OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 22 February 2022

Session 6

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

8th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Sue Webber (Lothian) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Fiona Collie (Carers UK)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Dr Donald Macaskill (Scottish Care)
Judith Proctor (Health and Social Care Scotland)
Humza Yousaf (Cabinet Secretary for Health and Social Care)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 22 February 2022

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): Welcome to the Health, Social Care and Sport Committee's eighth meeting in 2022. I have received no apologies from members.

The first item on our agenda is a decision on whether to take items 5 to 7 in private. Do members agree to take those items in private?

Members *indicated agreement.*

Social Care

09:00

The Convener: Our second agenda item is an evidence session on social care. I welcome our panellists for the next couple of hours, who are joining us online. We have Fiona Collie, who is the policy and public affairs manager for Carers Scotland; Annie Gunner Logan, who is the chief executive of the Coalition of Care and Support Providers in Scotland; Dr Donald Macaskill, who is the chief executive of Scottish Care; and Judith Proctor, who is the chief officer of the Edinburgh integration joint board and chair of Health and Social Care Scotland's chief officer group. I thank you all for giving us your time.

We decided to have this session as a result of the recent Audit Scotland report on social care, which will be the backdrop to our discussion. Many of the issues that are brought up in the report are familiar to us all. I want to ask about the fragility of the workforce. To me, one of the most striking things in the report is the statistic that nearly a quarter of people who start a job in social care leave that job within the first three months. I found that to be a staggering statistic. What is behind it? It surely cannot purely be about pay and the fact that people go somewhere else for pay reasons. I would like to get your thoughts on some of the workforce statistics in the report and your views on what is happening in that regard.

I will go first to Fiona Collie.

Fiona Collie (Carers UK): Obviously, we focus primarily on the unpaid workforce but, certainly, Carers UK has for a significant period noted the difficulties in recruiting staff, whether that is for services that support carers or as personal assistants. When we talked to carers about the issue, they discussed the need for, alongside better pay and terms and conditions more widely, better opportunities for career progression and training.

One of the most important issues that sits alongside the issues of terms and conditions and pay, is valuing of the workforce. Until the pandemic, social care felt a bit hidden. We often talked about the important role that the national health service plays, but we talked less about the significant role that social care plays in maintaining people's independence and enabling them to live good and positive lives. For example, it is about supporting people to continue to work, should they develop a disability. The role of social care has been very hidden. The profile of social care is an issue, and the national care service will be part of dealing with that. We need to talk about the importance of social care and the difference that it

makes to people's lives. That has been part of the problem, and it will continue to be part of the problem unless we make a difference to that.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): The question was whether the issue is just about pay, and the short answer is no. However, that does not mean that pay is not significant. We should also bear in mind that social care is not for everybody and that, in some respects, it is better for people to find that out sooner rather than later.

On pay, we need to acknowledge the work that has been done to increase pay at the lowest levels over the past couple of years. You will know that there have been several announcements, the most recent one being that pay will increase to £10.50 per hour at the lowest level. To present a counterfactual argument, the situation would certainly be much worse if that had not happened. It is good to see that focus.

However, the way in which pay uplifts have been implemented sets up new problems further down the line. All the focus is on pay at the lowest level. It does not take differentials into account and it does not take account of the career progression that Fiona Collie mentioned. When we look at the pay uplift that is coming in April, there seems to be a question about whether the increase in employers' national insurance contributions will be funded. We are in a difficult place.

As to what else can be done about that, we have submitted a couple of papers to Scottish Government colleagues, which I would be happy to share with the committee. The papers set out a range of actions that social care employers believe will help, based on their experience at the sharp end of recruitment.

In the longer term, we still need to address the core recommendations of the report on social care that came out from the Fair Work Convention in 2019. The report identified poor commissioning as a critical issue, and it had a lot to say about the pay-per-minute culture of a lot of social care employment. It recommended having better career progression for social care workers and giving them far more autonomy and authority to make decisions, rather than just giving them a roster of people to visit at someone else's behest.

The recommendations of the subsequent working group on fair work in social care made a significant number of recommendations about extending the scope of the pay uplift and raising pay levels not only for people who were on the minimum rate, but across the workforce. The working group made a strong pitch for pay parity between public sector employees and those in the third and private sectors, because there is still a two-tier system. None of that has been addressed—I presume that is because of affordability. We will not solve the on-going workforce challenges in a cost-neutral way, and there is no point in pretending that we can.

Dr Donald Macaskill (Scottish Care): That research was conducted by my colleague, Caroline Deane. That report came from Scottish Care.

Pay is one reason why people leave care jobs after a relatively short time. However, they know about the pay before they start the job. Therefore, although I do not disagree with anything that Annie Gunner Logan and Fiona Collie have said, there are other factors at play. Primary among them is the lack of societal value and significance that is placed on the role and work of care. We saw that during the pandemic. It took eight weeks until we began clapping not only for the NHS but for carers. It took weeks until supermarkets began recognising social care staff as being just as significant as NHS staff and giving them priority. Those two illustrations are indicative of a lack of societal value.

There are other reasons. People underestimate just how challenging the job of care is. It is a highly technical, skilled and professional job. That situation is not helped by politicians such as the Home Secretary describing that work as "low-skilled". Care is not a low-skill job. We know that some people are attracted to work in care because they think that it is easy. Working in care is one of the most rewarding things that an individual can do. It enables them to help and support other individuals to achieve what they want to achieve. That is physically, emotionally and psychologically demanding.

There are other factors. Often, people do not appreciate the need for registration and qualification. I am not saying that we should abandon those important criteria, which denote professionalism. One challenge is that people think that care is easy—they apply, then realise over time the reality of the demands alongside the rewards.

Undeniably, what holds people beyond the first six months is the relationship that they build up with those whom they are supporting. The statistics about people who leave care jobs after six months but within 18 months are just as troubling. What takes people away is the reality that—as Annie Gunner Logan said—we do not give care workers autonomy, and we pay them at a base level. Although that has improved, it is a little bit like trying to put a Mercedes engine into a rusty Mini Metro. As Audit Scotland indicated, the system of care and support is in need of radical reform and change. There is no point in addressing the issue of pay unless we address the issue of sustainability.

Judith Proctor (Health and Social Care Scotland): Good morning. I agree with most—in fact, all—of what has been said so far. Care is a really important job, and I hope that the pandemic has brought that into focus for people. We welcome the committee's shining a spotlight on it, because it is important for the future that we work towards a resolution.

It is an important job, and I agree with the comments that were made about working in care. People come into care with a perception and then they undertake the role and see how rewarding but difficult it is. I agree with the outline that Donald Macaskill gave. People are asked to undertake caring responsibilities for people with very complex needs. It is not simply a case of checking on people. They provide complex care for individuals across the geography that they work in. It can be an isolating job, and it can confer a lot of responsibility on people, which is difficult. I am not sure that people understand the reality of that.

Therefore, we need not only to value the job, but to help people to understand what it entails and the difference that it makes to people's lives. Collectively, we can do more to talk about care. We need to think about how we can make it an aspirational job. People aspire to perform roles in health and other public services. How can we make care a sector that people aspire to come into? How can we attract more younger people to come into care? Part of the challenge that we have experienced with turnover has been to do with the fact that it is an ageing population—it is a physically demanding job, and more and more of the people who provide care are older.

We need to think about how we attract people to do the job. In Edinburgh, we are doing some work with the colleges to shape care roles around the needs of students so that we can match those needs with care roles and make it easier for them to come into care, which will support our workforce. Pay aside, there is a lot that we could be doing around terms and conditions. However, I agree that the issue is also about pay. We need to reward people appropriately for doing a job that is significantly important to society and to the people who experience and benefit from that care.

I agree with what was said about poor commissioning. Some of the commissioning practices over past decades have not supported us in developing a workforce of valued partners. That has driven some of the factors that have driven people out of care. There is a lack of continuity for carers. People enjoy developing a professional working relationship with the people whom they care for, but we often ask carers to do jobs that are disjointed, and which do not support that. That is not good for the people who provide care or for the people who receive it. There is a range of factors in and around that.

In my area of Edinburgh, there are pay issues, because of the high cost of living and the high rates of pay that are offered in other sectors, which are attracting people away from care. There is definitely a geographical element here. I am sure that, if colleagues from some of the more remote and rural parts of Scotland were here, they would echo my remarks about the high cost of care and the high cost to carers in undertaking care roles in those areas.

The Convener: I thank you all for those opening comments, which provide a really good starting point on issues that my colleagues might want to dig into in more depth. I asked all the witnesses to respond to my opening question. My colleagues will probably pose their questions to specific individuals but, if anyone who is not directly asked a question has something to add, please put an R in the chat box.

On the theme of the social care workforce, I hand over to Sandesh Gulhane.

