scotland find the transition from CAMHS to adult services difficult, and that transitional support is patchy. The Scottish Government has already committed to considering SAMH's ask to extend CAMHS to age 25.[28] We would now like to see the Government act on this commitment, building on the work done by the Scottish Youth Parliament to improve the transitions process. There should also be a long-term commitment from Government to develop a specialist mental health service for 16 to 25 years olds. This has already been suggested by the Scottish Parliament's Health Committee, with other such services already existing elsewhere in the UK.

Finally, for children with family members needing support, it is unclear what these changes would exactly mean for this group, and therefore we would need more information before being able to provide an answer.

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

It is possible but that locating children's social work services within a National Care Service could improve the alignment of services, however we would caution that this greatly depends on both the design and the culture of the National Care Service. We would advocate that it is imperative to have a human rights based focus: allowing people to not just survive, but to thrive.

---

[26] Scottish Government The Children and Young People's Mental Health and Wellbeing Joint Delivery Board
[27] Scottish Government Rejected referrals to child and adolescent mental health services: audit 2018
[28] Scottish Parliament Public Petitions Committee Inquiry into mental health support for young people in Scotland SAMH Submission

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

There are of course risks whenever any new system is set up. We believe it would be essential for any system involving children to retain the current checks and balances that we have in respect to working with children and vulnerable people, as well as data protection and confidentiality. We would expect that a system designed with a human rights based focus would put the needs and safety of children first.

Health Care

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

YES.

As in our answer to Q21, if CHSCBs are to replace IJBs it is prudent that they take responsibility for functions currently delegated to IJBs in the area of community health. In regards to mental health, this includes important functions such as the community mental health service, which is already delegated to IJBs.

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

The existing integration framework through the Public Bodies (Joint Working) Scotland Act has not seen the much-needed shift from acute to community care. It is essential that unlike IJBs the new CHSCBs, with support from the National Care Service, be empowered to take a long-term approach to strategic planning and funding of services (see Q58 for more detail on this area).

In regards to the transition from hospital to community support, we know there are significant issues with people in mental health inpatient settings being unable to be discharged to the community due to a lack of appropriate social care or intensive mental health supports available.[29] This is detrimental to the health and recovery of people who remain in inpatient settings. SAMH spoke to the people we support ahead of our submission to the Independent Review, who told us that they had more agency when supported in the community. Things that people appreciated about community support included having their own accommodation, making friends and being able to engage with hobbies. One person told us that being supported in the community compared to inpatient treatment made them feel like "an adult again".[30]

It is crucial that the National Care Service and CHSCBs build on existing areas of good practice, such SAMH's Fife services, where a bespoke service to support long stay psychiatric inpatients into the community was designed in partnership with the health board, local authority and crucially the patients themselves. Importantly, this service is supported by

---

[29] SAMH Independent Review of Adult Social Care – SAMH Submission
[30] SAMH Review of Adult Social Care SAMH Response

a long-term 10 year contract. This demonstrates the importance of the resourcing and provision of specific mental health services in the community, which is currently lacking in many areas. We hope the creation of a National Care Service will provide a greater measure of consistency to the provision of specialist mental health support across the country.

An important issue related to the lack of community mental health care support is the problem of people being stuck within conditions of excessive security in psychiatric inpatient settings. There are instances where people cannot move in a community or low secure settings due to a lack of beds in lower secure wards and too few places available in community support services.[31] This matter needs addressed urgently, with SAMH calling for the right to challenge security levels for people in low secure settings. It is only through the increase of local community mental health provision, that people's existing and future rights to low security support will be realised.

Mental Health Services

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

Other

SAMH would like to see further detail concerning the inclusion of Mental Health Officers under a National Care Service. Under the Mental Health (Care and Treatment) Scotland Act 2003 and the Adults with Incapacity (Scotland) Act 2000, Mental Health Officers have an important safeguarding role when someone is subject to compulsory care and treatment for their mental health. Mental Health Officers provide a vital role in providing a check and balance on a medical professional's decision to detain a person in hospital, it is vital that this role retains a level of independence from the mental health system to uphold and protect people's human rights.

Currently there is a shortage of Mental Health Officers in Scotland, with the Scottish Social Services Council (SSSC) estimating there was a Mental Health Officer shortfall rate of 14.3 in 2020, increasing from 13.7 in 2019.[32] This is clearly having a detrimental effect on people's rights, as demonstrated by the Mental Welfare Commission's most recent monitoring report, where less than half (42.5%) of emergency detentions had consent from an Mental Health Officer; the lowest number in at least 10 years.[33] Therefore, SAMH is calling for the Scottish Government to urgently increase the number of Mental Health Officers.

