OFFICIAL REPORT
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Health, Social Care and Sport Committee

Tuesday 29 November 2022

Session 6

The Scottish Parliament
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Tuesday 29 November 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
35th 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)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Rachel Cackett (Coalition of Care and Support Providers in Scotland)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Karen Hedge (Scottish Care)
Fanchea Kelly (Blackwood Homes and Care)
Sandra MacLeod (Aberdeen City Health and Social Care Partnership)
Margaret McCarthy (Crossroads Caring Scotland)
Peter McCormick (Randolph Hill)
Geri McCormick (Glasgow City Integration Joint Board)
Nick Price (Granite Care Consortium)
Julie Welsh (Scotland Excel)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 29 November 2022

[The Convener opened the meeting at 09:02]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning and welcome to the 35th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance, and James Dornan is joining us online as his substitute.

The first item on our agenda is a decision on whether to take item 3 in private. Do members agree to do so?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (Charges to Overseas Visitors) (Scotland) Amendment (No 3) Regulations 2022 (SSI 2022/335)

09:03

The Convener: The next item on our agenda is consideration of Scottish statutory instrument 2022/335, which is a negative instrument. The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 22 November and made no recommendation on them.

The purpose of the regulations is to ensure that overseas visitors from the Bailiwick of Guernsey and Malta will not be charged for certain treatment that is provided by health boards in Scotland, in accordance with reciprocal healthcare agreements.

No motion to annul has been lodged in relation to the instrument. As members have no comments, I propose that the committee makes no recommendation on it. Do members agree?

Members *indicated agreement.*

National Care Service (Scotland) Bill: Stage1

09:04

The Convener: Our substantive item of business today is consideration of the National Care Service (Scotland) Bill. We will have two evidence sessions and both panels will focus on ethical commissioning and procurement and the long-term sustainability of social care services. Our first panel of witnesses are with us and I welcome them.

In the room, we have Rachel Cackett, who is the chief executive officer of the Coalition of Care and Support Providers in Scotland; Karen Hedge, who is deputy chief executive of Scottish Care; Geri McCormick, who is head of commissioning at the Glasgow city integration joint board; and Julie Welsh, who is chief executive of Scotland Excel. Joining us online, we have Sandra MacLeod, who is the chief officer at Aberdeen city health and social care partnership.

We move straight to questions, and I will start by asking about the proposal on care boards. I am particularly interested in what Geri McCormick and Sandra MacLeod think, given the arrangements in which they are involved, about the potential for care boards to integrate services more. The committee has heard that there are things that integration joint boards and health and social care partnerships cannot do, hence the need for care boards. What are the current arrangements for procurement of services? Who is involved? Who is round the table with voting rights? How might care boards promote further integration?

I will bring Geri McCormick in first, and then Sandra MacLeod, who is joining us online.

Geri McCormick (Glasgow City Integration Joint Board): Currently, all care groups are represented in our integration authority, the Glasgow IJB, and we have a healthy relationship, with contributions and discussions at a very early stage in the strategic planning that informs the direction of future commissioning.

As is the case now, in any future composition to support the aims of the bill, consideration will need to be given to the time that is required for planning and to ensuring that voices from all stakeholders, participators and, crucially, the recipients of services and support are heard. We increasingly need to recognise that a focus on services must include the support element, not just in the context of early intervention, but in a whole-system approach. That applies now, as we work with the IJB, and it must be a major consideration when it comes to the composition of any future care board.

The membership of the care board will be crucial in relation to not just the board's composition but its strength and the support that is offered to people who might require additional support if they are to be part of such a system.

The Convener: You said that the system is working well where you are, and you will want to take that good practice into any new system. Are there opportunities for care boards to do things slightly differently or to do things that you would like to do but are unable to do now?

Geri McCormick: It is about facilitating time and providing resources for participation and contribution. It is about accessibility and opening up involvement to individuals who might require additional support if they are to be fuller members, if I can put it in that way.

The Convener: You are talking about something more inclusive, with the resources being in place for the support that would enable that to happen.

Geri McCormick: Yes.

The Convener: Sandra, it would be helpful to hear your views on how things are working in Aberdeen city and what opportunities a care board might bring.

Sandra MacLeod (Aberdeen City Health and Social Care Partnership): In Aberdeen, we had a large review a few years ago of our care-at-home services in particular, which helped us to reshape our approach to strategic commissioning and engagement. We have a strategic commissioning board, which is made up of the private, third and independent sectors, along with others, and it helps us to shape our approach to commissioning. Although that board is not part of the main IJB, it is part of our governance framework and it can make substantive contributions to how we move forward with our procurement and commissioning arrangements.

The Convener: Aberdeen has been held up as an example of a place where things are being done slightly differently. We visited Aberdeen three weeks ago and met the Granite Care Consortium, which suggested to us that it is a model for a care board. What is your view on that?

Sandra MacLeod: We have worked really hard with the Granite Care Consortium and it has been a really positive outcome for us in the city. Picking up on the points that colleagues have made about the time that is needed, I note that, when we started to move away from the previous time-and-task commissioning to outcome-based, collaborative commissioning a few years ago, we

had to invest heavily in that and it was a big shift from the previous provision.

It is important that there is an equal partnership in any kind of board when we are talking about commissioning and that everybody is able to understand the views of each of the participants round the table. However, when we have a shared vision and we are looking for positive outcomes and understand one other's limitations, that really helps. The Granite Care Consortium was definitely born from a solid understanding of what it is like to be on both sides of the fence, from both the commissioning and procurement points of view. It also involves a lot of trust and a lot of relationship building. Those things are key in developing anything, because we need that equality in the procurement process.

The Convener: Before I hand over to my colleagues, I have a question for Rachel Cackett. Rachel, in your submission, you make some points about the notion of care boards and some recommendations as to what you would like them to look like. Given what we have heard about two areas where the bodies are, in effect, already working like care boards, it seems that there is good practice. From your perspective, what do you want to see in relation to care boards?

Rachel Cackett (Coalition of Care and Support Providers in Scotland): We have very good relationships with our providers and many of the current IJBs. However, my colleague has just brought up the issue of trust. You said that, in some areas, the bodies are already working like care boards, but at the moment we are having to take on trust what the care boards will look like. We do not yet know whether any area is working like a care board. Examples of really good practice have emerged through the integration work, but we also know that the status quo is not enough. Both the providers and the people who receive services are very clear on that.

There is a point about how we can take from what we have and learn from it, but there are also some key questions for us about the structure of the national care service in so far as we have been able to understand it thus far. We are certainly calling for greater clarity in the bill.

In the model of reform that we have put together, which we hope will help to create a vision for where we want social care to go, there is a really important point about subsidiarity to the individual. An awful lot of battles are going on at the moment about who will have power in a future in which we have a national care service. I was involved in the Public Bodies (Joint Working) (Scotland) Bill as it went through Parliament, and that happened at the beginning of integration as well.

However, the far more radical approach is to say that social care is an issue of relationships, and those relationships happen at the front line between the people who require care and support, their carers and the people who deliver that care and support. As much as possible should happen at the front line, which is why the self-directed support legislation, which we have still not implemented fully, is really important. There is an important point to consider about the link between SDS and ethical commissioning.

We should then look to the care boards to do the things that can be done as locally as possible but not at the front line. We should go up to the very top only at the point where nothing else can be done locally.

The issue is that, because the bill is a framework bill, we do not yet know very much about the care boards. I understand the process of co-design, but care boards are a fundamental part of the bill and, as we have read through it, we have become less and less sure about whether the national care service will be a commissioning body, a standards-setting body or a delivery body. That will depend partly on whether 73,000 staff are transferred from local government into a delivery body or whether the local care boards will become a commissioning arrangement. That is not clear to us, yet it seems fundamental.

We are not sure about the local accountability of care boards, either. Whatever the rights and wrongs of the current system, it is really important that social care holds that relationship within the local community. Most social care is built from the community up and we need to be really mindful of not removing that element. The point that colleagues have made about co-design and the time that is required for that is key. Again, however, the bill leaves a lot open in that regard.

We are about to commission a piece of work to examine the experience of third sector providers in the current arrangement so that we can learn from it and think about what we could take from it if we end up with a number of care boards. However, for us, there is something really important about putting co-production and co-design at the top. Under the bill, there will be care boards, but we are not entirely sure what will happen to the IJBs. We do not know whether they will be repealed and replaced or whether they will be morphed into the care board arrangement. That creates a lot of uncertainty for staff at the front line.

09:15

Above all of that, the co-design should go to the top. Therefore, rather than having a direct line from care boards to ministers, we strongly support Derek Feeley's original suggestion of a national

care board with a diversity of voices. Good decisions are made by diversity of voice. You have committees with people from different parties sitting and examining the detail of the bill. That should be applied to the national care service as well, although that is not to remove the minister's desire for ultimate accountability for social care or what has been heard through the consultation. Accountability with good advice and good engagement is much better accountability.

We would like an additional piece to be put in that is not a civil service department but a group of people who have lived experience of what it is to be in relationships at the front line and who will advise on the direction. We also want to see far more detail on what the care boards will be. Will they be commissioners, deliverers or both? How will they link to the IJBs that we have at present?

It is interesting that some of our colleagues who have always said that they do not particularly like IJBs now really like them. That has been a transformational shift. We need reform, but we also need to be really mindful of what we are asking for and how we can keep the local local.

The Convener: That is helpful and it is a good start to the conversation about what we need to keep, where the gaps are and what our aspirations are for reform.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): To pick up on what Rachel Cackett said, how much involvement is there now from community planning partnerships and people with lived experience on local improvement plans? How much are they involved in the IJBs at the moment?

Rachel Cackett: I suspect that my colleagues in the IJBs will be able to answer that far more fully. We are certainly looking at where providers are engaged and I think that that engagement is in a different place depending on which IJB you talk to.

There is something important in what we currently call strategic planning but hope to move into ethical commissioning. One really important point is that ethical commissioning does not need to wait for legislation. We could already move to a far more ethical commissioning framework. Some of the examples that you have heard from colleagues are moving us in that direction. Clearly, nobody has it completely right yet because we are all working in that direction, but the important points of ethical commissioning are how you involve people in decision making; where that decision making sits; how much trust there is between partners to be given the flexibility to, for example, amend care packages according to need rather than having to wait for an assessment to be done; the way in which funding is trusted to those who provide care; and the emphasis on the front-line relationship.

We can begin to see that happening in our commissioning and procurement programme, which is funded by the Scottish Government to help us to take the matter forward with partners. We are working with a number of partnerships around Scotland. In fact, we ran an event last week on ethical commissioning and how we could perhaps move more quickly than a national care service to get there.

Karen Hedge (Scottish Care): It might be helpful for the committee to know that I used to be a local authority commissioner so I have sat on different seats around that table and have the relevant experience.

I will cover a bit on the implementation gap with the Public Bodies (Joint Working) (Scotland) Act 2014. My concern about the creation of care boards is that we might just be recreating a system that simply moves people round to sit in a different seat. The underpinning principles and what we are trying to achieve in that space, particularly on localism and the ability to have local strategic plans to drive matters forward, are really important.

It is also important to note that the creation of Granite Care Consortium and similar approaches in other areas have happened because there has been investment in the sector to be able to engage strategically. The committee will see that the areas in which we have more progressive approaches—less competition and more collaboration with the sector—are spaces where, as Geri McCormick said, there is investment to give people time to digest information, come along and engage at senior strategic level. For instance, they include care providers being represented on IJBs. Scottish Care has a network of independent sector-leading IJB reps. They are not on every IJB in Scotland, but I would say that that would be fundamental to any care board, as we move forward.

Sandra MacLeod: I want to pick up on a couple of points. The first is on how IJBs are currently involved in community planning partnerships. In our local environment, in Aberdeen city, our strategic plan is absolutely linked to our local outcome improvement plan, and we are a strong part of the community planning partnership. The IJBs in the health and social care partnerships have a key role to play in their local communities, especially in examining lifestyle issues, poverty and child health as well as adult health. Fundamentally strong links have already been built there, certainly in Aberdeen city.