Sandesh Gulhane (Glasgow) (Con): Judith Proctor spoke about the need to consider how we inspire people to get into care. Donald Macaskill correctly described the skilled and challenging work that is involved in meeting people's care needs. Annie Gunner Logan said that only base pay has been uplifted.

09:15

Why should a teenager or a young person get into care, if it is as challenging as Donald Macaskill said it is? They could earn £10.10 an hour at Aldi or they could earn far less to do a more challenging job. They could work at Asda, where they would get similar starting pay but they would have the opportunity to get a degree and to work their way up through a career-focused strategy. Lots of people have done that. They could start off stacking shelves and end up as a senior manager who earns hundreds of thousands of pounds. Given such an environment, how can we get people into the care sector?

Annie Gunner Logan: You have articulated the precise questions that people who are looking at a career in care ask themselves. The difference between stacking shelves and being a social care worker or a support worker is like night and day in terms of the rewards, the fulfilment and the sense of purpose. Certainly, in the third sector, people are working for values-driven and mission-driven organisations that want to have the maximum possible social impact.

Those elements are all there but, if you are a teenager and you are looking to pay your bills and

make your way in the world, in the short term, you will get paid more somewhere else—there is no question about that. That is a recruitment issue.

We also need to look at the retention issue. Perhaps one of the more worrying things is how you keep people once you have persuaded them to come in, they have seen what it is like, they want to do it and they have accepted the terms and conditions. That is where career progression, autonomy and all the other things that we have talked about come into play. In the third sector, employers are really trying hard to address that.

One of the positives in the third sector is that we have tried hard to protect the workforce development and training budget, precisely in order that people can move up the ladder. That becomes very difficult when you have a Government policy that is only about the lowest level of pay and when differentials are being squeezed. That makes it much harder for employers to offer the opportunities that will keep people in the workforce. There are two issues—one is getting in people in the first place and the second is keeping them there.

Sandesh Gulhane: That is the crux of the problem—as you said, once you have got people in the door, keeping them is difficult because, as we have seen through the pandemic, maintaining wellbeing is difficult. The work that people have been doing is extremely challenging; even without the pandemic, it is extremely challenging. You are right that it is rewarding—I am a doctor because the job is rewarding—but I am not sure that that is enough when you are talking about people who are going into the care sector, because we need to not only keep them but give them some form of career.

Everyone starts off on lower pay, and people accept that if they can see that there is career progression—again, without wanting to promote Asda, I note that it pays for staff to get a degree while they are working. We need such clear career progression to happen in care. How can we encourage that to happen?

Annie Gunner Logan: I agree with everything that you say. I add that this is not only about teenagers and young people; we need to make sure that we do not dismiss the older workforce. Especially given the future demographics in Scotland, we need to make social care a suitable environment for the older workforce, who may not be looking for the opportunity to do a degree. In that case, we have a completely different set of proposals, where the rewarding experience that caring is counts for an awful lot more than perhaps the opportunity to do a degree.

However, largely, I agree with you that the prospects for younger people often appear more favourable in other fields. That is partly about affordability but, again, I refer everyone here to the 2019 Fair Work Convention report, which is now starting to gather dust a bit. It went into all of that and much more, yet the only thing that has been plucked out of it is the question of pay. I am not saying that pay is not important, but there is so much more to it than that. As I said, you are articulating exactly the kind of questions that people ask themselves when they look at this as a career.

Dr Macaskill: I think that we all recognise that pay is a critical element, but the Fair Work Convention report on social care—along with Annie Gunner Logan, I commend that to the committee—also highlighted how important it is that workers feel that they are being valued and treated with equality when they are at work. I cannot imagine any nurse in a hospital treating a patient, getting paid for that activity and then moving to another bed and not getting paid for the journey between patients. I cannot imagine such a worker in a clinical setting not being paid for taking their break, and yet that is precisely how we commission and contract social care.

It is so important that we look not just at pay but at how we value people—for instance, as the Fair Work Convention indicated, electronic call monitoring systems are now in effect the equivalent of electronic tagging of our workers. I cannot imagine a nurse in the community tolerating that degree of lack of trust, respect and individual autonomy.

As we have all said this morning, these women and men are highly skilled, professional individuals. Why do we continue to treat them as though they were untrustworthy teenagers? If we want to not just attract young people but hold on to those in our workforce, as Annie Gunner Logan said, we need to start to treat them in the way that we contract independent employers—in a way that values the front-line women and men in care.

Judith Proctor: Again, I agree with much of what has been said. There is no single fix for this. We need to look across the different groups of people who we want to attract into care. How do we grow the pipeline and the career escalator for individuals who want to come into care, who maybe then aspire to a career in the wider family of health and social care?

How do we attract people into care as a fantastic grounding for other caring professions? How are we, as wider public sector bodies, supporting individuals to train in other areas, should that be what they wish? We have shortages and challenges in relation to attracting social workers, for example. How are we supporting such individuals to become allied health professionals, nurses and so on? For those

who want that as a career pathway, care can be a valuable grounding.

As important for individuals who aspire to a career in care is how we make that a job that retains people and values them for doing that job well. We absolutely need to think about the terms and conditions—how people do the job, how we support them to do it, how we keep them safe in the job and how we keep them trained, motivated and supported. It is important that we create that as a good career and as a career that can lead people into a longer-term career in other parts of health and social care.

Fiona Collie: Part of what needs to be done to encourage people to join social care is talking about the wider aspects of social care and what they mean to people. We have people who provide direct care, but there is such a wide variety of roles across social care. Annie Gunner Logan will probably very much recognise this—I have worked in the voluntary sector for my whole career and I know that the work that is done in different aspects of social care to support people is not terribly visible but can help not only to encourage people to join social care but to retain them there.

I will talk briefly about commissioning. Some ways in which that has been done have blocked the expansion of self-directed support, particularly for older people, and that closes off opportunities. For those who are looking to employ someone from social care as a personal assistant, pay is critical. If they cannot offer the same pay as a council, for example, it is difficult to recruit staff. Services in the public, independent and third sectors recruit social care workers who would otherwise go to individuals who are trying to recruit personal assistants, so the equalisation of pay across the sector is important.

The Convener: David Torrance wants to ask a question about commissioning, which all our witnesses have mentioned.

David Torrance (Kirkcaldy) (SNP): Audit Scotland states that current commissioning procedures have led to competition between providers at the expense of collaboration. How can commissioning and procurement procedures be changed to encourage a more collaborative and less competitive approach by service providers and to shift the primary focus in decision making from cost to quality?

Fiona Collie: As I said, I have worked in the voluntary sector for my whole career. If you want to look at quality instead of cost, collaboration is critical. We have seen really good examples in the third and voluntary sectors of such collaboration, with organisations working together to find ways of being available to be commissioned for a service. However, the reality is that the commissioning process becomes challenging when it comes to levels of pay and so on. Larger organisations might have more scope to bid for a contract that gives people lower levels of pay and of terms and conditions, which means that smaller organisations get pushed out of the process.

There are opportunities for smaller and larger organisations to work together but, fundamentally, the health and social care partnerships, or whoever is commissioning services, need to encourage that collaboration. The commissioning process should state that it encourages such collaboration because, ultimately, what is important is the outcome for individuals.

Dr Macaskill: Commissioning is part of the issue that we are discussing. The Fair Work Convention report highlighted that the issue is not just commissioning but the way in which we procure and purchase services, as well as the contracts that we agree to with organisations and individuals.

We have known for years that the system as it is at the moment is simply driving standards down while ostensibly attempting to improve quality. We know what works, which is partnership models or alliance models, where individual providers work together collaboratively. That is happening in some parts of the country, such as Aberdeen. Everybody knows the solution to the problem; what we lack is the willingness to be honest and resource the significant change that is needed.

One of the key aims of self-directed support, which Fiona Collie mentioned, was enabling people to have choice. That is possible only if there is a market—if I can use that term—in which people can choose between different providers. The way in which we agree contracts and procure services is driving organisations out of the sector, regardless of whether they have a charitable or private business model.

09:30

As Derek Feeley's independent review report indicated, we need to move, and we need to do so fast and not while we wait for a national care service. We need to move to a model of alliance co-operative ethical commissioning that is about quality and not all about price. When the Homecare Association recently undertook work across the UK, it highlighted that not one Scottish local authority is paying what would be independently reviewed as the fair price for home care. We know the answers to the question; we just need everybody to get around the table to work together.

Annie Gunner Logan: Thanks to Mr Torrance for the question. I always feel as though I am on

"Mastermind" when this topic comes up, because I think of it as my specialist subject. It seems as though I have been talking about it for ever. One of the first times that I spoke to a Scottish Parliament health committee was in 2009, when the big issue of the day was reverse online auctions for social care contracts, whereby providers were encouraged to drop their hourly rates in competition with one another against the clock. We have come a long way since then. That particular practice bit the dust, largely because of the attention that the committee rightly gave it.