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

---

[31] MWC, Visit and Monitoring Report: Medium and Low Secure Forensic Wards, 2017 11 MWC, Report on announced visit to: Leverndale Hospital, 2019 12 MWC, Report on unannounced visit to: Stratheden Hospital, 2019

[32] Scottish Social Services Council, Mental Health Officers (Scotland) Report 2020, 2021 Available at: https://data.sssc.uk.com/images/MHO/MHO_Report_2020.pdf

[33] Mental Welfare Commission, Mental Health Act monitoring report 2020-21, 2021 (Available at: https://www.mwcscot.org.uk/sites/default/files/2021-09/MentalHealthAct_MonitoringReport_Sep2021.pdf)

Under the current system, many people often receive support for their mental health from a variety of providers, including NHS mental health services. Indeed, accessing social care support on discharge from hospital is a frequent route into social care.

During focus groups with individuals who use SAMH services, many people highlighted the need to better coordinate care, improve communication and share information between different providers. Unfortunately, some of the people we heard from had experienced issues like the loss of their health/care records and a breakdown in communication between providers when moving into new services or between them. Furthermore, people found the need to retell their story to different organisations involved in their care distressing and contradictory to their recovery.

> *"From one support to the other they didn't communicate. I was told I was moving [into a new social care service] on the Monday, but it was changed to the Wednesday. So I came on the Monday and there was no bed, no couch or anything. It was the communication. They didn't know anything. It was sad and stressful." (SAMH Service User – Supported Living)"*

As set out in our answer to question 7 the introduction of an integrated health and social care record and single planning process has potential to mitigate the need for people to retell distressing information and insure better coordination of care.

One example of coordinated mental health care and support which is already working well is the Distress Brief Intervention (DBI) programme, and SAMH recommends that learnings are taken from its operation. For this, the Scottish Government established a national DBI Programme Board while the partnership sites have established DBI Implementation Boards. This governance structure encourages inter-agency working, ensures the involvement of key stakeholders and enables this national DBI programme to be delivered by local providers in a way that suits their local circumstances.

In addition to this, integrated systems in a new National Care Service will be key to ensuring people's journeys are coherent. We believe such systems must increase the access that third sector social care providers have to NHS and other statutory systems. This will undoubtedly require the development of new national data sharing agreements - we provide more detail on the collection and sharing of data in the Using Data to Support Care section. Ultimately, such systems will ensure a National Care Service can provide person-centred and recovery-focused support.

Reformed Integration Joint Boards: Community Health and Social Care Boards

Governance model

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

YES.

We broadly agree with the proposal of Community Health and Social Care Boards (CHSCBs) to being the sole model of local delivery of community health and social care, but with a number of caveats and concerns.

While SAMH welcomed the Public Bodies (Joint Working) Scotland Act and the principle of integration of health and social care, the experience has not matched up to the aspirations of integration. Crucially, it has not resulted in fundamentally improved experiences or outcomes for people with mental health problems engaging with the health and social care system.

As Audit Scotland has found, there has been far too little progress on long term strategic planning at the local IJB level, with a lack of strategic collaborative leadership, confusion over governance and an "unwillingness to safely share data with staff and the public."[34] As a result, the ability of people with lived experience, as well as public and third sector providers such as SAMH, to positively influence local planning and decision-making has been limited and challenging.

Irrespective of the local structure of a National Care Service, lasting positive change for people requiring support for their mental health will only be achieved if people with lived experience and mental health service providers, including from the third sector, are fully involved in the coproduction of local mental health services - both in the health and social care sectors. This means the relationship between provider organisation and contracting bodies needs fundamentally rethought to ensure providers are at the heart of service design.

Problems with integration as currently organised have been compounded by significant budgetary constraints and a lack of integrated or long term financial planning.[35] This has resulted, as Audit Scotland points out, in little meaningful shift in budget and support services from acute settings to the community – a key policy goal of integration.[36] To date the experience of integration has been one largely of services designed to meet short-term budgetary constraints rather than the needs of the community.

If a National Care Service is to meaningfully change people lives and support them to live independently, it is crucial that this shift to community provision is achieved. This must result in an increased and diversified community support landscape for people with mental health problems. This will only be achieved if there is a significant budgetary shift to community settings to upscale the social care and community health sector.