The other point that I would like to make is about the ethical commissioning that colleagues pick up. In Aberdeen city, we started off by looking

at ethical planning, which took a considerable amount of time. As Karen Hedge said, having been on the commissioning side and having previously been on the provider side in the private sector, then having moved over to be within an arm's-length external organisation and working that through, we all know the key aspects that affect sustainability in any community. Staffing is one of those, for starters. Other aspects include moving away from zero-hours contracts, giving staff the ability to be in there, looking at funding and, as Rachel Cackett said, giving providers the contracts. The money is handed over and there is the ability to shape and shift contracts. All that is possible under the current legislation, the current IJB and the current system.

It is really important that there is mutual respect and trust, where bodies come together and have the belief that we are here to provide outcomes for people, rather than have a race to the bottom on time-and-task commissioning and trying to save funding. All that does is create problems in the longer term.

Regardless of the shape of the organisation as we move forward, the current structure does allow for such an approach when people are brave enough to start to take those steps forward.

Stephanie Callaghan: I would like to pick up on that. When we visited Granite Care Consortium, the providers themselves were stepping care up and down without having to reference back, which I think Rachel Cackett mentioned earlier, and we saw how important that had been. In the final report, there was also evidence of a reduced number of hospital admissions during the Covid pandemic.

I appreciate that there are criticisms and concerns about moving to a national care service but, assuming that it will happen, are there positives that we can take from what you are doing in Aberdeen? Many such approaches could be implemented in the current system but are not, which seems to be where the real problem is. What are the biggest lessons that we can take away from what is currently happening in Aberdeen, as regards a national care service coming into effect and ensuring that other areas are picking up on those strengths?

Sandra MacLeod: I think that it goes back to a key point that someone made earlier, about relationships and having mutual respect and a shared understanding that people need to work together, whether it be on the issue of staffing or about outcomes for individuals.

I will speak from my own experience both in the private sector and from my current position. I am mindful that all of our services are commissioned out in Aberdeen—we do not have internal care home services, so we are all external. One of the key things is to understand that, as much as we have third sector or independent providers, we all have a different model from that which we would have in the local authority system. However, there is no right or wrong way of delivering: we need a mixed economy of delivery within many environments because of rurality and other issues that exist. The key point that we can take away from that and bring into a future national care service is the importance of shared ownership and mutual trust.

The Granite Care Consortium has been open and transparent with its books, and we have helped it and are really open and honest when there is a problem. It is in everyone's interests that we work together and it is not in our interests for providers to fail.

When I first came into post, and previously, in my role with an ALEO, we had numerous failing providers—care homes, in particular—but, touch wood, we have not had a provider in the Granite Care Consortium fail since we put the model in place. There is adaptability, support of one another and people are working collaboratively. That creates conditions whereby those are seen as the principles of commissioning and not only as things that are nice to have.

The Convener: Emma, you wanted to come in on something that Sandra MacLeod said.

Emma Harper (South Scotland) (SNP): Yes, thanks. The time-and-task model came up during the committee's visit to Dumfries. Euan McLeod, who is from the Dumfries team, said that the team is working with the Granite Care Consortium and that part of what it hopes to do is move away from the time-and-task model. Will you tell us what that means and what we need to do better when we are planning the national care service to make care more deliverable?

Sandra MacLeod: A key thing, and one of the big drivers, is moving away from that model. We have done a lot of work locally on care management and in our hospitals, so that rather than say to someone, "You need to go home on twice-a-day care or four-times-a-day care", we flip that round and say that the provider needs to talk to the person. By that I mean that all we say is, "This person might need support with personal hygiene and getting up in the morning", and care providers would then sit with the individual and ask them what they need that support to look like.

I will give you two examples of that. Now, we might say to a person, "You need a shower three times a week and you will get care twice a day on certain days," but the alternative is to say, "You need support with your personal hygiene, so what do you want that to look like?" Personally, I would

rather have a bath—if I had that option—so I would ask if the carers could come on a Saturday, spend two hours with me, give me a huge bubbly bath and a wash and do all the other bits and pieces during that visit. That is personal choice. We would still support the same level of care and cost, but instead of it being delivered in two quick half-hour visits during which everybody is watching the clock, a person would get one really good visit.

Another option that we have is based on someone who needed assistance with meals. At first, somebody came in every day, helped the lady with her sandwich and gave her her meals on wheels—which is the traditional model—but then that person and her family chose for a carer to go in on a Sunday and spend about three and a half hours with the lady, which was the same amount of time overall, but during that longer visit, the carer cooked all of the lady's meals and put them in the fridge or freezer. From there on in, she was independent with her meals, but she would not have been if it were not for the support of the carer.

Those examples are a move away from the time-and-task model. They still meet people's needs and outcomes, but in a much more person-centred way. That involves moving away from carers having to say, "We are in here for 15 minutes, and this is what we have to do". Instead, it becomes about what support looks like for individuals. If we do not have flexibility in funding and commissioning arrangements to allow providers to do that, we will never move away from the time-and-task model.

Nobody would like to think that the only time they can have a shower every day is between 8 and 8:30, so we need to move away from that.

Rachel Cackett: The examples that Sandra gave show the human face of social care. The bill is rooted in structure, but those examples show the ways in which social care matters in the day-to-day lives of so many thousands of people in Scotland.

There are a couple of things to note in the context of the national care service bill. The first is that the principles that are currently in the bill do not really address the issue that Sandra brought up about choice and control being held by those on the front line. We shared a discussion paper with the committee that has some ideas on how we might strengthen some parts of the bill; choice and control are key to SDS.

We also heard about the diversity of providers. People can only choose how to have their care delivered if we have diversity of providers, and that is very much about how we manage our social care sector now.

I know that the committee is interested in the sustainability option—sorry, issue; it is not optional. We have to have a sustainable system. That issue is fundamental for us, as we are dealing with providers now who are looking to the future as well. We have to have a sector to deliver into the future.

09:30

Right now, that sector is under phenomenal stress—through resourcing, which colleagues have mentioned, and through lack of staffing, because we cannot pay enough. We are facing so many issues, let alone that of unmet need, particularly during this cost of living crisis. However, unmet need is not new. When it comes to the principles, there are key issues for us to think about that would give us more radical leverage to achieve the change that we all want.

A lot of disabled people's organisations have mentioned the bill's lack of a right to independent living. That would be an interesting place to start. We have never really implemented self-directed support and the level of choice and control that people should have in whatever supported ways work for them. We should look at why we still have that implementation gap, and at how not to do that again with the bill.

There are lots of things that we can look at, but we cannot do any of them without sufficient resource in both money and people. That is a significant pressure as we look forward.

There are three important messages from us, at this point. First, we have to deal with the here and now, in order to have the sustainability to go forward.

Secondly, we have to be clear that money really is available for the bill. This is an extraordinary time, which requires extraordinary measures. Given that stage 1 may last a little longer than expected—and given where we are—it would be helpful to have a revision of the financial memorandum, because inflation has gone through the roof, even since it was written. Things are moving so quickly, we need to be sure that the approach is affordable.

Thirdly, we need to come back to the bill and think about what we are aspiring to. Social care should be about the sorts of things that our colleague in Aberdeen has been talking about. Can the bill get us there? As providers, we are keen to work with you, the Government and others on that, to find where we can create additional levers, if the bill is the way forward.

Paul O'Kane (West Scotland) (Lab): I want to follow on from that by pulling some of the threads together and going back to first principles with the

Feeley review, which Rachel Cackett mentioned in a previous answer. Can the bill achieve what everyone agreed with regard to the review's aims, or is there too much focus now on structure as opposed to the investment in social care that we have just talked about? I appreciate that that is a broad question, but I ask Rachel Cackett and then Karen Hedge to comment.

Rachel Cackett: With the bill as it stands, as introduced, my answer would be no—it cannot achieve the aims of the Feeley review. With the bill as it could stand, my answer would be maybe. We want to do that work and see whether we can get closer to the aims of the Feeley review.

When Derek Feeley's report "Independent Review of Adult Social Care in Scotland" came out, we were excited; indeed, we were almost surprised at how positive we were. As time has gone on, though, it has felt as though we have got further and further away from it.

Last week, we had a meeting with our members to talk about the bill and our discussion paper before we submitted it to the committee—the paper has been on our website as of yesterday. What came out of that discussion was the high level of disillusionment among members, having moved from where we had been, post Covid—which was a really hard time—with a discussion about social care back on the agenda as well as radical reform that people could see the potential in, to where people feel that we are now, with a bill that does not meet that aspiration and nothing else on the table.

We have some time now. The question is: how do we shape things into what we want them to be? That is why we put together our model of reform; we felt that the vision that some colleagues have been talking about was somewhat missing. We need to be clear about what we are aiming for and then look at the bill and ask ourselves whether we can make it do those things. We are doing that work now. As things stand, though, the bill is too far from Feeley.

Karen Hedge: Like Rachel Cackett, we, too, were excited when the independent review reported, and we, too, had done work with members—with everyone and their granny, in fact. That work culminated in Scottish Care's report "'Coileanadh': Manifesting a flourishing social care future for Scotland", the findings of which matched what came out of the independent review of adult social care. That made us feel that we were in the right space; that the principles were right; that the passion was right; and that that was what we wanted to get right for the people of Scotland. However, this bill is limited to scope and process; we need to get the people back in there.

Earlier, I talked about the implementation gap in some of the good legislation that we already have in Scotland. My worry is that having a framework bill means that we have to travel even further to get to that end point. What we have in the bill is a bare minimum—a skeleton—and it means that we have to build much more on top of that as time goes on.

I totally get that there are advantages to that approach. We want to be agile and to be able to adapt as we progress, as our aspirations change, as technology advances and as the things that we want to do and to which we aspire in social care change. A framework bill is good for that, but I worry that, if we are fixed within what is a very limited process, we will never bridge the implementation gap and realise what it is that we aspire to in Scotland.

We need to consider that the creation of the national care service itself is an exercise in ethical commissioning. It comes back to choice and outcomes for people, not time-and-task management, and to fair work principles. It also comes down to collaboration, not competition, and the need to create the conditions that will allow us to work together.

A lot of people have talked about trust. Trust has to be earned but, with the current position, there is not a lot of it left out there. The goalposts have shifted so much recently. Work needs to go on, but we can underpin that with mutual respect and we can highlight good examples of where we have worked together recently. We need space to bring in innovation, and to think differently about our aspirations and how we achieve them through collaborating and working together. That requires progress, not perfection. Sometimes, when a bill is focused on process, it is too much in the space of perfection, and it is not about what matters to people as individuals and how we get that sort of thing in place.

Paul O'Kane: I want to push you on your feelings about the distance between the Feeley review and the current bill. Is the bill focusing too much on structure and not enough on culture?

Karen Hedge: Yes. That is partly to do with the consultation process that we have experienced. At Scottish Care's recent care home conference, our members in the audience were asked by those on the panel whether they had engaged with the consultation events for the national care service. Many of them—almost all of them—put their hands up. When they were then asked whether they felt as though they had been listened to, not one person in a room of 350 put their hand up.

We need to be careful here, because if that is the current experience of providers, how do we know that other people feel as though they have

been heard? How do we know that each and every person's thoughts and considerations are being put into the co-design process to ensure that what we get at the end is what we really want, and that it showcases Feeley's aspirations in the independent review of adult social care?

James Dornan (Glasgow Cathcart) (SNP): I have a question for Rachel Cackett. You have mentioned self-directed support a couple of times now, Rachel, and it seems to me that you are using it as an example of why we should not be going down this current route. Surely, though, a national care service with a uniform roll-out of self-directed support would be a good thing.

The problem with self-directed support—as I remember very well, being a Glasgow MSP—was that some local authorities used it in a completely different way from others. It was a great policy that was spoiled by patchy roll-out across the country.