After that, we spent a long time—many years—honing guidance that attempted to distinguish the procurement of social care support for people from the procurement of widgets and to prevent staff from being treated as a largely casualised workforce to be transferred through Transfer of Undertakings (Protection of Employment) Regulations from one employer to another without them or the people who they support having much say. We introduced a lot of flexibility for social care procurement in the Procurement Reform (Scotland) Act 2014. That has all been good and we are in a different place now from the one that we were in then.

However, fundamentally, Audit Scotland is correct in saying that we are still experiencing commissioning as a price-based competitive exercise for large contracts to provide services that are specified not by the people who will receive support but by procurement officials who have never met them, far less understood their individual needs. The push for ethical commissioning, which is a term that we are hearing more and more, and for procurement that recognises fair work and the exploration of more collaborative approaches is hugely welcome.

There are two positive things about that. My organisation is leading a programme of work, with Scottish Government funding, to support providers, commissioners, people who use support and anyone else who is interested to do things a bit differently and find ways to develop procurement practices that respect and give expression to the principles of self-directed support, as Donald Macaskill just said. Collaboration is not only about providers collaborating with one another; it is about commissioners, providers, the people who they support, families and unpaid carers all getting around the table for better outcomes. There is a lot of interest in that—hooray! We have a team of two and a half people doing that work. The independent review of adult social care called for a national improvement programme in this area and, boy, would we like to see that very soon.

The second positive thing is that the Scottish Government procurement directorate has recently issued an incredibly helpful policy note that says to commissioners and procurement officials, "Don't wait for the national care service—start now. Set your procurement activity; make sure that it is in alignment with the principles of ethical commissioning and fair work." And so say all of us.

The really important point is that the independent review recommended a revolution in commissioning, but the national care service proposals that came out in a consultation last year did not really follow through on that. I would go so far as to say that competitive tendering for social care is, in itself, unethical, and no amount of tinkering around the edges will change that. I worry that ethical commissioning is being interpreted as a way of ensuring that providers behave ethically. However, it has to start at the beginning, with a commissioning mindset that is ethical. That would rule out competitive tendering, as it would rule out any procurement that did not involve the individual choosing their own support. I could talk about that for ever, but I should probably let colleagues get a word in.

The Convener: David Torrance has a follow-up question.

David Torrance: Dr Macaskill, you mentioned Aberdeen and collaborative working. Will you expand on examples of best practice in collaborative working?

Dr Macaskill: It is very much along the lines that Annie Gunner Logan just described. The process of preparing a social care package begins with an initial conversation with the person who is being supported. She or he has significant input. At the assessment stage, they are allocated an individual budget. Good work highlights that they know what options are available to them and are able to exercise choice. That is all essentially about contracting and involving the person.

At that point, we make sure that the providers give good information and are able to support the person, perhaps through individual interview, so that the person has control and choice. Then we go all the way through the contractual relationship with the people who are paying for the care, which is the local authority, to make sure that the care is autonomous and that the front-line worker is trusted in what she or he does.

There is some interesting work being done by colleagues of mine in Aberdeen on the role of the care technologist. We have so much potential to enable people to live independently in their home for much longer by using home technology. As part of our overall work in Aberdeen, that project is looking at the potential for giving autonomy to front-line care workers and the person who uses the care support.

There is no simple answer. There are lots of models, but they have a consistent thread, which is partnership, collaboration, equality of treatment and, critically, trust. I agree with Annie Gunner Logan that a competitive tendering process is unethical. What best practice has as its heart is collaboration rather than competition, and trust rather than suspicion.

Emma Harper (South Scotland) (SNP): I have a quick question about self-directed support. A couple of panel members have mentioned that and we raised it in the Health and Sport Committee in a previous parliamentary session. There is a document from 2011 that talks about barriers to self-directed support and things that help it. Do any panellists—perhaps Annie Gunner Logan or Fiona Collie—have a feeling about how well we are doing with self-directed support? In my case work, I have people who are not really aware of it or what it does. How are we doing with it now?

The Convener: It would be good to go to Fiona Collie on that.

Fiona Collie: The position is variable. The problem is that it is inconsistent. Some individuals and their carers will be given a clear offer of self-directed support. It will be a straightforward process in their local area and they will be provided with support and information to enable them to make decisions. However, it is not consistent. Many carers and individuals do not know about self-directed support at all.

Our colleagues in the Coalition of Carers in Scotland asked about the previous flexibilities in self-directed support. The Government produced guidance saying that, at the moment, when it is very difficult for providers to provide the support that people need—breaks and day services being two particular examples—it was not possible for people to use their direct payment or option to purchase something else. More than half of carers had no idea that that was happening or that the flexibility was available.

When we talked to carers, they told us about some of the things that would have been really valuable to them. That included being trusted—Donald Macaskill mentioned trust—and having a smaller administrative burden. If someone takes on a direct payment and is employing someone, there is a lot of administration. Even if they are using other options, there is a lot of administration. There is a real need to remove the bureaucracy around that and to say to individuals and their carers, "You know what is best suited to your needs and what will make a difference to your life. We trust you to use a direct payment to purchase support from an individual provider and we will not ask for reams of paperwork or loads of receipts. We will trust you." We are still some way from that.

Dr Macaskill: With respect, the fact that Ms Harper had to ask how we are doing with self-directed support shows the answer, which is that we are doing pathetically. The Social Care (Self-directed Support) (Scotland) Act 2013 was probably one of the most progressive and dynamic pieces of social care legislation anywhere in western Europe, if not much wider. Maybe one of the problems was that we talked about self-directed support when we should have said, "This is now how you get support—this is social care and social care assessment." It still dismays and sometimes angers me that I hear people saying, "There is the social care assessment, and that person is on self-directed support." All social care should be self-directed support. The answer to Ms Harper's question is that the fact that we are still talking about self-directed support as if it is a different creature shows that we have failed in communication and implementation, as Derek Feeley said.

To look at it from the perspective of the older people I support, we did research in February 2020, just before the pandemic. Our analysis showed that only 3 per cent of older individuals living in residential or nursing care accessed self-directed support and only 5 per cent knew about it. That has not changed during the pandemic, so the answer to Ms Harper's question is that we are not where we should be.

Annie Gunner Logan: Where self-directed support works, it works well but, in my view, there are some fundamental misunderstandings about what it means. For example, I still see people confusing it with direct payments and thinking that that is all there is to it.

We have to remind ourselves constantly that there are four options in self-directed support and one of them is that people can say, "I do not really want to choose my support provider, so can somebody just arrange something for me?" That is fine, but the principles of self-directed support still apply to whatever service is arranged for that person, and they should have as much say as they want in how it is delivered to them.

The committee might be interested in looking a bit more into how self-directed support options 1 and 2—particularly direct payments—were handled during the pandemic. People were not always able to continue the arrangements or access the same support that they had previously, because services were withdrawn or there were staff shortages. It was incredibly difficult for those people to use the resources that they had any more creatively. Fiona Collie talked a little about the audit requirements and the obstacles that are put in the way of people who want to spend their resources creatively. That was a huge issue during the pandemic.

In answer to the last question, I said that the "Independent Review of Adult Social Care in Scotland" recommended a national improvement programme for commissioning. It also recommended a national improvement programme for self-directed support, and we could light a bonfire under that. We would be pleased to see that. Donald Macaskill is absolutely right that self-directed support should be mainstream, but it is not. We still seem to be looking for the magic bullet to solve social care, but this Parliament legislated for self-directed support nearly 10 years ago, when it passed the 2013 act. If we had introduced the measures properly, we would not be facing some of the problems that we are facing now.

The Convener: We move to questions from Evelyn Tweed on leadership.

Evelyn Tweed (Stirling) (SNP): Good morning to the witnesses; it is good to see you here today. It is nice to hear that some positives have come out of the pandemic; it has shone a light on the importance of social care and all the things that we need to look at in relation to the social care service in Scotland.

My questions are about leadership. Audit Scotland has highlighted that we also have an issue with retaining leaders in the social care sector. What can we do to help with that? What are the reasons behind it? We have talked about other sections of the social care service, but what can we do for our leaders and how can we make the service sustainable in the long term for them? That question goes to Annie Gunner Logan, because she touched on that earlier.

09:45

Annie Gunner Logan: That is a very good question. The topic is gaining a lot more traction. The Scottish Government convenes a national leadership development programme that looks right across health and social care. In some ways, it tries to address the issue that you are alluding to, which is that there is a bit of a hierarchy of leadership in health and social care. Health is definitely still the dominant party in that.

We need to recognise that most of the leaders in social care are not part of the public sector. They are the leaders of third and independent sector social care organisations, who often find themselves completely out of the loop. I was chatting to some of my colleagues about that recently. If you are the chief executive of a social care organisation in the third sector with £50 million turnover, your main point of contact with the system will be a junior contracts officer. That is how it works.