Direct budgeting of CHSCBs by the Scottish Government may in part help achieve this. As has been noted above, the delegation of budgets locally from local authorities and health boards to IJBs has not resulted in budgets – and therefore strategic planning - being integrated in practice. Irrespective of the budgetary allocation mechanism, lasting change to peoples experience will only be achieved if overall CHSBs budgets and associated allocation to social care and mental health services are adequate and sustainable to meet the growing needs of people requiring support with their mental health.

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

YES

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

---

[34] Audit Scotland Health and social care integration Update on progress 2018
[35] Audit Scotland Health and social care integration Update on progress 2018
[36] Audit Scotland Health and social care integration Update on progress 2018

members. Who else should be represented on the Community Health and Social Care Boards?

Fundamental to the success of CHSCBs as agents of change at the local level will be meaningful lived experience engagement and collaborative decision making. We warmly welcome commitments for membership of the boards to include lived experience voice, carers and third sector representation. But membership of the boards will only be meaningful if all members are provided the support to fully engage with the boards work.

The experience of IJBs has been challenging for third sector providers and people with lived experience. Single third sector members of local IJBs have been expected to represent the views and needs of a large complex sector – across various specialisms and care groups. In practice, this is not possible. The same is true for carer representatives and lived experience representatives. Practical challenges, again pointed out by Audit Scotland include a lack of time for representatives to engage with papers and gather views from across the third sector (or lived experience communities) ahead of IJB meeting, and little opportunity to input during IJB meetings themselves.[37]

The Scottish Government must take learning from the previous iteration of integration and IJBs when finalising proposals for membership of CHSCBs. Importantly the makeup of the boards should much more adequately reflect the role of the third sector in the delivery of health and social care with greater representation on the boards. Formal support should be in place for representatives, including people with lived experience, as well as processes to gather views from their relevant sectors and populations, to allow all to more effectively take part in the process of local decision making. This will require changes in culture alongside appropriate formal rules and process governing the operation of the boards.

We strongly support the proposal for all members of the CHSCBs to have voting rights.

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

YES

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

Please refer to our answer to Q62

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

YES

---

[37] Audit Scotland Health and social care integration Update on progress 2018

Commissioning of services

Structure of Standards and Processes

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

YES

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

YES

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

YES

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

While answering yes to the previous questions on the proposed Structure of Standards and Processes, SAMH has a number of concerns about the overall direction and ambition for commissioning and procurement.

We are concerned that the proposals alone will not lead to the much-needed radical shift in commissioning and procurement called for in the Independent Review. As the review set out, to ensure person centred and human rights based services, we need a fundamental break with the current model of competition. Cost-driven procurement processes must change to culture of collaboration. It is crucial that the power in-balance between people receiving care, social care providers and commissioning bodies is addressed.

In order to achieve a person centred approach, we believe social care providers, whether they are third sector or independent also need to be involved in the design of social care services, not just the delivery. Co-production including from providers and people with lived experience is mentioned in the proposed Structure of Standards and Processes – this is welcome. However, with no additional details, more information is needed on how this process will work in practice. Currently providers in many areas are at the end of a supply chain, delivering support services that have not been designed with a person-centred or recovery ethos in mind. SAMH believes that social care services should be designed around practices that achieve the best outcomes for individuals. From our experience, social care services are often designed with a focus on local authority budgets, which can result in providers having to compromise their approach. For the National Care Service to be successful in empowering people requiring support, as well as those delivering care and services, this approach must change.

It is crucial that the model adopted by the National Care Service, particularly at a local level, moves away from a reliance on generic frameworks for adult social care. The emphasis on national minimum quality standards and an outcomes-focused approach to care in the Structure of Standards and Processes is welcome. But does not give us confidence that a framework approach to commissioning and procurement will end. It is essential that people with mental health problems can access specialist mental health social care support, delivered by practitioners with specialist training in mental health.

Our experience with social care services commissioned through local generic frameworks has too often resulted in people with mental health problems not being supported by practitioners and services that can cater to their needs. For example, SAMH has previously highlighted instances where learning disability professionals oversee the provision of mental health support, despite there being a distinct difference between mental health and learning disability.[38]

The Scottish Government must at the earliest opportunity work with people with lived experience of social care, front line practitioners and providers to further develop and expand on the proposed Structure of Standards and Processes. We suggest that this should include reflection of the *"Big Ideas- for changing how care is planes, purchased and paid for"* published by CCPS in 2020.[39] These include suggestions for Provider Alliances, allowing for long-term contracts and sharing of risk.[40]

At a minimum, we renew our call made in our submission to the Independent Review and our Standing up for Scotland manifesto to introduce a statutory minimum of five year social care contracts, to help reduce the culture of short-term in commissioning and the burden on providers. This would have the important benefit of reducing distress for people in receipt of care as well as frontline staff, who find frequent changes in provider (and employer) challenging and at times distressing.