Rachel Cackett: I agree with your final statement—it was a great policy with patchy roll-out. There is, therefore, a need to look at how we make a great policy work, without necessarily having to rewrite it. I cannot yet see how the NCS bill as published—I am not saying that it will look like this eventually—supports, or becomes a national delivery agent for, self-directed support, not least because its principles do not match the principles of self-directed support.

If that is the ultimate policy aim, we should go back to the principles and look at them again. That said, I do not see how giving people the sort of choice that they require, which will require keeping enough providers in the market to enable that choice, will at this point in time be served by the NCS bill—that is, by creating a national structure at great cost, with no costs in the financial memorandum that are actually for service delivery, when we know that we have significant issues with resourcing services as things stand.

If that is the aspiration, that is fantastic, but it would need some tweaking. Actually, it would need more than tweaking: the bill would need significant amendments at stage 2 in order to get there. If the idea is to take that choice-and-control message to people who can then direct their own packages of support and choose whom they go to for those packages, in a space in which they can be assured of the quality of the service that they receive, and where fair work principles—which are not currently applied—are applied equally and fairly across that workforce, I am with you. However, the bill needs quite a bit of work to get to that point.

The Convener: Before I bring in Karen Hedge, I remind members that we are only on theme 1 of five, and we are now halfway through our time for this session. I have given theme 1 a good airing, because it is important to get a lot of things out early on, but I give a hint to members about succinct questions and maybe to witnesses about succinct answers.

Karen Hedge: I will go fast then, convener—what Rachel said. [*Laughter.*] What I would say is that there has been a complete and ageist failure to implement SDS in care homes.

The Convener: Emma Harper has some questions on commissioning and procurement.

Emma Harper: I know that we have already talked a little about those issues. Rachel, I have brought up on my iPad the paper that CCPS submitted to us, in which you made recommendations about amendments that you would like to see. That sort of evidence is fantastic, because we really want to hear about amendments that you think will be good for the bill and which will ensure that it delivers the national care service—or, at least, a way forward with co-design. Thank you for that—I found it really helpful.

I am interested to hear the panel's views on commissioning and procurement, on what "ethical" means and on how we move forward with that. That question is for Rachel Cackett, first of all, and then for Julie Welsh from Scotland Excel.

Rachel Cackett: I am glad that the paper is helpful. That was certainly our intent.

We often talk about ethical commissioning and then procurement, but we need to think about ethical procurement, too. Very good principles for ethical commissioning have already been laid out, but the bill's principles will need to be strengthened if they are to be, as we would like, applied to an ethical commissioning and procurement practice.

A lot has been said about the procurement process in the legislation, and I will just note three things about that. First, as we have said, a lot of ethical procurement can be carried out already, so the bill is not necessary for that.

Secondly, although the bill has the potential to restrict contracts, it does not remove competitive tendering, which we think is a real issue. We need to look a great deal more at that area in the legislation.

Thirdly, we think that the definition of "ethical commissioning" is very scant at the moment and needs to be stronger to ensure that everybody understands that endeavour. The fact is that none of us has completely cracked it yet. There are really good examples of it around the country, but we have not really cracked the process itself. We certainly could have been further along with that, but I think that, sometimes, there is an issue with people's appetite for risk. We hear from members

that there might be a local appetite for ethical commissioning, but there are also legal and financial questions about how much power to give up. We need to be able to deal with that.

We also need to be clear about the fact that the procurement parts of legislation are there to be used. It is not just about taking European Union regulations and putting them into Scots law, even though that is where they sit. The fact is that we could have used some of those regulations already, but we have not done so.

It would be really good to see a clear intention to move to an ethical procurement process, but we should also remove competitive tendering from social care. Social care is about relationship-based care and support, and that sort of thing should not be put into the competitive tendering space.

Julie Welsh (Scotland Excel): As you will know, we are a national shared service for local government and HSCPs, and we put in place a number of different care service arrangements for children, adults and older people.

On competitive tendering, contrary to what was stated in the Feeley report, there is absolutely no competitive tendering within care as far as the national frameworks are concerned. I agree that there is no place for that sort of thing: it should be all about standards and quality. The rate will be assessed, but not in a competitive way; in the national frameworks, there is no process by which people are excluded if their rate is too high. Nothing like that happens.

We also collaborate in everything that we do, which is important. We work very closely with local government and HSCPs to design the specifications for what is needed in the national arrangements.

09:45

We have been building in more ethical arrangements for the past few years and prior to the Feeley report. For example, our care and support framework has been up and running since 2020. Someone asked earlier, “If you have the levers to do it, why have not you done it?” I can actually give you a good example in that respect. We went out to market for the care and support arrangements. We had a completely flexible approach that was not based on comparing rates; instead, it was about quality and standards, and we had built in things such as travel time for individual carers. Despite that, however, we could not get all our councils and HSCPs to use the national framework.

There is a good reason for that: the sustainable rates come back at 14 per cent more expensive than the rates that we are currently being paid by local government and HSCPs. It does not matter how good the vehicle is; if the money is not in the system to pay for what is required, people will find other ways. I think that the care and support arrangements are an example of a good vehicle that is in place but which is not used as widely as it should be.

Geri McCormick: When it comes to national practice, the challenge is that there is no one common standard across the piece and there are variations. It is essential that many of the principles that we are discussing are seen as part of the national care board going forward. In fact, those principles are encompassed by the Glasgow Alliance to End Homelessness, which demonstrates a number of the values in respect of its approach to ethical commissioning and procurement. Learning from that process and from all the stakeholders involved in it should help inform the bill’s development. For example, Health Improvement Scotland considered Glasgow’s experience in a lessons-learned exercise to inform what can be done going forward, and we need to maximise what is around by using examples such as the Granite Care Consortium. The fact is that we learn best from such practical examples.

Finally, all of that work is based on relationships, which all my colleagues have mentioned and which we certainly believe in. As recently as last week, all the members of this panel—with the exception of Julie Welsh, who was nevertheless represented—were at a meeting of the national group for ethical commissioning. There is a cohesiveness there that will support things. As I have said, this is all about relationships, and it is about risk enablement and trust, too. We are talking about a whole-system approach, which we need to address for individuals, the IJB, the care board that we might have in the future and, indeed, the whole system with regard to community planning and so on.

Karen Hedge: I spoke earlier about the principles for ethical commissioning. Rather than repeat them, I can ping them to the clerk later, if that would be helpful. However, I really want to reinforce the points that have been made about the gap between commissioning ideology and what happens in procurement when financial—or other—resources that are available to enact services are taken into account.

For example, some areas require providers to sign up to the fair work charter, as should happen; as we know, if people’s terms and conditions are aligned with fair work, they are more likely, among other things, to be happy in their work and to stay in their workplace. The problem, however, is that in the areas where providers have signed the fair work charter, people are not getting paid

sustainable rates to enable the fair work principles to be put into action. There is a huge question there about whether you can just throw something into a contract and then require a provider to deliver on it. If the provider is not able to do that, because they have not received enough resource or not enough resource has been allocated in the strategic planning context to create the conditions to enact the fair work provisions, where does responsibility lie? That is a big question that we need to consider when we think about ethical commissioning.

The Convener: I know that Rachel Cackett wants to come in. Emma, do you have anything that you want to put to Rachel? I am very conscious of time and have my eye on the clock.

Emma Harper: I will be quick and will cite some specific information that we heard in Dumfries, which will also be directly relevant for Julie Welsh. I am using that example because Dumfries is in my patch and I was at the table when it was said. We heard that Scotland Excel can sometimes be challenging to work with and heard examples of delays in passing on uplifts in pay, which led to staff leaving, and of delays in processing variations or refusals to consider variations. I do not know the specific details, but there was a standard rate, despite local differences in costs. It would be interesting to hear from Julie Welsh about any direct experience of how Scotland Excel works with providers and about what would happen if Scotland Excel were no longer involved in commissioning arrangements for social care.

Julie Welsh: I do not recognise some of the examples that you have given, but if you can give me specific details, I will have a look to see what has happened. There are sometimes delays to or variations in the process because it is a really complex area. When we did our first national care arrangement, which I think was in 2012, we totally underestimated how long it would take to get all the right parties round the table and to ensure that we built in all the right things. There are sometimes delays.

You asked about there being a standard rate despite local differences. The only example that I can think of is the national care home contract, which I worked on with colleagues who are around this table. We are looking at whether we can change and redevelop that. There is a single national rate for care homes, which is established with those who are here and with others. Generally, for things such as care and support, providers submit their rates and that will be the rate. We ask them, particularly within that framework, to submit a sustainable rate that involves payment of the real living wage. So, there is only one example to which your question would apply, which is the national care home contract.

You asked what would happen if we were not here. That depends on what happens with the national care service. If the status quo remains, the 32 local authorities or HSCPs would do that work on their own. That would further dilute what we are trying to achieve, which is to standardise good practice and to ensure that people get the real living wage and other benefits. There is a real risk there.

Over and above that, there is the issue of resourcing. There would be numerous exercises in different councils and HSCPs that providers would have to respond to. It is likely that there would be a number of local arrangements. When we mooted that to the sector in connection with the national care home contract, no one really wanted to go down that route. They like the fact that a lot of that is done at national level. It may not all be done perfectly, but it certainly frees them up to do good local commissioning.

The Convener: Sandra MacLeod wants to make a specific point.

Sandra MacLeod: Although I understand the suggestion that it is far easier to have national procurement and commissioning, we must be mindful that Scotland is very varied. Even care home contracts and care-at-home contracts are not necessarily widely applicable. What suits the middle of Glasgow does not suit the middle of the Cairngorms. We must be mindful that local variations are needed.

We can work together to agree on the best principles, but we must ensure that we have the ability for local variation. I appreciate that things take time, but that time can be to the detriment of service provision in some areas. We absolutely need key principles at national level and some guidance and support about how we can share the burden, but we cannot move away to saying that we are moving forward with one national standard. That will not work across the whole of Scotland. Shetland and Orkney are very different to Glasgow and Edinburgh, and we must be really mindful of that.

The Convener: I know that people want to come in and add to that. I must go to questions from other members and move things along. I call Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): This is probably a question for Rachel Cackett in the first instance. Given funding pressures, how likely is it that voluntary providers will be able to deliver on the fair work principles that are in the bill, and how can we strengthen the bill to ensure that those principles are a reality for voluntary sector providers?

Rachel Cackett: That picks up on why I put my hand up during the previous comments, so that is

helpful. Fair work is crucial here, and I understand some of the issues around legislative competence and what can go into the bill. We have been promised fair work for some years now, but this year, in which we are looking at an NCS bill, we have gone further away from fair work, not closer.

When the uplift, which was less than 5 per cent, was given to social care staff in the third sector at the start of the financial year, it was done on a formula that we do not understand, and was not based on a 100 per cent contract value. It was given based on an estimate of how many staff at a certain level you have in an organisation. That had all sorts of profound impacts, even before we got into future pay rises for other parts of the sector, which meant that individual employers could not maintain differentials and made it difficult to fill management jobs.

We then got into a situation where pay offers were offered to other public sector colleagues. I certainly do not begrudge them that in the slightest—people should be paid fairly for what they do. First, there was a local government offer, then a national health service offer and then a revised NHS offer, which bears no resemblance to the take-home pay that a care worker working in third sector social care would enjoy. The minimum threshold for a social care worker is now £10.50 an hour, and the new pay offer to the NHS puts a band 4 at more than £13 an hour.

We have looked across recruitment sites and found a £3,000 or £4,000 difference in starting salaries between the public and third sector, so when we speak about fair work, we are way off it at the moment. We are entirely beholden as employers of commissioned services to the contract value. I listened to Julie Welsh's point about asking for people to put in a realistic amount, but that amount is not payable; it is not there, because the uplift has not been given.

The real living wage was then announced, and although I appreciate that the payment deadline for that is May, the Living Wage Foundation has asked for that to come in quickly because of the current situation over the winter. If we were to maintain the differential before that announcement between the real living wage and a starting salary in social care, social care staff would already be on £11.55 an hour as a starting salary. If we compare that with our public sector, which is what I thought that we were aiming at—parity—we are way off.