As I speak, I am already thinking, "Oh dear, somebody is going to say to me that I am obsessing about status and hierarchies." I am not. It is just that those people understand their business, the people whom they support and the mission that they are on, but they are somehow not part of the leadership effort and they really need to be. I bang on about that endlessly in the meetings that I attend because, at the moment, there is definitely a hierarchy and the independent sector is pretty much at the bottom of it when it comes to leadership. I would like that to change.

Another point that I raise in those meetings is that leadership in the third sector and independent sector is a much riskier business than it is anywhere else because, if you get it wrong, it is not just your job but your organisation that will fall over. Social care organisations are not called into being by statute. We are here in the third sector because we want to be. For me, that is what "voluntary sector" means—you are there voluntarily. However, if you do not get the right leadership, it is a hugely risky business.

Dr Macaskill: The social care sector and workforce have shown exemplary leadership, especially over the past 22 or 23 months.

If we are going to solve the crisis of leadership that we face, we need to examine the experience during the pandemic and learn some lessons. That starts with respecting the professionalism of the front-line nurse or social care worker and giving them the autonomy and trust that I have spoken of. It continues with the necessity of recognising that we cannot simply reward front-line workers by increasing their salaries without recognising the importance of differentials. If a senior carer is paid only 40p an hour more than somebody who is just in the door, that is about not valuing leadership, because the individuals who are supervisors, co-ordinators and senior carers are our leaders now and our senior leaders of tomorrow.

We also need to take a whole-system approach to leadership. Thankfully, the Scottish Government's new work is beginning to do that. By that, I mean that we have to recognise the mutuality of our health and care systems. The insights, experience and expertise of leaders in social care need to be understood, appreciated and valued by senior leaders in our health system. That involves more conversation, collaboration and opportunity to get together. Sadly, in the past year, there have been significant reductions in the occasions and opportunities for health and social care leaders to get together.

Leadership is something that affects the whole of the sector and, at the moment—sadly—because of the experience of the pandemic, because of burnout, emotional stress and fatigue, we are losing many leaders. In the care home

sector, that is significantly because of disproportionate scrutiny, which has resulted in many nurse leaders in particular choosing to leave the sector.

Judith Proctor: I will focus on the issues that have been raised already but also on the high turnover, particularly of senior leaders in HSCPs, which a number of Audit Scotland reports have highlighted. Chief officers, specifically, have been in place for around eight years, as long as we have had HSCPs; in that time, almost every HSCP in Scotland has had turnover of their chief officer and some of them have had several chief officers. Not just that, but we are seeing some challenges in relation to the number of applicants for other senior leadership roles within health and social care.

There is a question to be asked about how attractive those roles are to the people who are junior and middle managers. Are we making the roles aspirational or are they jobs that people just do not want to undertake? Probably every chief officer would be able to recount situations where they have not been able to recruit for senior roles within their systems. There is something in that about how we prepare, select and succession plan for leadership in our system; it is the same in health and social care partnerships as it is in the third and independent sectors. There is a national conversation to be had about how we prepare people to lead in public life in Scotland. It took a while to get the national leadership programme—Project Lift—to also include and embrace third sector leadership, but the opportunities there are relatively small, considering the size and scale of the sector. We need to think about the programmes that we have in place and the support that goes to support individuals once they are in place.

On the role of chief officers specifically, there is something about the complexity of the structures that we work within, which was recognised by Derek Feeley in his report, that makes leadership across health and social care particularly challenging, given the three organisations that they effectively lead and work within.

We have to really look at leadership. I know that the Scottish Government has undertaken some work on that; it would be good to see the outcome of that work in relation to the thinking around how we recruit, retain, prepare and support people to aspire to a leadership job in the future.

The Convener: Evelyn, you had a follow-up question.

Evelyn Tweed: Judith Proctor has just answered it.

The Convener: That is great. I will go to Sue Webber.

Sue Webber (Lothian) (Con): Judith Proctor mentioned the outcome of the Scottish Government work and some of the issues around the turnover of senior staff in councils, the NHS and the integration authorities. How do the working conditions of more senior staff compare with those of the broader workforce in the social care sectors?

Judith Proctor: There are differences in terms of the roles. I would never claim that you are not well rewarded in a very senior role as a health and social care chief officer. However, that comes with a range of accountabilities and responsibilities in a complex structure, which would differ in different organisations.

We need to peel it back and think about what values and skills we are looking for in leadership across the public sector and what outcomes we are trying to achieve. We then need to think through how we support individuals into those roles and then once they are in the role. Getting the job is only part of the process; you then have to perform in that role and deliver the outcomes of the organisation that you are working in. We need to have a discussion about what we are looking for in public life in Scotland and how we support individuals into those roles.

As Donald Macaskill touched on, we need to think about the support that we give to different organisations and the resources that they have to prepare and support leaders. He talked about the care home sector. It is important to note that not every care home provider or organisation will have the same resources available to support, prepare and retain their leadership. When we think about the resources that are required to deliver high-quality health and social care, we need to understand that part of that involves preparing and supporting the workforce and part of it involves preparing and supporting the leaders in that workforce, who undertake a critical role. Donald Macaskill touched on the role of care home leaders and managers throughout the pandemic.

The same applies to the care-at-home sector. If we compared what we would want those organisations to have with what they actually have, we would probably find gaps in the resources that are available to them for preparing and supporting leaders. There is no consistency in that regard, but I imagine that Donald Macaskill and Annie Gunner Logan would be better able to answer that question.

However, the same applies in the public sector. Not every health and social care partnership, local authority and health board will have the same resources to support and develop their leaders.

Sue Webber: Annie Gunner Logan talked about how some senior leaders are out of the loop and

are not part of the leadership effort, which might contribute to a lack of trust and a lack of understanding of one another's working practices and business pressures. We have a lot of short-term posts and an ageing workforce. All those things affect people's leadership capacity. What can be done to improve understanding? What role does the Scottish National Party Government have in building trust between the various sectors and leaderships?

I ask Annie Gunner Logan and Donald Macaskill to answer.

Annie Gunner Logan: Thank you for the questions. Some of that work is already happening. I think that I mentioned the national leadership development programme in which we are now involved. We are round the table for that, which is great because we have not done it before. The exact same conversations and points are being raised in that forum.

There is an issue about how we break out of siloed leadership. There is a view in the NHS that you can be an NHS leader only if you have grown up through the NHS. The same applies to local authorities and, in many respects, to the voluntary sector. We all have to see ourselves as part of a collective and collaborative endeavour. In the same way as we are talking about career progression up ladders within silos, we need to look at leadership movement across the sectors and we need to look a bit more at cross-fertilisation.

I will add one more point. Pre-pandemic, there was a lot of interest in what we call citizen leadership in social care, and in putting people who use care services and unpaid carers into leadership positions. That seems to have gone a bit quiet, so it would be useful to revive the concept, because there was some really interesting thinking being done around that.

Dr Macaskill: Thank you for the questions. I have always favoured a leadership model that is not about being so far ahead of the group that you are leading that you cannot see them or know their experiences, but is about being at the heart of the group. That, at its best, is what social care leadership has enabled. During the pandemic, care home managers, managers in home-care organisations and senior leaders literally rolled up their sleeves and did the work of caring. We saw that over Christmas and January, when we faced real staffing challenges as a result of omicron. That model of inclusive, participative and equal leadership is at the heart of social care.

In times of real challenge, health and social care partnerships, the independent third sector and central Government have worked really well collaboratively. I would like that work to continue, but my fear is that we will, as Annie Gunner Logan suggested, fall back into silos and lose the sense of mutuality and collaboration.

We should recognise that leadership requires resources, as Judith Proctor said. My worry is that, as well as haemorrhaging gifted women and men from leadership positions in our care sector because of the stress and strain of the pandemic, we are not nurturing and growing leaders in more junior positions, such as supervisors. We know how we can do that work; it is partly about there being a dedicated resource to enable leadership in the social care sector.

10:00

Annie Gunner Logan: If the committee wants to get into more detail on what is done around leadership in social care specifically, NHS Education for Scotland and the Scottish Social Services Council have information. For propriety's sake, I declare that I am a non-executive member of the board of NES.

The Convener: Witnesses have mentioned additional information that you want to put our way. Please, as usual, forward that information to the committee.

Gillian Mackay (Central Scotland) (Green): Audit Scotland has highlighted that cultural differences between partner organisations are barriers to collaborative working. How can we better overcome those barriers and foster collaborative working and greater integration of services?

Judith Proctor: Much of the answer to what you have asked about cultural barriers to greater integration of services has been touched on. Donald Macaskill mentioned the lack of opportunities over the past couple of years with the pandemic; we must definitely reflect on that.

We will address those cultural barriers partly through greater understanding of the context of the organisations in which we work, and of our roles within those contexts. Opportunities for development of relationships among sector leaders are important—for example, opportunities such as saw with the Scottish Leaders Forum, which has been quite active in that area. The work that Annie Gunner Logan just talked about will, we hope, also help somewhat to address the issue.