Market research and analysis

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

YES

National commissioning and procurement services

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

YES

Reformed Integration Joint Boards: Community Health and Social Care Boards

Q73. Is there anything you would add to these core principles?

We agree broadly with the core principles, but would echo the call from See Me to make sure that there is an explicit reference to discrimination and protected characteristics.

Q74. Are there any principles you would remove?

---

[38] SAMH Independent Review of Adult Social Care – SAMH Submission
[39] CCPS Big Ideas- for changing how care is planes, purchased and paid for 2020
[40] CCPS Big Ideas- for changing how care is planes, purchased and paid for 2020

NO

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

The phrasing "where possible" and "where appropriate," should be removed.

In section 9, SAMH believes that regulators should always be involving people with lived experience, including those using services, family and loved ones of those using services, experienced care providers and unpaid carers in the development and delivery of scrutiny. In addition, there should be regular periods where scrutiny is reviewed and it can be assessed if it is still working, while consulting with these lived experience groups. We would recommend that representatives from these groups should sit on any Boards formed by the regulator and have voting powers.

On point 10 of the core principles scrutiny should always, by default, take account of legislative requirements. The phrase "where appropriate," may be taken to signal that the law is malleable, and could be undermined.

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

We do not feel able to answer yes or no to this question, but wish to highlight concerns about the impact of regulatory powers on provider workload. During the pandemic scrutiny of providers from a variety of statutory bodies increased. This often duplicated work for providers and those regulating services. Whether enforcement powers are maintained or enhanced it is crucial that providers subject to these powers are given the direct support and guidance from the regulatory body they need.

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

YES

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

All Providers

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

YES

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

YES

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

YES

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

YES

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

YES

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

It is crucial that regulatory bodies work together from board level, to individual investigations, as part of their standard practice.

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

All paid staff with a direct role in the care of service users, such as personal assistants, health care assistants and day care in adult services should be registered with the regulator. It is however important that the regulator makes it easy to register, and their requirements are made transparent and achievable.

Valuing people who work in social care

Fair Work

Q87. Do you think a 'Fair Work Accreditation Scheme" would encourage providers to improve social care workforce terms and conditions?

YES

SAMH believes that social care must be a valued, highly skilled and attractive sector to work in, with opportunities for staff retention and development. Fundamental to this are fair attractive working conditions and adequate remuneration. At present, the country is facing a social care workforce crisis alongside a high turnover of staff due to a number of reasons that have only been, compounded by the impact of the pandemic and brexit.

People working in the social care sector continued to deliver life changing support throughput the pandemic at great risk to themselves. SAMH believes that it is essential that the skills, values and dedication of the workforce is recognised as social care is reformed.

We welcome steps taken over recent years to strengthen the social care workforce, including the work of the Fair Work in Social Care Implementation Group, which is tasked with implementing the 2019 recommendations from the Fair Work Convention.[41] Progress included a national approach to the implementation of the real living wage. However, more must be done to ensure a minimum level of employment standards across the sector.

SAMH broadly agrees with the proposal for a Fair Work Accreditation Scheme. However, it will be critical that the development of an accreditation scheme is done in partnership with third sector providers and frontline staff, and recognises the diversity of job roles in the social care sector.

It is also essential that commitments under a Fair Work Accreditation Scheme are achievable for third sector providers, in the framework of commissioned services and restricted budgets. In particular, any resource implications for providers must be fully compensated through service contracts, such as pay and wider terms and conditions. As outlined in previous sections on commissioning, the current model of competitive tendering acts to prioritise 'price' rather than service quality. It would be highly damaging for people requiring social care support if third sector providers were disadvantaged or 'priced out' of tenders for social care services due to fair work expectations that they were not resourced for.

Finally, there needs to be more clarity on whether the proposed accreditation scheme is compulsory, something SAMH would support if commitments in the scheme are properly resourced. Any alternative opt-in scheme would be at risk of not producing a minimum fair work standard, as providers could opt out and set terms and conditions below the agreed minimum standard. The onus should be on the National Care Service to support providers to ensure compliance with the scheme.