I guess that there is a little scepticism—or perhaps a large amount of scepticism—in the sector about what the fair work exemplar wording means, because we are not there. We have been told that for years, but we are worse off. As we currently attempt to do it, ethical commissioning, including through the national contracts through Scotland Excel, cannot possibly deliver on fair work, and I would like to see the bill significantly strengthened in that area.

Part of that is how allocative decisions are made at national level on what goes into social care. For example, I am very aware of that in all the winter pressures work. The winter plan for Scotland talks a lot about the NHS and additional staff, but it does not say that about social care. The local government pay award includes the offer of SSSC fees being paid by national Government, but it does not offer that to the third sector. We are far apart, and our members would be very keen for the bill to be strengthened, so that we can trust—I go back to that word—that the fair work principles that we have all signed up to can be delivered through all commissioned services.

Let us remember that the £10.50 uplift was only for registered adult social care, not for all social care, and it was not an uplift for all staff. It is now far behind other uplifts that have been offered, but there is no mention of that in the public discourse. We have talked about the value of our social care workforce during Covid and beyond, but that is not being matched in the slightest by the value that is placed on it by contracts and awards through pay offers.

Karen Hedge: I will keep it short, because Rachel just said what I was going to add, which was the point about the costs of regulation being included in the local government offer. We have exactly the same scenario for independent sector care providers as we do for our voluntary sector care staff.

Fair work principles apply across the board, but it is not possible to enact them on the rates that we are currently paid. We also have the £10.90 aspiration, based on the Fair Work Convention's recommendations. In reality, though, even that is not enough.

10:00

The Convener: Gillian, do you have a follow-up question?

Gillian Mackay: Yes. This question is specifically for Karen Hedge. You will have seen the paper from the Scottish Trades Union Congress on profit in the care sector. I stress that this does not apply to all private providers, but some are taking a significant amount of money out of the sector in profit. Given the pressure on funding for services and workers' wages in the sector, should the amount of profit that is allowed out of the system be capped under ethical procurement? Should companies be prevented from banking in tax havens?

Karen Hedge: First, we need to consider that profit is already capped through Government payments. The national care home contract caps profit or return at 4 per cent. In the cost modelling that I have done locally, often for care-at-home providers, the funds that are paid to providers are capped at around 3 or 4 per cent. For a bank to consider a company to be financially sustainable, the company needs to meet something called EBITDA—earnings before interest, taxes, depreciation and amortization—which sits at 7.5 per cent. The Competition and Markets Authority suggested that a return rate should sit between 8 and 9 per cent. If you compare the sector with other industries, hairdressers get about 11 per cent and hotels get 14 or 15 per cent. There is already a cap in place for publicly funded care.

I do not know whether people understand what the national care home contract rate works out at when we break it down. The rate for a care home at the moment is about £5 an hour. That involves fairly complex care—for example, for people with advanced dementia. Quite a significant and important level of care is delivered in care homes now; it is quite different from 10 or 15 years ago, or even five years ago. We can compare that to, for instance, my kids' after-school club, at a local church hall, where it costs more than double that for an hour of care. It is worth explaining the current rates to people. For a local authority to deliver the equivalent, we are talking 2 or 2.5 times that cost, while a hospital bed alone is three times that cost.

In undertaking this work on the national care service, it is definitely worth considering providing more explanation of the cost lines and how we have got to where we are. I would be very happy to work with people on that.

The Convener: We have touched on national and local governance arrangements, but we have specific questions on that area from Emma Harper and Paul O'Kane.

Emma Harper: A lot of this has been covered already, so I will be really brief.

One of the issues that is coming out is to do with how local government wants to be part of delivering care now that we are going to create the national care boards. For example, how do we manage that shift to make sure that we can show local authorities that this is about local delivery, with national guidance? It is not about taking control into ministerial offices; it is about the delivery of care at the local level, with national guidance that underpins what the care quality needs to look like.

Karen Hedge: Creating that local guidance and flexibility is really important for local innovation to flourish and to create the conditions in which people can collaborate and effect change.

We have to bear in mind the role of the regulators in this space. Many of them also have a role in improvement, so when we are talking about quality and conditions, we need to make sure that we are tapping into aspirations there. Obviously, the independent review of inspection, scrutiny and regulation is also going on at the moment.

Oversight arrangements were introduced during the pandemic that are a de facto regulation mechanism in relation to health needs. They, too, need to be considered, because of how they have been enacted. They are not always beneficial in the front line and they have led to challenges for individuals who live in care homes.

I guess that I am saying that, when we talk about improvements and standards, it would be great to work with providers in that space and see what sort of work they have been doing and the good stuff that is going on out there. There are great examples, and I would be happy to contribute them.

Paul O'Kane: I wonder whether we can look at the relationships that already exist on a local level. Both CCPS and Scotland Excel have expressed concern that the focus on structure could be to the detriment of the existing local relationships. Rachel Cackett has commented on that, which was helpful, and I want to ask Julie Welsh to elaborate on the Scotland Excel concerns. Julie, do you feel that there is a risk that the bill could damage already well-established and successful local relationships?

Julie Welsh: I do not think that we know enough at the moment to say whether that is the case. As someone mentioned earlier—I think that it was Rachel—we do not know whether this will be a commissioning model or a delivery model, and that is quite fundamental to your question.

If the intention is to have a different national body do exactly what we are currently doing, I imagine that we could duplicate those relationships in some way and that the staff would transfer across in order to do that. I think that it is achievable. What would potentially get lost is the years of experience of doing this and the learning that we have had along the way.

I believe that the relationships can be maintained, but basically it will depend on the structure that is decided on.

Paul O'Kane: Do you feel, though, that people become fatigued by structural change? I think that it is fair to say that, in this sector particularly, we have seen various structural changes over many years, and actually what people are driving at is cultural change. Integration, on which we are not

quite at the 10-year mark, would be an example of that. What are your thoughts?

Julie Welsh: I suppose that we are more fortunate than some of the others who are represented on this panel, who are more on the front line. We basically put in place the arrangements, so we are not on the front line dealing in the same way with the changes that you have talked about.

From speaking to my teams, I think that there is a lot of concern, as would be expected, because they really do not know where their jobs will be. That can be detrimental to performance in the kind of work that we are trying to do now. There is a bit of a risk that, because we are focusing a lot of our efforts on supporting the NCS work, we are not doing the innovative things with our current portfolio that we should be doing.

For us, it might be less about the fatigue, because we did not experience that the last time, and more about the concern and worry about how all this is going to look and what it means for people.

Sandesh Gulhane (Glasgow) (Con): Rachel Cackett, when I looked at your submission, something stuck out for me. You said:

> "in its current form the Bill is a curious mix of specificity in relation to the powers it gives to ministers and permissiveness in relation to the interpretation of the delivery of key principles".

For clarification, are you saying that the bill gives too many powers to ministers? Would you like to see autonomy retained at local level?

Rachel Cackett: It is quite hard to answer your first question. The bill places, for example, intervention powers with ministers to use when they feel that things are not going right and they need a certain bar; at the same time, the core accountabilities of ministers that are set out on page 2 of the bill are very thin indeed. As we said in the discussion paper that we submitted to the committee yesterday, we feel that if ministers want to be accountable for social care, what that accountability is for needs to be clearer—not necessarily stronger, but clearer.

Also, the way in which ministers will be held to account needs to be clearer. For example, we are very aware that in the bill there are no provisions—apart from in one place—that call for regular reporting to Parliament, as there would be in other bills. Often the social security legislation is highlighted as a model for this bill as a framework bill, but the social security legislation comes with a commissioner approach that is not replicated in this bill—although I argue that it might need to come with more resource than was put into the social security legislation.

What ministers choose to do is a political decision, and it is for Parliament to decide whether that is the right thing. If that is going to be the way forward, it certainly has to be done with clarity and with the ability for recourse to be clear when accountability is not being discharged as it should be.

It is interesting to pick up on the previous conversation. Obviously, we are getting into a discussion about whether we should stick with IJBs or move to local care boards. We are going backwards and forwards on whether there should be joint accountability between local government and national Government through IJBs and the NHS or whether we should create care boards, although we are not quite sure what they are.

I go back to my original point about the model of change. We should be looking at subsidiarity to the individual level and leaving the responsibility and accountability for how care is delivered to the front line, supported at the local and national levels, and we need to be clear about what sits at each level. The decision about what care somebody wants and feels that they need should be made at the front line. We already have very good policy around self-directed support, although it is not necessarily very well implemented.

It is not as simple as saying whether the approach should be what we already have, because what we have already is not working everywhere. We know that need is unmet and that some people have had and still have very poor experiences in trying to get the care that they want in the time in which it is required. That is because there are not enough resources or staff, and some things go wrong at the relational level.

The question is not as simple as the one with which we are being presented, because we have a framework bill that is about taking or not taking accountability to ministers. We have got a bit stuck in a groove, and we need to step back and think, "Okay. Let's be clear about what accountability is to be held by ministers. Let's make sure that that accountability is transparent, but let us start at the other end and think about what needs to happen at the front line and then work up." We have a bill that would set up a culture that starts by holding things at the top and then goes down. I would argue that that is probably the wrong way round.

Sandesh Gulhane: I do not mean to keep picking on you, Rachel, but I want to come back on something that you said. James Dornan talked about this when he asked you about patchy delivery. You have said previously that the status quo is not good enough, and you have talked about that in response to me. With the local governance arrangements that we have now and the way in which ministers are in charge of health and social care, could we not do a lot of things

right now without having a national care service bill?

Rachel Cackett: We could absolutely be closer to fair work than we are without a national care service bill, and we could be further down the line of ethical commissioning in some of the ways that colleagues who are starting to make those moves have described. The same goes for ethical procurement. There are some tweaks at the edges that could be improved legislatively, but we do not necessarily need to change legislation for the core of what we could do.

Despite the new-found evangelism for IJBs, it is clear that some things are not working as well as they should be. Audit Scotland will have sat in front of this committee to talk about some of its reports. There are always improvements that we can make. We know that the way in which third sector providers are currently commissioned and procured in many areas is not good enough and that the availability of care and support for people in many areas is not good enough. That is why, in our discussions with members, we have looked at what we need to do now.

That is not to say that reform is not required. Our membership has been really clear with me that there has to be reform. That is why we came up with the model. We need to consider where some things could and should be legislated for and how they could translate into a bill. I am not saying that there should not be a national care service or a national care service bill. There are things that could be really improved by national oversight and national setting of frameworks, but we need not wait for that; there are things that we can do now while we wait for the national care service to come in and we all try to shape it together.

On the sustainability of the sector, we published a document around a month ago—on 1 November—that looked at the immediate actions that we thought that the Scottish Government could take to ensure a sustainable sector for a national care service. We are waiting for a response to that document.

10:15

The Convener: We will move on to an issue that we have skirted around throughout the morning, which is the sequencing of the legislation and the co-design process and how you want to see that work. I will go to James Dornan to start off questions on that theme.

James Dornan: It was interesting to hear what Rachel Cackett said. The most important line was that this should be not top down but bottom up. There are perhaps some concerns from witnesses about not so much whether there is a need for reform as whether reform should be now and what it should look like.

Let us work on the basis that the likelihood is that the bill will pass and all the organisations here will be involved in the co-design. What would you like to see in that co-design? Surely this is an opportunity to create the national care service that you would like to see.

I will go to Geri McCormick first.

Geri McCormick: In terms of our involvement in co-design, we would like to be clear about what has been working and what we should continue, and we would like an acknowledgement of the fatigue around consultation.

From a Glasgow perspective, at the moment, we can cite partnership working as working well. That is the case across all areas. It is about organisations and individuals having a clear voice and it is about listening; more than that, it is about ensuring that we are acting and that there is constant dialogue about where we are going in relation to the views that are around.

James Dornan: Therefore, the national care service might give you a platform to espouse what you are doing as being a way for other parts of the country to do things and for the national care service to work on the same sort of basis.