I have talked about the complex structures that we work in across health and social care. For us, as chief officers, the barriers are very real. NHS culture is different from local authorities' identity and culture. In our health and social care partnerships, we try to develop a culture and a way of working that is distinctly different and which supports collaboration, cross-sector working and

the integration and delivery of services as if we are a single organisation, which is quite difficult when the terms and conditions of people who work in that organisation are those of the NHS and the local authority. Derek Feeley highlighted that in his report and underscored some of the challenges.

We will have to wait to see what emerges from the consultation on the national care service, and whether the measures and the legislation that are put in place following the consultation begin to address that problem, because it is a challenging context in which to work.

Dr Macaskill: One of the many conversations that I had during the pandemic was with a senior general practitioner, who confessed that it was only during the pandemic that he began to really understand what social care and the job of front-line care—in a care home, in that instance—were like.

Ms Mackay's question about culture highlights the importance of us all having opportunities to learn—not quite to walk in another person's shoes, but to understand their world. At our best during the pandemic, we have taken off the—dare I say it?—professional arrogance and have been more appropriately humble in admitting that we do not know everything, whether that has been colleagues from social care talking about the health system or colleagues from the health system talking about social care.

The future that I see—with regard to addressing the very real cultural barriers that reports from before the pandemic highlighted as being among the major barriers to effective integration—involves our building on our experience during the pandemic. We must be inclusive.

As some colleagues will know, I have at times been critical of the sense that healthcare and social care have talked to and engaged with each other at statutory level, but the children—by which I mean the 76 per cent of social care that is delivered by the independent and third sectors—are not at the table. As we move forward, it needs to be a priority that all those who have something to contribute and are key players work together to change the culture. That is about listening to each other, sharing knowledge and experience, building trust and recognising mutual risk, rather than being about placing risk with one partner at the expense of others.

Fiona Collie: I could not agree more with what Donald Macaskill has just said. I would like us to build on the pandemic experience of being able to do things that seemed, in the past, to be impossible: for example, close working with, and inclusion in important working groups—such as the pandemic response group—of people who use services, and carers. Their inclusion added value to that group and built understanding of what carers experience. I have heard Donald Macaskill speaking at those meetings; there is now greater understanding of the situations that care workers are in and their experiences. That needs to continue.

Annie Gunner Logan mentioned citizen leadership. The culture on boards, such as integration joint boards, is very important in building collaborative leadership. Carers were very pleased to see in the proposals on the national care service that they and people who use services should have an equal voice on boards. Their views should be equally regarded in decisions on development and delivery of services in their area.

There has been a little bit of tokenism in the integrated joint boards. In general, there is one person from the voluntary sector, one service user and one person who is a carer on the board. It is a huge job to be that one person speaking for the whole sector or group of people. Carers, for example, have found that their voice is not what it could be or that their views are not as valued as they should be, given that they are people who provide often very complex care. As the community health and care boards develop, there is a lot of work to be done on collaborative leadership and on ensuring that everyone on the board has equal value in decision making.

Annie Gunner Logan: First, a big "amen" to everything that Fiona Collie has just said about collaborative leadership and culture. When we talk about culture in health and social care, there is often an implication that the cultural divide is between the NHS or healthcare on one hand, and social care on the other. However, as I have already said, there is a culture difference between the public sector and everyone else.

One of the biggest cultural barriers is the persistent inability of leaders in the public sector—present company excepted—to recognise providers as partners. We are not just suppliers that are to be managed through application of contracts and contract management. As you will see from the Audit Scotland report, the vast majority of social care is delivered outside the public sector, but there is still huge mistrust. It sometimes feels as though public sector colleagues have a strong impulse to count the spoons after we have been round for tea. That needs to end. That is one of our key criticisms of the national care service proposals. However, we might get on to that later, so I will keep my powder dry, for the moment.

If all we do is rearrange the structure without addressing the culture that sits underneath—the system that sees people who rely on social care as units of cost, and care services as commodities

to be traded in a market—we will not get very far. That is the bit of the culture that I would most like to see being addressed.

Gillian Mackay: I will briefly pick up on something that Donald Macaskill said. For some care workers, there is a lot of recording of visits. It is often to support families in terms of knowing what has happened during visits, but it can be used to try to keep track of workers because of mistrust in them. How do we improve the culture for care workers in particular, as we go forward?

Dr Macaskill: The "Fair Work in Scotland" report, which has been much mentioned already, highlighted electronic monitoring as a disincentive for front-line care staff. Such systems were introduced partly to support lone working and to increase worker safety and wellbeing, and partly to ensure that families and others were confident that care had been undertaken. However, the ways in which they are frequently used, not least to allocate financial return—that is, to pay the worker or provider—have become really damaging.

Before the pandemic, that was one of the major reasons home-care workers gave for why they no longer wished to work in the sector. It is interesting that, during the pandemic, most of those systems were removed virtually overnight; the world did not collapse and we did not see inappropriate behaviour or actions on the part of staff because they were, and are, trustworthy and committed individuals.

The answer is that we must develop systems whereby we trust and give autonomy to front-line workers. I would like us to get to a context in which a home-care organisation could be contracted in a way that enabled staff to be employed under a contract that gave them a case load—much as happens in community nursing and other contexts—and autonomy to work through that case load to identify where there is more or less need for intervention. In other words, I would like us to treat those amazing women and men with the trust and respect that they deserve, and to give them the autonomy that they wish for. We would then be able to remove what are, in my view, quite offensive systems that electronically tag workers.

The Convener: We have a couple of supplementary questions on that theme before we move on. They will have to be short. Please keep an eye on the time, colleagues, and direct your questions.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): We have spoken a lot about terms and conditions and culture. I am currently a councillor on South Lanarkshire Council. I know that one of the things that families want most is one front door for all services. However, that can be problematic when staff have different pay and conditions. Do the witnesses have examples of success? What does it look like? Is it about shared budgets, responsibilities and decision making? I am interested in things that we can do now, instead of waiting for the national care service to come along.

The Convener: We do not have time to go round all the witnesses, so perhaps you could ask individual witnesses.

Stephanie Callaghan: If anybody has a particularly good example, I would be keen to hear it.

Judith Proctor: I am happy to address that question. There are a number of really good examples where integration has happened in health and social care partnerships, regardless of the issue of there being different terms and conditions. In my partnership, the front-line teams are integrated, co-located and operate as single teams, in which we endeavour to ensure that the skills that individuals have through their registration and profession are best used to support the individuals whom we are there to serve.

10:15

For example, with our "three conversations" approach in Edinburgh, we support all our front-line staff in understanding how to work with individuals using a person-centred approach—what matters to the individual, the outcome that they are trying to achieve, and the wraparound care and support that are needed to help them do so. In order to be really collaborative, we are trying to include the community and third sectors as partners in that work.

You will have seen throughout the pandemic good examples from across Scotland of support being provided for care home oversight. We probably had a rocky start in that respect. I know that some of our providers felt that the public sector was, as it were, marking their homework. However, in many areas we got to a really good place in collaborating with the sector to ensure that our care homes had, over and above their own provision, access to personal protective equipment and support for infection control and prevention. There are many such examples from across Scotland, but the issue of terms and conditions comes up again and again as a barrier to doing that sort of thing at the pace at which we would want to do it. That was recognised in the Feeley review.

Dr Macaskill: I will make a fairly quick comment. It is always risky to highlight one area of the country over another when one is in a national role, but what I keep hearing about Fife health and

social care partnership is worthy of greater exploration. It features a very close alliance between statutory colleagues and the independent and third sectors in delivery of home care and was, in particular, used to address workforce challenges during the pandemic and, latterly, during the omicron wave.

I know that Scottish Care's independent sector lead has worked very closely on new approaches to contracting and commissioning and to front-line delivery, and I know that there has been a lot of mutual work and collaboration with the care home sector.

As Judith Proctor said, it is not difficult to highlight where things have worked. We also know why they have worked; it is usually because people have sat together, listened to each other and removed the hierarchy where a hierarchy is inappropriate. They also—I keep coming back to the word of the day—trust each other. There are plenty of examples, but I consider Fife to be worthy of further exploration.

The Convener: We will have a quick question from Sandesh Gulhane, and then we will have to move on.

Sandesh Gulhane: My question is for Judith Proctor. If problems occur, will integration authorities blame health boards, or vice versa? Bearing in mind the changes that are proposed for the future, will that situation lead to a vacuum of accountability?

Judith Proctor: I have talked about the complex context that we work within. However, in the situation that you describe, the accountabilities across health and social care are pretty clear. The accountable officer in a health board is the chief executive, and the chief officer of a health and social care partnership or IJB is jointly accountable to them as well as to the chief executive of the local authority.