Q88. What do you think would make social care workers feel more valued in their role? (Please rank as many as you want of the following in order of importance, e.g. 1, 2, 3…)

OTHER

It is not possible to rank the options, as we believe that they are all equally important in making social care a more attractive and valued sector for people to work in.

We would also like to highlight that social care and community health care are high stress environments, particularly (but not exclusively) in light of the ongoing covid pandemic. Research from the GMB Union found that three quarters of social care workers mental health worsened during the pandemic. With women, people with disabilities and those working in residential care settings reporting the most significant rises in poor mental health.[42] Supporting the mental wellbeing of the workforce is essential to the fair work agenda. While we warmly welcome commitments from the government including £8 million of funding for workforce wellbeing and the establishment of a National Wellbeing Hub for

---

[41] Scottish Government Fair work action plan: annual report 2021
[42] GMB Three quarters of care workers' mental health has worsened during pandemic | GMB 2021

health and social care workers, more must be done.[43] Access to support for mental health and wellbeing and increasing the mental health expertise of the sector must be embedded into workforce planning and the quality improvement functions of the National Care Service.

Q89. How could additional responsibility at senior/managerial levels be better recognised?

OTHER

As with Q88 it is not possible to rank the suggestions. Improved pay, improved terms and conditions, and access to training and development are all equally important to recognising the value or managerial roles.

Q90. Should the National Care Service establish a national forum with workforce representation, employers, Community Health and Social Care Boards to advise it on workforce priorities, terms and conditions and collective bargaining?

YES

A national forum is a welcome proposal, if adequately supported and resourced. The key to its success will be ensuring its membership represents the diverse nature of the social care sector (both employees and providers), and in ensuring that all members are supported to be meaningfully involved in its operation. To ensure the forum avoids becoming tokenistic, there should be a legal duty placed on the National Care Service, as well as upon Scottish Ministers, to outline why advice from the national forum is not accepted in cases where Ministers reject its advice.

Workforce Planning

Q91. What would make it easier to plan for workforce across the social care sector? (Please tick all that apply.)

OTHER

All the proposals outlined by the Scottish Government have merit. It is important to highlight that a national approach to workforce planning, while potentially beneficial, must be responsive to local needs and demographics. Local feedback through CHSCBs to the national functions of the National Care Service on workforce planning will require adequate resourcing and a high quality national data set. It is important that workforce planning data and functions link with training and development functions of the National Care Service. With workforce planning data used to inform local training needs and direct funding to these.

Training and Development

---

[43] Scottish Government [£8 million package for health and social care workforce wellbeing - gov.scot (www.gov.scot)](www.gov.scot) 2021

Q92. Do you agree that the National Care Service should set training and development requirements for the social care workforce?

YES

SAMH believes the National Care Service should work alongside the SSSC to communicate consistent minimum standards on training and development. However, it should be for specialist social care providers to determine the suitable Continuing Professional Development (CPD) training required for their own workforce, based on their own knowledge and expertise concerning the people they support.

SAMH supports See Me's recommendation that universal training for the social care workforce should include mental health literacy and aim to reduce mental health stigma and discrimination. Like See Me, we have heard from people who have experienced stigma and discrimination in health and social care settings.

In particular, respondents to a SAMH survey on social care highlighted the need for staff conducting social care assessments or review meetings to have more knowledge about mental health problems. Indeed, we know that other disability assessments, including those for social security payments, often disadvantage people with mental health problems due to the assessor's focus on physical health problems, and a lack of understanding concerning the impact of mental health problems. [44],[45] As one respondent to our social care survey explained, "a one-time visit with me doesn't prove that I do or do not need care."

Therefore, for people to receive person-centred and holistic care from the National Care Service, it is critical that the social care workforce is aware of the fluctuating nature of mental health problems.

Q93. Do you agree that the National Care Service should be able to provide and/or secure the provision of training and development for the social care workforce?

YES

---

[44] SAMH, 'It was a confusion' Universal Credit and Mental Health: Recommendations for Change, March 2019 (Available at: https://www.samh.org.uk/documents/ItWasAConfusionReport_ONLINE_VERSION.pdf)
[45] SAMH & Mind, Submission to the Work and Pensions Committee inquiry on PIP and ESA assessments (Available at:
https://www.samh.org.uk/documents/Mind_and_SAMH_submission_to_the_Work_and_Pensions_Committees_inquiry_into_PIP_and_ESA_assessments.pdf)