Geri McCormick: Yes, it might do that. Further detail on how the consultation will develop would allow us to be reassured, or more reassured, about what it will bring. That is our starting point. It is important and essential that the principle of engaging with all stakeholders is continued and that we do not lose what is quite a strong baseline of current evidence and practice that we can bring forward.

Karen Hedge: I will pick up on what Geri McCormick said about malaise. The care sector is currently experiencing a crisis like no other. We thought that things were hard during the pandemic but, for a variety of reasons, the aftermath of the pandemic has been significantly worse. In one area of Scotland alone, we have seen a 32 per cent increase in unmet need. We are really in dire circumstances. Our members do not have capacity to engage effectively in a co-design process because they are out there pulling shifts, frankly.

At this point, it is about how we move to ensure that we are supporting the system through the current winter pressures. I have called on the Scottish Government for an immediate stand-down of all non-essential demands on the sector, to enable people to get out there and support social care and, through doing so, to support people who access care and support, their loved ones, and the health sector, so that, as we come

out of winter, we have more space and capacity to engage effectively. We fundamentally agree that reform is required, but the current pressures are not enabling people to engage in a way that is effective.

In addition to that, at any public session that care providers have been to—for example, events with people speaking on panels or in formal sessions—there has been nobody there representing providers. Providers have therefore felt that their voice is not represented—indeed, oftentimes an unrealistic view of a care provider's aspirations is presented at those meetings, because they are very one-sided and providers do not have the space to put their own voices out there.

Fundamentally, reform is required—but should that happen in the midst of a crisis? Not really. I made that call at our conference, where I was sitting next to someone from the Scottish Government, who said, "Yeah, I hear what you are saying, but see that survey on technology, it is really important. We need it for the national care service, so could you just do it?" It is not important—looking after people and our staff is what is important right now.

James Dornan: Let us work on the basis that we will all be in the room. What would you like to see in the bill?

Karen Hedge: The bill has to be co-designed. We did a piece of work a couple of years ago that fed into the independent review of adult social care, which I am happy to submit to the clerk—there is a framework for a national care service and a paper that is called "'Coileanadh': Manifesting a flourishing social care future for Scotland".

We would be looking to have the provider sector represented and for providers to have a space to speak when panels and public sessions take place. We have had an offer from the Scottish Government to speak to providers, but now is not the time, because providers do not have the capacity for that. We need to be able to create the space in the system to allow people to contribute effectively when they are able to do so.

The Convener: Presumably, that would be done to inform the secondary legislation that will fill in some of the detail on how the service will work.

Karen Hedge: Yes, but at the moment providers are putting out fires.

The Convener: The framework, however, will provide the platform on which to have that secondary legislation, so we are looking at a couple of years down the line.

Karen Hedge: Yes, but there are demands on the sector now to fill in copious numbers of surveys to inform that work.

The Convener: Okay. Stephanie Callaghan wants to come in.

Stephanie Callaghan: I go back to what the Granite Care Consortium did in Aberdeen. There has been a real shift in power. The health and social care partnership essentially handed over a budget. The providers were at the table, and they were able to work collaboratively to provide seamless care and to shift things to each other if things did not quite fit.

I keep hearing, "We don't want to lose all the good work we've done." I say to Geri McCormick that I totally appreciate that. A lot of great work has come out of the IJBs, but we still hear that voices are not being heard. Providers feel that they are not heard and that they need to be at the table. Surely having providers at the table, and not just as people who can speak to the IJB, is really what care boards are all about. There is a difference between engagement and listening, co-designing and continuing to be part of the process all the way through.

I am worried about the idea that we would lose lots of good work. Surely there would be the people around the table who are already there as well as the providers and people with lived experience, so that people would move forward together in a growing, collaborative process.

Sandra MacLeod: I have a couple of points to make. A question was asked about what the service would look like. My points will pick up on that, as well.

I absolutely understand that we need lots of views and voices, and that everyone needs to co-design the service. I fully support that, but we must understand where that work would take place and what the purpose of the board would be. In many cases, a board will provide a level of scrutiny and governance and a level of approval or not, as things progress.

It is important that voices are heard at the local level. I think that Rachel Cackett said that. The question is how that is enacted. Decisions will be made and there will be scrutiny in a board, and work will happen to bring forward papers and decisions to the board in other areas. The question is how we will find resources and—Karen Hedge and Rachel Cackett have said this—how we will create the space for providers, the third sector and people who use the service and have lived experience to be engaged in co-design before things even get to a board.

My worry is that we are so focused on who will be around the board that we are not focusing on

how information will get to it and how the co-design will be made. Fundamentally, if it is still made by officers, the current culture will not change. We need to deal with the cultural aspect.

We have to consider what a board needs to look like. This is about a national care service, but we cannot escape what Covid has shown us: that health and social care are entwined. We cannot do anything across health, primary care or social care that does not impact on another part of the service. The boards need to be balanced, as do the workstreams and the groups that enable decisions to be made. We cannot pull out health, and we cannot just have a care service; we have to ensure that all of that is entwined together.

Paul O'Kane: Rachel, CCPS submission's says:

"The Scottish Government appears to have taken the view that aspects of the detailed implementation of the Bill should be subject to codesign but that the overall approach to system redesign and structural reform should not."

Do you think that that is back to front in some ways and that there should have been co-design in advance of the bill to inform what it looks like? How would you respond to those who have called for a pause on the bill to try to get it right?

Rachel Cackett: We are where we are. The bill has not embodied the principle of co-design in its development. However, to pick up on what Karen Hedge said, having got to this point, it is really important that the process that we have been promised as the bill is implemented will be fully embraced through what happens from the bill from this point on.

The Government is setting up some groups. I agree with Karen Hedge that this is a very difficult time in which to get providers engaged, but our providers are engaged. In the past two weeks, I have run two events on the bill, and there were fantastic turnouts because people know that the bill will reform the sector for good or ill, depending on where we end up at the end of the process. It really matters to people, and they want to be engaged, but this is a difficult time in which to do so.

There is something in the bill that the discussion paper that we have shared mentions. Despite the language of co-design, even in what is being proposed for the post-framework process and the strategic process that will happen locally, there is still quite a traditional consultation process. People will write a document and give it to a few people, and they can tell them what they think. That is not co-design.

Fundamentally, we need to look at what is in the bill and the expectations that are being set by primary legislation of what co-design is. I go back to what one of my colleagues said. Co-design requires purpose, and sometimes the purpose is not yet clear enough. That goes back to the issue of the principles being stronger.

As I have said, we are where we are. Derek Feeley's work was very engaged. If we can get ourselves back towards that, we can probably salvage a little bit of that sense of people's engagement. People were very engaged through that process, despite Covid.

We are not saying that we are at the stage at which the bill should be paused—I am not quite sure what that would be—but we are saying that the bill is not yet where it could be. We are doing everything that we can with our members, the committee and others to ask whether we can make it better and closer to what we want it to be. The committee is in a similar process. We are at stage 1, and we need to see what the potential is to get the bill to where we want it to be. As I have said, it is not where we would want it to be now.

The Convener: That is why we have these sessions.

Rachel Cackett: Absolutely.

Tess White (North East Scotland) (Con): My question is for Sandra MacLeod. In your written submission, you emphasised that

"It is essential that the scrutiny of legislation by Parliament and stakeholders is not diluted by using secondary legislation over primary legislation."

What would you prefer to see in the bill at this stage? What do you understand as co-design with respect to the bill?

Sandra MacLeod: A lot of my colleagues have picked up some of the key parts. At the moment, the bill seems very much to be a framework that does not give us explicit direction. That means that secondary legislation can allow more work for it to be interpreted. Karen Hedge clarified that point. I support that.

Co-design takes time. It takes time for all of us to be in the same space. I echo what Rachel Cackett said. Fundamentally, if we do not have a clear purpose and clear principles, we can lose track of anything that is set out. We need to ensure that there are those fundamentals.

We need a broad outline of what the system will look like. Is it about commissioning? Will the approach be local or national? We need to know what exactly we are working with; we can then start the co-design process. Will it be a commissioning framework? If not, will we have all the staff across there? What will that look like? What will the geographical boundaries be? All of that needs to clarified in the bill. With the secondary legislation, we can start to work through things, and co-design properly.

10:30

The Convener: Does Tess White have a follow-up question?

Tess White: No.

The Convener: In that case, Sandesh Gulhane can ask the last question.

Sandesh Gulhane: That is very kind. Thank you.

I want to ask about the transparency of co-design. Once people have fed in—as we think they will do—it will be about how things are decided and how people will come to decisions when there are conflicting views. Who will make those decisions? What transparency is there? What do you understand will happen?

Julie Welsh: It is quite hard to understand the landscape of the various groups, meetings and requests for information because of the scale of what is being requested. Currently, things do not seem terribly transparent, but that is because so much is going on, and it is quite difficult to get our heads around what groups we should and should not be on, and what we should attend. I hope that we can improve that over time as part of the process. That has been challenging for us. Resources are required, particularly at the moment.

I have discussed with a number of people work that is still being done. The other panel members have given loads of examples of how important that work is. How can people find the space to free themselves up and get involved in co-design discussions when they face the challenges on the front line that they are facing? If there was some way to make that simpler and a bit easier, that would help all of us.

The Convener: I thank all of you for your time this morning. The session has been very helpful. I am particularly glad that you have given suggestions on what you want to see in the bill and the process. That will be extremely helpful for us as we put together our report.

We will pause for 10 minutes to allow for a change of witnesses.

10:32

Meeting suspended.

10:45

On resuming—

The Convener: We move on to our second evidence session on the National Care Service (Scotland) Bill. I welcome our second panel of witnesses: Fanchea Kelly is the chief executive of Blackwood Homes and Care; Margaret McCarthy is the chief executive officer for Crossroads Caring Scotland; Peter McCormick is the managing director of Randolph Hill; and joining us online is Nick Price, who is a representative of the Granite Care Consortium. I will hand over to my colleague Gillian Mackay.

Gillian Mackay: To what extent do the witnesses believe the bill will enable or support care services to uphold fair work principles and improve conditions for staff? How, if at all, will it help to address workforce challenges around recruitment and retention? Peter McCormick is looking at me, so I will go to him first.

Peter McCormick (Randolph Hill): To some degree, it is difficult to answer a lot of those questions, because the bill is in its first stages. That is what I said in my response to the consultation—there is a low level of detail, so it is difficult to pin things down. One of the things that I hope for from the bill is that a national framework might result in more consistency across the country. There are different challenges around the country, and those need to be treated slightly differently, but they are not so radically different that a radically different approach is needed in each area. Consistency across the country would help.

The Convener: We will go to Margaret McCarthy next. You do not need to press the button on the microphone; that will be done for you.

Margaret McCarthy (Crossroads Caring Scotland): I echo what Peter McCormick said. It is about the detail. In principle, I am thinking about a national care service in the sense of everything being nationalised, and one would hope that that would include rates of pay. From a provider's point of view, we are seeing a mass exodus of staff due to fair work and pay issues. If we could come to a point where there was consistency on rates of pay, which really means the rates that we are paid for delivery, that would make a big difference. Therefore, it is about the detail.

Fanchea Kelly (Blackwood Homes and Care): I echo most of that. We have care services around the country and different markets are very different, but in all of those there is a fairly consistent theme of staff turnover that is much higher than it is in, say, our housing services. That often comes down to two things: one is the nature of the work—personal care is not a job for everybody; the other is the pay level, relative to pay in hospitality and retail.

That combination of the fact that personal care is not for everybody and those other opportunities—depending on the local market and the local economy—means that we have a consistently high turnover. In turn, that means that

the business margins are very fine and quite often negative. We invest quite a bit of the available money in training and induction and then people leave, so my board consistently asks, "Is that us, or is that the sector?" All the data show that it is the sector, and we do the best that we can with regard to paying for travel and those kinds of issues to give people that wider set of benefits. However, there is the very simple thing that the pay rate does not equate to the rates elsewhere—mainly, as I say, in hospitality and retail.