An IJB delivers its ambitions through setting directions, which are statutory instruments that neither partner organisation can veto. In other words, no one can say that they are not going to deliver a direction. However, directions happen at the end of a long process of joint collaborative planning, so they should not come out of the blue for either partner. Our work is highly collaborative and we carry out joint planning across our various organisations. If a problem was to occur, we would work through the appropriate governance channels and the issue would be reported and investigated properly.

I am not aware of any situation in which an IJB has blamed a health board for a problem. We have mechanisms for the delivery of directions. We have various audit reports to ensure the delivery of directions, and the chief officer has a unique role as both the chief officer of the IJB and the joint director who is responsible for operational delivery. There are multiple routes to ensure that there is appropriate delivery of a direction and that the planning of the service change that the direction signals, and oversight of that through governance processes, are in place. I would be happy to work through an example of that.

Annie Gunner Logan: It is an interesting question, because it is about what happens when the NHS board and the council blame each other for problems. One solution to that would be to go back to what my colleague Fiona Collie said earlier about widening the pool of decision makers and giving all the stakeholders a say and a vote on local boards, so that it is not just the two big ones slugging it out.

The question came up in the discussions on the Public Bodies (Joint Working) (Scotland) Act 2014, which led to the formal integration of health and social care. It was knocked back at that point, but I think that it is time to revisit it, and also to replicate that at national level with a national care service board that has more than two stakeholders involved in it, who will have a say. That is another of the things that Derek Feeley recommended in the independent review that were not then followed through into the national care service proposals. We could fish all those things back out of the pond and give them another run for their money.

Gillian Mackay: Audit Scotland highlights in its briefing that there is

"No individual social care record in the same way that each member of society has an NHS record."

It says:

"This makes it difficult to assess whether social care is meeting people's needs."

What are your views on the introduction of a single social care record?

Judith Proctor: All our social care systems use similar platforms, because of the pool from which we can commission. The systems that we have in place for social care recording are largely legacy systems that local authorities acquired through the procurement that was in place at the time.

A single record would be helpful for individuals, but it is more complex than just being about the system that we use. It comes down to the paradigm and the way in which we work with individuals. Any system is only as good as the way that you are willing to work with individuals, how the assessments are carried out and how you engage in conversations with the individuals about the outcomes that they are trying to achieve. We need to start by asking what the purpose,

philosophy or paradigm of the way that we work with individuals is, and then build a system on that.

On whether that should be a national system, I point to the huge challenges in developing and procuring a single system, as well as the huge cost. We need to start discussions around the NCS by asking what we are here to do, how we unify what we already have as far as possible, and how we work towards a system that makes it easy for people to move their care across areas and for individuals to have their own access and to own their data. That is the starting point and we should build any system from there. Developing a national system would be time consuming as well as hugely costly.

Dr Macaskill: The aspiration of having a national system, which has been highlighted by Audit Scotland and the Accounts Commission, is absolutely the right thing. Recently, my organisation, along with the Health and Social Care Alliance Scotland, produced a human-rights-based set of principles for the creation of a national or more local data system. At the end of the day, when we talk about data, we are also talking about a person—someone who uses social care or health services—only having to tell their story once. There is nothing worse than the continuous reassessment of individuals whereby they have to go through their story, which will often be emotional and challenging, on numerous occasions.

As Judith Proctor said, there will be challenges. However, technology has advanced considerably in the past 18 months, partly as a result of the pandemic. We can overcome some of those challenges, and it is perfectly possible that we can create a system on a platform that covers Scotland. However, it is critical that the record is something that the citizen owns and has access to, and that she or he determines who has access to it, whether it is an ambulance driver, a social care worker or a general practitioner. In this day and age, it is a nonsense that I have to formally request sight of my health record. It is my record, so I should have access to it.

In partnership with primary care or social care, it is perfectly possible for us to move to a situation in which the citizen has control over his or her data and does not have to tell their story on numerous occasions.

Annie Gunner Logan: We have a programme of work that is supporting our sector to embrace digital technology, and data is a huge part of that. The situation that Gillian Mackay describes is absolutely the case and is on everyone's radar. We are running a series of sessions with the Data Lab to support our members to better understand and use their data.

The big question for us, as it is for Donald Macaskill, is about who controls the data. We are pushing for citizen-held data as the ultimate goal but, in the meantime, it is absolutely critical that citizens have access to and control over their data.

There are big questions about what hot data we are looking for. The most important thing is data about outcomes for people rather than about system throughput and institutional outcomes. Those are important, but only as a proxy for data about outcomes for people.

The other big point is about the challenges that our sector faces. I am sorry to grind this axe again, but providers are somehow still seen as outsiders in relation to their ability to access the necessary data from our statutory partners to support individuals and to better understand the environment in order to plan new services and innovate.

There is the challenge of working across different technical and information governance systems. We absolutely support the creation of shared data standards and we are working with members on that. However, it would be very risky indeed—it would actually be dangerous—to impose a single technical system on everyone, because many organisations in our sector have already invested heavily in that. The last thing that we want is for that investment to be binned and those organisations to have to invest in something else because that is mandated from the top. We should absolutely have shared standards on data, but we should not have a single system.

Fiona Collie: An individual system or individual record would probably be helpful, although I do not know whether it is technically possible. Whether the system is national or local is not really relevant; the most important thing is what it measures and that there is consistency. There has to be consistency in what goes into records and consistency of individuals' access to their records. I completely agree with Donald Macaskill that individuals should have access to their data.

The Audit Scotland report mentions that there is no consistent way to measure the level of unmet need. There is a good opportunity to have consistency in the data and information that are collected. Critically, across all areas, we need to measure unmet need and record where individuals are assessed but their support needs do not meet local eligibility criteria. We need to understand the level of need in our communities, and that can be done through data and monitoring.

The "tell me once" point is critical. Carers consistently talk about having to tell the same story again and again. As Donald Macaskill said, it is often a very emotional story. There is an issue about who has access to the information and

people not having to tell their story again. It is up for debate whether the system should be national or local, but we need to have an easily accessible individual record.

A question was raised by carers about what to do if they are caring for someone who lacks capacity. There are some tricky questions around who has access to that record and whether carers would have access to be able to support their care of the person who lacks capacity. We need to resolve all those issues before we put significant investment into a national record.

10:30

The Convener: We are into our last half hour. That was my heavy hint to members to keep their questions short and succinct. Panellists have to tell us what they think, so I will not curtail them, but I ask members to keep their questions short and sharp.

Stephanie Callaghan has some questions on financial planning.

Stephanie Callaghan: Fiona Collie led us into the theme of financial planning really well when she spoke about unmet need. We have the rise in demand as the population ages and we have pressures on local government funding. I think that we can all agree that only meeting critical and substantial needs is not good enough and that we need to look beyond that. Has the level of unmet need been estimated for those people who fall below the eligibility criteria? How much would it cost to meet those needs?

Fiona Collie: Those are easy ones to answer. [*Laughter*.]

Unmet need in relation to people who fall below the eligibility criteria has not been measured, so it is difficult to estimate how much it would cost to deliver that support. I can give you a figure that has been worked out around the right to a break from caring. Over the pandemic, nearly seven in 10 carers have not had any sort of break from caring. If you were to deliver a fairly universal but limited right to a break from caring, the estimated cost would be around £500 million. That is just one element. If you think about other levels of unmet need and low levels of support requirements, you can imagine that that amount would go up significantly.

It is about how we choose what we invest in and how we value social care. It is about making that investment.

Dr Macaskill: I do not like the phrase “unmet need” because I do not think that it belongs in social care. If social care is about enabling support to allow a person to achieve their full potential as a citizen in the community, to live independently and so forth, there has to be an element of preventative care and support.

Derek Feeley highlighted in his report—and numerous others have said this over the years—that we have stripped out that preventative support from how we offer care in our communities. Economically, that is really questionable because, if we intervene appropriately early, we prevent much more expensive, often acute and secondary care interventions, so “unmet need” as we define it very narrowly is almost about what happens after the horse has bolted.

We should be asking what resource is required in the social care system, not to create dependency but to foster independence, to prevent harm and degeneration and decline at an earlier stage, and in that sense not only to enable individuals to live more positively, but to see economic benefit for the health and care system.

Stephanie Callaghan: That is great. Those are really interesting points and they answer a lot of the follow-up questions that I had.

Donald, will you expand a wee bit on what evidence we have on the relative cost effectiveness of investing in preventative care, as opposed to waiting until things come to crisis and spending a lot at that point?

Dr Macaskill: We certainly have evidence on the cost of unnecessary hospital admissions. I am generalising, but £2,900 is the rough cost of an untreated stay over a week in hospital. The equivalent cost of supporting somebody in a care home or in their own home is significantly less than that. I would not defend the national care home contract as it stands, but at least we would be in the territory of saving £1,500. That is the economic benefit of preventing somebody from having an unnecessary hospital admission and supporting them in the community—in their home or in a homely setting in a care home.

It is much more challenging to look at the whole system and ask what the economic benefit would be of investing earlier in the curve to prevent people from having to purchase or be provided with more expensive care and support. Before we introduced free personal care, the vast majority—67 per cent—of the home care that was delivered in Scotland was what we described as preventative early intervention support to enable somebody to live on their own. It was not personal care as such. Now, the vast majority of home care is personal care. In fact, the latest data that I saw showed that only 3 per cent of home care was non-personal care.

If we invest in helping people to remain well and keep healthy and independent—in other words, if we take a preventative approach rather than a reactive approach, which personal care ultimately

is—the fiscal saving will be enormous, even if the initial investment is considerable. Much more important, the wellbeing and welfare of the individuals who are cared for and supported will be incalculable.

Annie Gunner Logan: I will make a couple of points. I think that I am right in saying that measuring unmet need was another recommendation from the Feeley report and independent review. That has not entirely been translated into the proposals for the national care service.

A couple of years before the pandemic, Audit Scotland produced a report that put a figure on how much it would cost to keep providing social work services in the same way. Was it £3 billion, Donald? I cannot remember, but it produced a number. The point that Audit Scotland was making was that we cannot keep doing what we are doing, because there is not enough money, so we have to approach the matter differently. In its report, Audit Scotland said exactly the same thing that William Roe said in his "Changing Lives" report and that Campbell Christie said in his report. Everybody has been talking about that ever since, but we have never actually managed to do it.

I will make two points. First, on social care, I come back to my point that, instead of looking for the magic bullet, we need to get serious about the one that we already have, which is self-directed support. Ultimately, if there is a resource issue, which there is, we need the people who rely on social care and their families to advise us on how best to spend what we have, rather than assumptions being made on their behalf.

On the preventative agenda, we need to get really serious about what it now pleases us to call place making. Local authorities are understandably spending a lot of time defending their position on retaining control over the commissioning and delivery of formal social care, but it might be more useful for them to have as their key focus ensuring that their communities are places where there is a thriving system of less formal, voluntary sector led and wellbeing-focused support, with the ultimate goal of people not getting into the formal system at all. We need to have much more focus on that, rather than fighting over who will control social care. That is a key role for local authorities, and it would be brilliant to get moving on that.

The Convener: I will bring in Fiona Collie, and then we must move on to talk about the national care service.

Fiona Collie: On preventative support and understanding the costs, we know that one in five carers give up work to care, and we have the evidence on poorer health outcomes, disability, mental and physical ill health and long-term poverty. If we consider in a silo what it might cost to invest in social care for preventative support, we miss the other costs elsewhere in the system. We need a whole-system model.

Oxfam Scotland has done some interesting work on care and caring, which might be helpful. The Centre for International Research on Care, Labour and Equalities—CIRCLE—at the University of Sheffield, which is led by Professor Sue Yeandle, is also doing work on sustainable care. I will happily share that information with the committee as it might also be helpful.

The Convener: A couple of my colleagues want to talk about the national care service. We could do a whole evidence session on that—we will do many—but we will have some initial questions on it.

Emma Harper: I will be short and will focus my comments on the Audit Scotland briefing. One of the key messages says:

> "Regardless of what happens with reform, some things cannot wait. A clear plan is needed now to address the significant challenges facing social care in Scotland".

There are things that we can do without legislation. Setting aside longer-term challenges, what can be done with the social care sector to address immediate short-term issues? What specific actions could be taken to address the short-term challenges?

Annie Gunner Logan: That is a good question. We are broadly in agreement with what Audit Scotland says. I will be brief, because I have talked about some of the things that we should be cracking on with already. We need to do something serious about pay for social care workers. You can get chapter and verse on that from the recommendations of the fair work in social care group, because it is all there. The recommendations have been before ministers for a while, so they really should get a shift on with them.

The other thing that we could do immediately is put an absolute pause on any further competitive tendering of social care and put some real effort into supporting the push for more collaborative approaches. As I said, we are already doing some work on that—it is on people's radar. There is a lot of support for it, so I would say that we need to give it a bit more welly.

Dr Macaskill: I completely agree with Annie Gunner Logan. The report by Audit Scotland and the Accounts Commission is absolutely spot on. We cannot wait for the dream of the national care service, because, at the moment, many providers and people who are employed in social care are living a bit of a nightmare.

I would like a national summit involving all stakeholders to be held immediately. In the recent past, there have been too many initiatives and instances of part of the system but not everybody having been involved. Annie Gunner Logan has already articulated—[*Inaudible.*]—delivered by the independent and third sector, with the stakeholders making decisions and basing them on a lot of presumption without the sector's engagement.

As Annie Gunner Logan said, it is critical to address the pay issue. However, it is all very well saying to a front-line care worker that they are getting paid £10.50, £11, £12 or even £15 an hour, but that is no good if the employer and organisation collapses because there is insufficient sustainable funding to keep it going. We do not want well-paid care workers on the dole; we want well-paid care workers working for organisations that, regardless of their business models, exist to do the job of care rather than to struggle to keep going.

At the moment, my membership fears that we will lose a significant number of care organisations because of fiscal unsustainability. Therefore, I want a summit where everybody is at the table, not just the usual suspects.

Fiona Collie: I will give you my top three actions. The first is the creation of more flexibility and real consistency in self-directed support. It is not good enough to have examples of good practice only in some areas, or within areas, or for some areas to have flexibility and others to have none. Self-directed support needs to be led by carers as individuals. The other two actions are the addition of short-term budgets to support individuals to be discharged from hospital and to support families in that situation, and the prioritisation of reopening day services and services that support people to have a break from caring.

We also need to address charging for social care—at a bare minimum, looking closely in every area around disability-related expenditure. Disabled people and carers are the people most likely to be in poverty in Scotland, so we need to find a way of ensuring that care charging does not push them further into poverty, particularly with the additional costs that they face for heating, energy and the services that they are provided with.

10:45

Paul O'Kane (West Scotland) (Lab): We now have the analysis of the responses to the consultation on the national care service. There is obviously a clear degree of support for moving to a national care service, but much of the information in the analysis poses more questions. It is quite interesting that 33 per cent of respondents said that they were dissatisfied with the consultation process. I am keen to get a sense of your and your members' experience of that process, but also of the next steps that you would like to see as we go into the longer-term work on the national care service.

Annie Gunner Logan: The consultation was a mighty thing, wasn't it? It was 96 questions, some of which we did not answer because they were clearly for individuals. We took a pick-and-mix approach to it and answered the questions where we felt we had some experience, expertise and a stake, and we left the rest, which most people did.

I read the analysis. I have not read every single response, because that would take me a while to do—I think that there were 1,300 responses in the end. I will talk about the key points that we raised in our response to the consultation.

We need to consider the proposals through the lens of the independent review of adult social care that Derek Feeley produced. I have mentioned a couple of areas this morning in which we are not entirely confident that his recommendations have all been carried through into the national care service. We did a bit of comparing and contrasting with the report, which is important.

We made the point that there did not seem to be a coherent model of change in the proposals. It is all very well saying what we want to happen, but we need a model of change to achieve that. In so far as there is such a model, it seems to be, first, to centralise things more and, secondly, for everybody to try a bit harder. We did not think that that was quite enough, particularly around the cultural issues that I have mentioned this morning.

We felt that a bit of work still needed to be done on the balance between national and local accountability. I know that other stakeholders who were directly involved in that work were very concerned about that point. As outsiders, we thought that that issue needed to be unpacked a bit more. We wanted to see a much more central focus on co-production, particularly with people who rely on social care, as well as with their families and carers.

We also gave quite a bit of thought to the scale of the service—are we actually capable of doing this, given everything else that is going on?—and we wondered about the widening of the scope. Ministers, along with everybody else, are still thinking about that point—in particular, about the extension of the national care service to children's services and criminal justice, when Feeley's original recommendations were confined to adult social care. We had all those questions about that extension, and, looking at the consultation responses analysis, we were not alone in having

them. It is comforting to think that we did not go out on a limb with our comments.

We want to delve a bit more into those big issues as we go forward.

The Convener: I was going to bring in Donald Macaskill, but I see from my computer that he might have dropped out. It is back to you, Paul, while we get Dr Macaskill back.

Paul O'Kane: My follow-up question is about next steps. Some of the respondents have asked for a clear road map for how we are going to get to the legislation and for implementation. Annie Gunner Logan has talked about addressing some of those points. Are people keen for the short-term solutions that we have just talked about to be set out clearly, as well as the longer-term piece of work?

The Convener: I will bring in Annie Gunner Logan and then Dr Macaskill.