This is not the question that I think that you are asking, but given the amount of money that will have to be invested in structures, if I had a preference, it would be to put a lot more of that into the front line, in recognition of the work that people do. Our care staff, particularly those whom we were talking about earlier—the people who have been around for a long time, for whom caring is a huge commitment rather than a career in many ways—really did feel valued after the pandemic. They worked extremely hard, but they felt that there was recognition of the value that they brought to society. However, that has gone again, and more of a change is needed on that front.

I think that the principle of fair work is there, and we could build on that. Everybody talks about the crisis in care and, although I tend to talk about solutions rather than crisis, I have to say that it is a very difficult time at the moment. That might be an issue for the committee to consider. Leading up to the period when the national care service is established, I think that we need much clearer signals that it is understood that care has a major value to probably all of us in Scotland.

The Convener: I come to Nick Price in Aberdeen.

Nick Price (Granite Care Consortium): When Derek Feeley's report was first published, there was a huge flurry of excitement throughout the sector, because it encompassed a lot of what the majority of providers across Scotland had been calling for, for as long as I can remember. I remain optimistic that a lot of those recommendations will follow through into the structure of the national care service.

I have worked in health and social care for a long time, and I can honestly say that the past six to nine months have been the hardest that I have ever seen. With regard to retention, the churn within the sector has always been high but, previously, we have always managed to recruit. However, the recruitment pressures now are ones that I have never seen or experienced before.

Speaking now as a provider, rather than as a co-chair of the Granite Care Consortium, we do not typically lose care and support staff to other care home providers. We lose them to our NHS or health and social care partnership colleagues, or to employers outwith the sector. The primary reason for that is terms and conditions.

Gillian Mackay: To pick up on what Nick Price has just said about terms and conditions, obviously, pay is a huge part of the recruitment and retention side of things, but we also hear from people who work in the sector that things such as zero-hours contracts and holiday pay are a huge part of their working life.

What would you like to see in the bill to ensure that we continue to improve terms and conditions for workers and continue to recruit, as well as retain the current workforce? That question goes first to Nick Price.

Nick Price: I do not want to step outside of Scotland, but for years the United Kingdom Homecare Association has published a recommended rate, which is significantly more than what we are paid by our best-paying partnership. Therefore, we would like to see some sort of structure that would align with that.

I think that it was mentioned in the earlier evidence session that our NHS colleagues are paying band 4 staff about £13.50 an hour. We need to pay our care and support staff at that level. As a care home provider, we need to be able to pay staff for shifts. We need those guarantees from our commissioners, because the majority of care and support in Scotland is spot-purchased in slots of half an hour or 45 minutes and, in some areas, 15 minutes. That does not fit into ethical commissioning at all.

Providers obviously need a level of profitability. I know that that is a bit of a bad word, but we need to be sustainable. On a personal note, I have always said that I am happy to commit to not exceeding that level as an organisation and to pass as much as we can over to our workforce, because without a workforce we do not have a sector.

I do not know whether that fully answers your question.

Gillian Mackay: It does—thank you, Nick.

Fanchea Kelly: [*Inaudible*.]—certainly, as a provider, we pay holidays and travel, so we try to set the best terms and conditions that we can. We think that that should be standard and we think that standards should be set by the Scottish Social Services Council—or whoever the regulator is—so that they are recognised and, therefore, funded.

Margaret McCarthy: I just want to emphasise that point. If you ask most providers, they will say that they actually do not want to have zero-hour contracts for their staff, but a lot of people choose

them for reasons of work-life balance for themselves.

As an organisation, we pay travel time and all training. Everything is paid at the rate of £10.50. For me, the issue is that, if a provider organisation is paying that out but the rates that are paid by certain councils do not meet that rate, the organisation inevitably dips into its reserves, and that is quite often where deficits come in for providers. There is a whole issue around consistency, around ethical commissioning and around looking at how we are delivering care generally. There needs to be a real revamp of how we deliver care at home, in particular, so that we retain staff, which would actually service our communities better as well. I emphasise again that what we are talking about here is that the rates that are given to deliver the service do not actually meet what providers are putting out.

The Convener: Regarding what you have just said about the local authorities giving you a particular rate while you are paying your staff more than that, do you see that as an issue that a national care service might address?

Margaret McCarthy: That takes me back to my answer to the first question, which is that I hope that it would. That is why I said, in a positive way, that I would agree with that as long as we are looking at a national rate. I know that that would be very difficult, because in rural areas there is additional travel time and mileage and so on. However, there should be some standard, and I would take it back to the home-care rate that is out there. We need to get to a point where the rates that are paid are equal. We need to get a point where staff who are delivering care at home or any other care-home or home-care service in the community with the third sector are paid an equivalent to what health support staff are paid. That is a big issue, because we have people moving.

The Convener: I would like to come back to Nick Price. You mentioned churn between social care providers. We know from our visit to Aberdeen that the Granite Care Consortium has been trying to address and stop the churn between providers. Can you tell us a bit about how you have managed that?

Nick Price: We have a very transparent approach among the 10 board members of Granite Care Consortium, which is a combination of independent and third sector organisations. We have shared our terms and conditions. Obviously, there are differences in organisational structures, and some are national providers while some are local, but I think that our transparent approach has supported that. We try to get as close as possible to paying the same hourly rate. I also know that the majority of GCC providers pay a good bit over and above the £10.50.

However, I am not sure that that has been the key element that stopped the churn. I think that people are looking outside of care at home, because they know that they can take a similar job in an NHS environment in which they will not be working all hours. They will be on set shifts and know what they are going to walk away with paywise at the end of the month. They will have support on hand from other colleagues, such as nurses and doctors. It is not a lone working environment. I think that that it is a far better, more appealing, better-paid option than going from house to house in all weathers. I think that the appeal of being a care and support worker is, unfortunately, going downhill.

The Convener: I assume that you have finished your questioning, Gillian.

Gillian Mackay: Yes.

The Convener: In fact, I jumped in and took over. Tess White, do you have questions in this area?

Tess White: I have one question for Fanchea Kelly and Margaret McCarthy. The Scottish Care chief executive, Donald Macaskill, has estimated that 30 to 40 per cent of the country's residential adult care facilities might close permanently because of the immediate challenges that they face. In your opinion, would the projected £1.3 billion that is earmarked for the national care service be better invested in the local delivery of social care now?

11:00

Fanchea Kelly: That is a good question. I said earlier that there is a crisis happening now and if we want to retain a proper understanding of what kind of care is needed in Scotland, we need to invest in it in the near future. I fully understand the pressures on overall budgets, but a choice needs to be made, for a range of adult care services.

Without wanting to seem overoptimistic, we need to think more about how to prevent crisis, because crisis is more expensive. That is the piece that is consistently not given enough attention—including in the bill—because it is difficult. However, everybody knows from their own family and their own circumstances—certainly we know from our businesses—that doing more on prevention and early intervention is not only what people want but it saves the state money as well. We have evidence for that. Donald Macaskill may well be right that you would lose quite a lot in the next couple of years while the national care service is being set up, so we need to juggle needs carefully.

Margaret McCarthy: I agree. On prevention, where we are seeing a lot of stress—and where a lot of money could be better invested—is in relation to unpaid carers. In quite a lot of our work, we are going into a household with two people in it—a husband and wife, for example. We are going in to care for the husband and the wife is the main carer. There is a real lack of investment in giving people purposeful breaks at that point. On the long term, I totally agree that the money would be better invested at this stage.

I am a wee bit concerned about the amount of money that is being spent on the national care service. I agree with the idea, but there is a crisis now in how we as a society address social care in our communities. Having worked in health and social care for over 37 years, I agree that this is probably the worst that I have ever seen it, and I am really concerned that, if we have to wait two years for the national care service to get pushed in, a lot could happen in that time. We will lose more staff. I have a real concern that there will be more crises than we have ever had. At the end of the day, the one thing that is missing a lot of the time—I know that Shared Care Scotland has made this point to the committee—is a focus on the role of unpaid carers, and that is going to put so much more pressure on them.

Emma Harper: I am interested in the language in the bill around training and the recruitment and retention of the workforce. We are starting to move away from the time-and-task model and are looking at real ways of helping to support retention and recruitment and valuing people by engaging in training. What do you think about the provision in the bill that

"The Scottish Ministers and care boards may ... provide training"

and about how training helps in relation to valuing our staff and maybe retaining them even longer and supporting the continuing recognition of the professionalism of care? A lot of the care that is provided is really complex, so I am interested to hear your thoughts about what is in the bill as far as the language around training goes.

Margaret McCarthy: As organisations, we all have mandatory training. You are right—very complex care requires very complex training and we as an organisation find that very difficult to access at times. If that training were nationalised in some way so that providers could tap into it better, that would be amazing—I am thinking about some of the very complex training that is needed. However, that brings us back to the same old question around the investment in that. How much money will be put into the training budget so that we can retain more staff?

Emma Harper: On recruitment and retention, if the Government committed to supporting on-going, continuing professional learning to unburden providers with regard to the financial aspects of having to send people away to do online or face-to-face training, would you welcome that?

Margaret McCarthy: It would come back to the detail and what kind of training we were talking about; for example, are we talking about moving and handling or first aid? As well as it being about what level of training we are talking about, it is also about where it comes off in relation to rates. For example, would money be taken off our rates to furnish that budget? It is not that I do not welcome it—I do, because we sometimes have difficulty in accessing training. However, it will be about the detail of it, if I am honest.

Fanchea Kelly: I agree with Margaret McCarthy. The practical point is that we absolutely want good training. We see daily that it is hugely important. The issue is that, when people are training, there is a cost in covering their shift or whatever. You end up having to do rota scheduling and you still need numbers of staff to make sure that the rota is covered. That is about the detail that Margaret talked about; that is probably where all our heads go as we say that we would absolutely support having good consistent training. The logistics of that would still need to be taken into account in thinking about how it would be commissioned.

Emma Harper: Not all training is done away from any place. As a former clinical educator, I used to go right into the intensive care unit, operating theatre or ward and do direct education. Education can be delivered on the ground in the area where care is provided as well.

Margaret McCarthy: Providers are very good at doing that, because we have had to think outside the box to ensure that our staff are still able to deliver according to the SSSC legislative requirements, especially during the pandemic. We use a lot of hands-on and online training. If there is an opportunity to pull out some of the bigger training that has to be done in person or some of the more complex training that is necessary because of clients' needs, that would be welcome. We have to try to navigate through the health sector to get that level of training and it is quite difficult sometimes. However, as providers, we are already very good at sourcing that online and doing hands-on training and peer support and peer training.

Peter McCormick: When I started in the sector 20 years ago, we could access a lot of training through the health sector and the health boards and so on. The history of it is that there has been a slide to provide less support to the care sector,

and so we have taken that on board ourselves and we do an awful lot more training. If we are going to be moving back in the direction of having more support centrally, it needs co-production—to use the word that is used—and we need to be involved in deciding which bits of training are the most sensible to do.

There also needs to be a long-term commitment. As I said, from our point of view, lots of things that used to be standard and shared have evaporated over the past 20 years and are no longer available.

Nick Price: Peter McCormick has pipped me to the post in relation to one aspect that I was going to raise.

The other aspect is about SSSC registration and the mandatory Scottish vocational qualification level 2, which obviously comes at quite a significant cost. If that could be funded centrally, that would help. Learning and development in the sector is essential, so any suggestion that will increase funding or availability, which will in turn increase retention in the sector, would help.

Carol Mochan (South Scotland) (Lab): I will take us back to an issue that was mentioned previously. I have done a lot of work with the allied health professions, which are very keen to talk about early intervention and prevention. Is that about a change in attitude and approach, or should there be something in the bill that would help that happen?