Annie Gunner Logan: The short answer is yes. The approach that we are taking at CCPS is that we want to help with that. Of our own accord, we are putting some pieces of work in train to contribute to the on-going discussion. For example, we have just signed off an agreement with the Fraser of Allander Institute to look at the economics around the national care service and the affordability of some of the commitments that are being made. We want to look a bit more at commissioning and procurement: surprise, surprise! You would expect that from us, I think. We want to consider the cost modelling for pay parity between the voluntary and private sectors and the public sector. We want to look at all kinds of stuff. We have a programme of work that is trying to contribute to that thinking, to support the process that you are describing and to determine where we go from here. As a stakeholder, we have a responsibility to do that and we want to be part of that. Instead of just asking other people, "Would you please get on with it?" we are very much in the mix ourselves.

Dr Macaskill: I apologise for dropping out—it is because of another Ayrshire storm that does not have a name yet.

Like many other people, I held many events on the consultation. One of the participants, who was a front-line nurse, said, "This would burst yer semmit." She expressed the view of a lot of people that the consultation document was long. She went on to say that it asked questions that she did not want to answer, and it asked them in quite a closed way. Our general organisational sense was that the consultation was not as open and engaging a process as it could potentially have been, regardless of the number of people who filled in the form.

As an organisation, we have submitted our own response and I do not want to repeat it, although it is along very similar lines to what Annie Gunner Logan has said. I will add, however, that we felt that the consultation process lacked a vision and a desire for culture change. In particular, it lacked the reference to human rights that was so central to the Feeley report. That was missing—it was nowhere to be seen in the consultation document. As an organisation and as individuals, our fear was that the sense of real energy and vision that Derek Feeley and his colleagues managed to engender—despite the initial criticism of people such as me—was not present. Like others, I do not want to see the creation of a monolithic system that does not have a soul, because that is what we need.

We found it really regrettable that the prospect and potential of innovation, not least in technology and its use, was largely missing from the consultation. If we are creating a national care service that is to be fit for purpose today but that contains the vision and aspiration that we share now, while pointing to the prospect of a much more dynamic and creative future, we have some work to do, considering what is in the consultation.

Fiona Collie: I will reflect on the consultation. Carers were hugely involved in the independent review; there was lots of energy around that. There was then a huge consultation on the national care service. The scope was wide and we had to involve carers in a relatively short space of time. Carers were very engaged in that process.

We would very much appreciate a road map. Carers were concerned about the Government proposals becoming too focused on structures and processes, with not enough focus, as Donald Macaskill mentioned, on human rights and enabling people to live their best lives. The scope goes beyond the remit of the Feeley report. The national care service should be developed incrementally. We should start with adult social care and other areas should be included once more consideration has been given to the implications of widening the scope.

One carer said that the national care service needs to be properly funded, to be informed by people who use it and to have compassion, good relationships and rights at its heart. Significant work needs to be done to ensure that carers and people with lived experience are involved as equal partners in the on-going development of the national care service and of new national and local structures and processes.

There is a lot of work to be done, so a road map that provides the steps on the way is very important to help people to be involved in the process.

The Convener: You have led us nicely on to our final theme, which is on carers.

Carol Mochan (South Scotland) (Lab): Fiona Collie mentioned carers a number of times, and they are an important part of the discussion. We know that unpaid carers provide the bulk of our social care. There is a thought that some carers are unaware of exactly what their rights are, or of what is in place to support them. Will the witnesses, particularly Fiona Collie, share some of their thoughts on that with us? What are the key things that we should be thinking about in relation to providing a new strategy for supporting carers to ensure that they get what they are entitled to?

Fiona Collie: You have hit the nail on the head in relation to people identifying as carers. We know that about 400,000 people became carers during the pandemic, on top of the 700,000 people who were already providing care. How many of those people know about their rights? That is an on-going process. People become carers every day, and enabling them to understand their rights is a challenge, because some people recognise themselves only as a family member who is helping out their mum, their dad, their sister or whoever it is, and not as a carer who has rights. There is an on-going need for public awareness. Rather than a one-off activity; there should be a significant and continual public communications campaign at the national level, by each health and social care partnership, to enable carers to access their rights.

We have grappled with the issue for many years. There are some opportunities for GPs, who have a critical role in identifying carers. However, it is not just about identifying them; GPs have an important role in referring carers to support in local carers centres. I pay tribute to the work of carers centres during the pandemic. They have taken on huge responsibilities and have undertaken more activity to support carers when very little support was available, particularly for people who were new to caring. The service is valuable and we need to invest in it.

As I said, there is a long-term issue in trying to get people to identify as carers. We need to keep working on that and to look for every opportunity as we develop the national care service.

Dr Macaskill: Front-line care staff continually talk about the absolute awe and admiration that they have for unpaid family carers, not least during the pandemic—[*Inaudible*.]—been restricted and the opportunities for respite have been withdrawn.

I will point out two things that they have remarked to me. The first is about the sheer mental health impact and distress that unpaid carers are now experiencing in Scotland. We need to give much greater priority to them. We have done a lot for paid carers, but we need to give especial priority to that reality—[*Inaudible*.]—and the national working group on bereavement. We are also hearing, as paid organisations, of the need for intensive additional bereavement co-ordinated support for family carers at the stage in their life when they—[*Inaudible*.]

From my perspective, nearly a third of paid care staff also engage in unpaid care at home. The stress and strain of the recent period have been enormous. I do not think that the carer organisations and paid carer organisations have come together as much as we have—[*Inaudible*.]—mental health issues, especially at this time.

The Convener: Finally, before we have to suspend, I will bring in Annie Gunner Logan.

Annie Gunner Logan: I will be brief. All of us who are involved in social care have been kind of walloped by the pandemic one way or another but, arguably, unpaid carers have had the most to deal with, not least because they have had to pick up the pieces when other services have been withdrawn.

I want to pay tribute to my former colleague Susan McKinstery, who sadly died earlier this month. She had a lot to say about the issue, including to Derek Feeley. Her example of what she had to deal with during the pandemic is worth revisiting in this discussion.

I moan a lot about how the third sector gets left out of the room when decisions are made—you have heard me moaning about some of that this morning. However, it is much worse for unpaid carers, because they are not always even told where the room is, never mind invited into it. I go back to the point that we have all made this morning about giving carers their rightful place, alongside all the other stakeholders, as partners and decision makers. That is long overdue.

The Convener: Judith Proctor has had to leave us. I thank all our witnesses for their time. You have brought up very interesting points, which we will take forward. As I said, if you want to direct us to any additional information or reports, please do so.

I suspend the meeting. We will come back at quarter past 11 for our next agenda item.

11:02

Meeting suspended.

11:15

On resuming—

Subordinate Legislation

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2022 [Draft]

The Convener: Our third agenda item is consideration of an affirmative Scottish statutory instrument. I welcome Humza Yousaf, Cabinet Secretary for Health and Social Care, who will give evidence to the committee. He is accompanied by Scottish Government officials: Marianne Barker is the unit head of adult social care charging; Ian Golightly is a policy manager in adult social care charging; and Clare Thomas is a policy manager in adult social care charging.

I invite the cabinet secretary to give a statement on the instrument.

The Cabinet Secretary for Health and Social Care (Humza Yousaf): Good morning, convener; I hope that you and the committee members are keeping safe and well.

I thank you for the opportunity to speak to the committee about the proposed amendment to the Community Care (Personal Care and Nursing Care) (Scotland) Regulations 2002 (SSI 2002/303).

I am sure that members are aware that the draft amendment regulations that are before the committee make a routine annual increase to the rates for free personal and nursing care. Those payments help to cover the cost of services for self-funding adults in residential care. Historically, the payments have increased in line with inflation. However, emerging evidence—including from the Scottish care home census—clearly shows that the cost of providing care has increased.

To help redress that, last year we made an above-inflation increase of 7.5 per cent to the rates of payment, which was a significant increase on the inflation rate that was previously used.

We feel that it is again appropriate to make an above-inflation increase to the rates this year, and the amendment regulations that are before you propose a 10 per cent uplift for 2022-23. That will mean that the weekly payment rates for personal care for self-funders will rise from £193.50 to £212.85, and the nursing care component will rise from £87.10 to £95.80.

It is estimated that that increase will cost around £15 million in the next financial year, which will be fully funded by additional provisions within the local government settlement, as outlined in the recent 2022-23 Scottish budget.

The most recent official statistics show that more than 10,000 self-funders receive free personal and nursing care payments, and they should all benefit from those changes. I am happy to take questions from the committee.

The Convener: I see no indication that any member wishes to ask a question or contribute to a debate, so we move to formal consideration of the instrument.

Motion moved,

That the Health, Social Care and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2022 [draft] be approved.

Motion agreed to.

The Convener: At our next meeting on 1 March, the committee will receive an update from key stakeholders on tackling alcohol harms. We will also take evidence from the Cabinet Secretary for Health and Social Care on two affirmative SSIs. That concludes the public part of our meeting.

11:18

Meeting continued in private until 12:07.

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