Fanchea Kelly: We would definitely like to see something on that in the bill. During the Feeley review, we were very encouraged by the fact that we were talking about independent living and helping people. If you help people to live independently, you are also broadly looking at preventing crisis—the two do not always match but they are closely linked. There really is not enough clarity in Scotland—indeed, not just in Scotland—about the fact that helping people to live independently is, in itself, something that we should have a set of standards for, including with regard to how we work across disciplines and so on. Therefore, we would welcome something on that in the bill, particularly given the demographics in Scotland—with more of us hopefully living longer but needing support rather than full care—and given the fact that there is a whole way of looking at that in communities.

Therefore, we would welcome a set of standards around that and recognition, ideally in the bill, that Scotland wants to create a whole new sector. We have talked to the Chartered Institute of Housing about that, and I think that it is very interested in the idea. We have also talked to the Cabinet Secretary for Social Justice, Housing and Local Government about whether more could be done to encourage that as one of the more radical changes in Scotland. The bill rightly has to focus on structures, but it does not seem to most of us to be just about those. Therefore, we would really welcome the introduction of that as a sector, with standards and recognition of what that means professionally.

Nick Price: The Granite Care Consortium has taken the approach of a more focused view on early intervention. Through the contract, providers have the autonomy to step up and step down packages of care when they deem it necessary. For example, if someone is going through a period of crisis due to an infection or something else and they need a higher level of care, that can be put in place for one, two or three weeks—whatever is required—and, if they improve, it can be stepped back. However, that has been achieved only through taking a step away from a time-and-task model to a purely outcomes-focused personalised model of care delivery.

The Convener: I will bring in Emma Harper, who has questions about commissioning and procurement.

Emma Harper: In the last evidence session, we heard about ethical commissioning and procurement. The language around ethical commissioning is really important with regard to how we procure services. The bill refers to reserving the right

"to participate in procurement by type of organisation".

I am interested to hear what your involvement has been in how services are commissioned. What do you want to see in the bill specifically to support an ethical commissioning and procurement framework?

Peter McCormick: Those of us who are here as witnesses work in two associated but slightly different sectors. In the care sector, we have the national care home contract. In the care-at-home sector, there tend to be more spot purchases and regional purchases.

We talked earlier about the terms and conditions for staff; in my experience, the national care home contract and those spot purchases really just provide the bare minimum for a contract of employment. We were talking about things such as sick pay; there are also things such as pensions, which we did not talk about earlier. Those are not covered in that way. For example, the national care home contract provides for statutory sick pay only. Many providers have taken steps to add additional terms and conditions, but they are not really doing it from the money that they get from those core contracts. There is a raft of things that many people in other sectors enjoy—you can name them yourselves; you know

what they are—and it would be ideal if those could be included in the framework of the legislation.

Emma Harper: You want that to be part of the bill or considered through the co-design process in the future. What you are describing, such as someone looking down the line to their pension, is a huge consideration for people with regard to the job that they do. We heard in the evidence that we took way back at the beginning of the process that most care staff are women who are aged between 50 and 65 and who are often carers themselves.

When we are considering the way in which contracts are created and delivered, we need to bear in mind the particular groups of individuals who provide the care. Would you want that consideration to be part of the co-design process, once the bill moves forward and we look at the devil in the detail?

11:15

Margaret McCarthy: On the ethical commissioning side—to answer a bit of your question about where we are with that—some authorities have made steps forward in how they work with providers around developing contracts. I would not want to say that the situation is negative across the board, because it is not—some authorities are very good at that work and are considering how to develop contracts around tests of change too.

In answer to your question about our staff, you are right to say that, out of some 400 staff, the majority are female and that, nine times out of 10, they are working mums. We have to build something into our contracts around how we manage that with regard to pension, childcare and time out for after-school care. We are building in all those things as an organisation, but they are not built in when we do a contract, so I would like to see a recognition of childcare responsibilities in there.

Nick Price: As Margaret said, a lot of good work is going on in pockets across Scotland. Many councils put ethical demands in their contracts, but, unfortunately, as they are not appropriately funded, those demands are not achievable. The councils can pay out only what they are funded to pay out, so it is very difficult. The aspirations are there, but—certainly with all the councils that we work with—there is a lack of funding.

An essential criterion is parity on fair work—a fair job across social care, health and the health and social care partnerships. People do the same job in those three different areas, but social care is the poor relation at the moment, which is a problem.

Emma Harper: I have a wee final question, which might go to Nick. We heard last week that the integration joint board in Dumfries will work with the Granite Care Consortium to examine what you are doing in Aberdeen, which could then be mirrored. Really good work has taken place and you have highlighted local authorities and IJBs that offer good examples of collaborative working and ethical delivery of care; I would like to see that work go forward.

Should we take those bits of good work and build them into the co-design so that, when the care service is delivered, we are using really good examples of work that exists out there now? That is part of what we are hearing about the Granite Care Consortium, which is now linking with Dumfries and Galloway.

Nick Price: I agree entirely with everything that you have said. We have been fortunate in Aberdeen, because the chief officer had the vision of where she wanted to get to. When she took that decision at the beginning of the pandemic, it raised quite a number of eyebrows. The thing that I asked at the time, once I got my head around the proposal, was, “If not now, when?”, because someone needed to take that step forward—we, as providers, have been asking for that for as long as I can remember.

A lot of good work is going on around Scotland; the national care service should capitalise on it and not look to reinvent the wheel completely. What has really worked in Aberdeen specifically is not just the trust and the co-production between the partnership and the providers, but the fact that the 10 providers who make up the consortium have shared values and a shared vision and want to deliver the best services that they can to support the people for whom they ultimately work.

The culture has to be right: if the culture is not right and there is no trust, the essential foundations are not there.

Fanchea Kelly: I absolutely agree; although culture is hard to put into a bill, it is important.

We have been speaking about the female workforce. We have about 600 people around the country, and they are mainly—but not only—women. There are a lot of grandparents and people who are at different stages of their lives. Part-time work is a very important aspect because we need to consider where the workforce are in their own lives and whether they are able to survive on that.

I have one thing to say about overall commissioning. Health and social care partnerships are required to produce a market statement—I am not sure that I am using quite the right language—before they commission, and that statement should set out what the conditions are

locally and what they are commissioning against. In our experience, that process has not been very successful, because quite often commissioning is done because of immediate problems rather than for future planning.

We should strengthen the side of things that is to do with knowing local markets and conditions for employment and the workforce, because it would be helpful if people had to engage in discussions on that before the commissioning of services took place. The idea is right, but in practice it is not even properly recognised.

Stephanie Callaghan: My question is a follow-up to Emma Harper's. Nick Price, what difference has having a co-ordinating role—as opposed to competing with each other—made to providers and to those who receive care from you?

Nick Price: Removing the competitive element has meant that good work practices and different business ideas and recruitment and retention strategies can be shared in a safe space—frankly, with the knowledge that there is more than enough work for everybody.

There have always been really good provider-council relationships—in Aberdeen, in particular—but now we have our own GCC back-office team, which shares data with the partnership, and we have open-book accounts. It is a completely different, unique dynamic of trust and partnership. It is so much healthier to remove the competitive, "Keep everything to yourself" dynamic.

Stephanie Callaghan: What difference has it made to the people who receive care?

Nick Price: We put out a survey recently, and generally those who responded reported high satisfaction levels.

Working as a consortium means that we can work in partnership if one provider can provide only five days of care per week and the other can provide two days per week. If one provider is struggling with a package of care because it is outwith their geography, we are able to move packages around and work in partnership with them.

I always have to come back to the fact that we set up the consortium during a pandemic, when it was exceptionally difficult, but doing so meant that during periods in which there were a lot of sicknesses and absences, and during high-pressure periods, we were able to rely on the other consortium providers as a support network.

I am pretty confident, because we recently put out our biannual service users satisfaction survey, and the feedback has probably been the best that we have ever had. We also had our highest number of returns. Our return rate is normally between 18 and 20 per cent, and this time it was just over 30 per cent, so there is increased engagement and increased satisfaction, and I know that that is not unique to us.

The Convener: Do you think that moving away from the time-and-task model has meant that fewer people are getting into crisis? It would be helpful if you could mention how your approach contributes to some of the lowest delayed-discharge figures in the country.

Nick Price: Moving away from time and task has undoubtedly been one of the key successes of our approach. It gives providers the autonomy to step up and step down packages as required. We mentioned this when the committee was up in Aberdeen a couple of weeks ago: we are also looking at embedding enablement into how we deliver care and support in Aberdeen, and we are running a test of change with three or four providers. It is around three months into a six-month project and has so far been very positive.

Sorry, what was the second part of your question?

The Convener: Does the change in how Granite Care Consortium works have anything to do with the lower delayed discharge figures in Grampian than there are in the rest of the country?

Nick Price: Absolutely; we were able to work in partnership with Bon Accord Care, which is the ALEO. As I said a couple of minutes ago, providers were able to work together; perhaps one provider could not take on a whole package but could take on half and work in partnership with another provider until they were able to take on the whole package.

Through our back-office structure, we have daily operations meetings between providers—all providers are invited, but who attends depends on what is going on operationally—so that they can discuss how things are on a daily basis, whether they have capacity, any pressures that they are experiencing and any other issues. We also have two-monthly board meetings; we have a structure of partnership and communication. Lisa Stephen, who is the operations director, and her team are in regular communication with all providers, Bon Accord Care, the resource co-ordinators in the partnership and the hospital discharge team. We have a group of staff who pull all the aspects together—health, social care and the council. Having that communication and that place to discuss resource and so on is important. It is absolutely partnership working that has meant that Aberdeen has the lowest delayed discharges.

The Convener: I hand over to Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): Good morning, panel, and thanks for all your submissions. I would like to dig more into how you all got on during the

pandemic. We have heard some good evidence about how people worked and collaborated. Margaret McCarthy, you said that you really had to think outside the box. Can you tell us about what happened during the pandemic and how we can harness that work to take it forward into the national care service?

Margaret McCarthy: I echo that. We were in a consortium, but providers and health partnerships rallied round together. There was more of a cohesive approach of all being out for the one goal of ensuring that services were delivered. Initially, during the pandemic, it was not like that, but we saw that collective approach across the whole country during the crisis in May-June time, when things were getting heavy. Partnerships and providers were all trying to figure out, "How does this work? How can we deliver?"

11:30

On the pandemic, I come back to staff. When every other set of staff in the country retreated, all our front-line staff went forward. They were there on their own, doing what they do every day. The fact that there was recognition of that galvanised them. They could see that the public were behind them and that everyone thought that they were doing a fantastic job. Unfortunately, as we come out of the pandemic, that has stopped. People have exited the sector a lot more quickly because they cannot see where their value is, whereas during the pandemic they were recognised as having massive value.

I would not like to say, "We did this and we did that." The biggest thing for me during the pandemic was the experience of the value of front-line staff, who did everything that they could do to ensure that their service users had some sort of delivery, knowing that they were the only people they would see throughout the day. There was a learning curve for us as an organisation. We learned not to underestimate our front-line staff. We never underestimated them before the pandemic, but we learned how important that is. Their value was pushed up. There was a whole process of co-production, working together and collaboration.

What also helped was the fact that some local authorities had more understanding, and the fact that they paid not on actual hours but on planned hours took a lot of pressure off organisations. Whereas, previously, we had CM2000 and we had to clock in and clock out, all of that was stopped. The fact that we were allowed to look at stepping up and stepping down on time and task gave a lot more autonomy to providers. I hope that the pandemic proved to authorities that, as providers that deliver the service, we are able to make those decisions and that we do not need someone telling us, "This is a half-hour call and you can't do any more than that." We can be given X hours that we have to deliver for clients and can figure out with the client when that is delivered to them. I think that the pandemic brought that more to light.

Fanchea Kelly: There are a few aspects that I would like to mention. In housing and care—we are talking mainly about care today—what our front-line staff needed to be able to deliver in order to keep customers safe became the absolute focus. As a leader, I learned more about masks than I ever wanted to know. The nature of the crisis meant that it was dead important that, at all levels, we had that understanding and that we applied it in how we went about procuring supplies and so on.

We were able to use the national guidance and to interpret it for our staff. The fact that we could give them those tools and say, "Here's what you must do," meant that they had really clear guidelines. They understood that the purpose was to keep not just the customer, but themselves and their families, safe at that time. We were very proud of the fact that we managed that well, although there were a lot of ups and downs during the period. None of us will forget it.

The learning that has come out of the pandemic is absolutely massive, and it will probably dictate what we do in the next 10 years. I absolutely agree with Margaret McCarthy on the waste that there was in the system, whereby we counted one another in and out, which costs money and time. That was simply not needed and it was demonstrated that it was not needed. We are a member of the consortium in Aberdeen, too, so we understand that that has helped to change where we use our resourcing. Frankly, there is now more useful output.

We learned a lot of things like that, but what was most important for us as leaders was the fact that there was recognition of the importance of the job at the front line. People were very clear about how much we valued and appreciated that. That is partly why we want the committee to be clear about the fact that that job is just as important now as it was during the pandemic in keeping people safe; it is also important in helping them to live in a way that they choose to live a bit more.

The Convener: I want to respond to something that Margaret McCarthy has said a couple of times. Margaret, you said that, during the pandemic, staff had autonomy to make decisions based on client need without the system dictating what they should do and that they felt valued because they had that autonomy but that, since the pandemic, people feel less valued. Do you think that those two things go hand in hand? Has the system come back in and taken away the autonomy? How do you see the national care

service being able to provide a framework so that the autonomy comes back and there are better outcomes for staff and the people they care for?

Margaret McCarthy: I totally agree with that. It does not apply in all areas, but, during the pandemic, some of our partners in authorities were too busy doing other things, so they said, "Please get on with it. We trust you to get on with it." However, now that we are out of the pandemic, it is a bit like they are saying, "No, we don't trust you to get on with it. Can we take that back?"

The Convener: Even though you proved that you can be trusted.

Margaret McCarthy: Even though we proved that. I do not disrespect that approach, because, at the end of the day, authorities have to work within guidance and legislation, and I appreciate that some of that was suspended during the pandemic to allow other things to happen. However, for providers, it was like one day we had the autonomy to make decisions and the next day we did not.

I would like to see the national care service bill push that autonomy. A bit like what Nick Price said around the Granite Care Consortium, providers should be able to make those decisions collectively, and our doing so is actually for the greater good. It is not about providers trying to have autonomy to create a big thing for ourselves; it is so that we can deliver for the people who use the service every day. If we all want to work for the same greater good—clients—then some of the bureaucracy and autonomy has to change.

The Convener: There has to be flexibility to meet need.

Margaret McCarthy: Absolutely. At the end of the day, I see our staff on the front line having autonomy, because they are working with clients every day and I am not, so they should have autonomy to make decisions. We give that autonomy, but how much autonomy we can give staff is restricted by contracts and the time-and-task approach. Front-line staff should be able to make decisions such as whether a person will shower today or tomorrow, if they think that today is not the best day to do it.

The Convener: If we get that right, and if people have autonomy, do you think that it will go some way towards stopping their leaving the sector?

Margaret McCarthy: The reason why people stay in the sector for a long time is certainly not pay; people stay because caring is what they want to do. The more we value that, the longer people will stay and the more people will feel they are getting something back. Everybody wants to leave their job at the end of the day and feel that they did a really good job and had a good day. The further we go down the route of not paying staff well and putting them into boxes in which they cannot move and make decisions, the less often people will leave their work at the end of a shift and feel that they have had a good day. Pay rates and valuing people go hand in hand.

Nick Price: Your conversation with Margaret pretty much covered everything that I was going to say.

The only additional point that I will make is that, at the moment, we hear a lot about the current pay disputes with the NHS. During the pandemic, care staff were considered as equal—they were trusted, respected and so on. However, now that we are out of the other end of the pandemic, the NHS is looking at a 7.5 per cent pay rise, at least, and social care staff are not, so they are back to feeling undervalued again.

Emma Harper: Both Margaret McCarthy and Nick Price spoke about trust, and Jim Gatherum, from Notwen House care home, in Dumfries, said that we should focus on trust and relationship-centred care, which all relate to the previous questions about autonomy. Do the witnesses think we should ensure that the bill focuses on autonomy, trust and relationship building as ways in which the national care service should support people?

Margaret McCarthy: The national care service should be built around co-production, because it is all about our working together towards the same goal. I back—100 per cent—the suggestion that the bill has to be about relationship building, trust and collaborative working. Everybody should have an equal share on the table. There should be a level playing field rather than providers and authorities being separate, which is how it feels sometimes. To achieve that, I would like to see that being more robust in the bill.

Sandesh Gulhane: I will turn to Peter McCormick. Randolph Hill is concerned about the NCS creating unnecessary bureaucracy. How do you think we can keep that to a minimum?

Peter McCormick: I put in my submission that, during the pandemic, a number of different things occurred in reaction to an unknown virus that would have an unknown affect on people. To a great degree, we can understand why that happened. However, an awful lot of things seem to have become embedded in the system, and we seem to have accepted that they are here and we will leave them in place.

I think that there needs to be a full-scale root-and-branch look at the various things that are being asked of the sector in terms of information provision. Do we need to ask for those things today? Is it really necessary? It is all very well for

someone to think, “I’d quite like this information.” That is fine, but I do not think that the amount of work that is going into providing the information is being weighed up against how much it is used at the other end.

A whole raft of things have happened—some for good reasons and some not. I understand why, in the difficulties of the pandemic, those things happened, but we could do with a pause so that we can go back and look at some of those things.

Sandesh Gulhane: A lot of the organisations that are involved with the NCS seem to have overlapping responsibilities. Are each agency’s roles and responsibilities sufficiently outlined in the bill?

Peter McCormick: I do not think that they are outlined in the bill as it is written. There would need to be far more detail. Again, historically in the care home sector—and I think the care-at-home sector is the same—our regulatory body before the pandemic was the Care Inspectorate. A number of other bodies have been asked to come in and look at things, particularly the health boards but also the health and social care partnerships and social work departments.

The Care Inspectorate is a national body and has parameters that it works to. I may have all sorts of comments about that, but at least we understand the framework in which it is working. During the pandemic, different health boards and different health and social care partnerships were looking at different things. I think that it would be good to have some consistency. During the pandemic, it was quite difficult that we were sometimes getting different, conflicting advice from different agencies, which was nigh on impossible to deal with.

The Convener: Stephanie Callaghan has some questions about housing and care.

Stephanie Callaghan: Fanchea—I hope that I am pronouncing your name properly—it is helpful that your submission sets out three clear priorities for the bill to discover and deliver on: empowering individuals to have more choice, clear leadership and support for using digital service design, and the inclusion of representation by housing organisations. Looking at the digital aspect, you spoke about a much greater and more explicit join-up between digital health and care strategies and focused intentions for investment. What would that look like? What recommendations would you like to see in the committee’s report?

Fanchea Kelly: You can tell that we are frustrated that the bill has focused mainly, but not exclusively, on structures—although there is some information on principles—rather than on changing the way of working so that individuals can have more choice in and control over how they live. Our purpose is to help people to live independently, and we try to do that regardless of the service, whether that is housing or care.

A lot of our work has been trying to make sure that people are digitally included—that they have not only the skills, but also the devices, to allow that, and we try to understand their digital needs. Early on, we worked with the Edinburgh health and social care partnership on the night support service, which goes back four or five years. Our manager, Linda Brown, is sitting behind me. More than 200 customers go through that service, which has saved the health and social care partnership a significant amount of money.

That gave customers choice and control over who they wanted in their house; they did not want the 15-minute visits by people whom they did not know. They could also stay in control of how they contacted us. The original assessment helped work out the best way of doing that. That was done through our system called Clever Cogs; it had helped through videoconferencing—really, it was a video calling system.

11:45

The service works very well. Often, the people who were involved in a person’s care felt that the person either would not be able to use the system or that the risks were too much, but in many cases they were totally underestimating what people wanted to do and could do. I could give you a lot more on that. Having worked through that, we now have significant experience of what people want and need from a digital service that helps them to look after their own health and wellbeing and to prevent things such as unnecessary calls to ambulances.

What we have been talking about is a crisis in workforce, and given demographics, that will not change quickly, as far as we can see, even with better pay and conditions. We think that there should be a much clearer focus on digital services to supplement or augment, although certainly not to replace, the human element. We feel that we are missing a trick.

The main conference of DigiFest is on tomorrow, I think, although its online events have been going on for a month. Having that link with the digital health and care strategy is fundamental to realising what can be done now, rather than just talking about what happens in three to five years when the national care service will be operating fully. We think that much more is needed in the bill on recognising that digital is a legitimate way of working. In the meantime, that would also get the health and social care partnerships, and us as providers, to ask and answer the questions about appropriate use of digital in the next while.

This involves questions of data ownership, which is a big issue. The practice of us all using digital more in ways that suit us is really important.

Our experience in Edinburgh is that things have gone back a bit. We have extremely good relations in Edinburgh, and we do some work in Glasgow, but things have gone back a bit to the bureaucratic stuff that people feel they must do in the commissioning routes. There is stuff that we could take away, but in a service like that it is more about scaling up and mainstreaming, in commissioning terms. That is the kind of background that the bill could help to bring forward.

Without knowing the detail of the bill, it is quite hard to say exactly how it fits in, but that absence is stark. The bill is really missing a trick that could save a lot of time and money and give people more choice about how they live.

Stephanie Callaghan: Thanks very much. I will stay with you for a moment, Fanchea. You say in your written submission that the bill should

"include representation by housing organisations"

and that its being about wellbeing and prevention is absolutely central. We know that there has been variation among health and social care partnerships and that some really good work on providing wraparound care is being done in some areas, while in others it is simply not as strong. You have described the omission of housing as being a "significant concern". Could you say briefly how its inclusion would help the population to live healthier lives for longer at home? Would the other witnesses agree or have alternative views?

Fanchea Kelly: I will be brief. For us, it is about neighbourhood and community, and, within the neighbourhood and community, having a range of ways of accessing services. You can do that—there are plenty of examples. Maybe it is back to the good examples to say that those underpin the local co-production.

Again, our concern is about the big structures taking over the discussion. At neighbourhood level, the question is how to get the range of services where people live—their house, their neighbourhood and their care services—not join up but fit together with the right representation on the accountability structures. That is what we would like to see.

Stephanie Callaghan: Thank you.

The Convener: I will move on to the final theme of measuring success and hand over to Paul O'Kane.

Paul O'Kane: I will try to draw some of this together and think about the broad theme of how we will measure the success or otherwise of the bill. There has been a lot of discussion this morning, and with other witnesses, of Derek Feeley's review and of how to achieve what was set out in that review. How will we assess and measure the success of the national care service bill, and will the current level of detail in the bill be sufficient to allow us to judge whether it has achieved its aims? I will start with Peter McCormick, and then Margaret McCarthy, Fanchea Kelly and Nick Price might want to come in.

Peter McCormick: You could glibly say that the way that you measure success is by whether people get the care that they need, wherever that is. There are all sorts of ways that you can look at that. We talked about the health service and the number of people who are inappropriately still in hospital waiting for a placement and the number of people who are unable to get the care that they need because that is still to be assessed or provided. That is the number-crunching aspect of it but, to go back to the initial point, it is just about whether people get care when they need it.

Paul O'Kane: In the Randolph Hill submission, you spoke about being concerned about an absence of criteria to judge success or failure. Do you recognise that there is not enough detail in the bill to measure success against?

Peter McCormick: Well, perhaps, and that could be said with regard to recent history, too. In various meetings with colleagues from the partnerships and so on, there is a lot of talk about the difficulties that they are having in relation to the crisis, but, for some strange reason—I always find it slightly surprising—it is not talked about in much detail in the press. It seems to be a hidden issue.

In various meetings—I am largely based in Edinburgh and the Lothians—I have heard about a fairly large amount of care-at-home provision that is not being provided because providers do not have the resources and because, perhaps equally, the partnership does not have the resources to pay for it. That just does not seem to be a topic that is discussed by the general population, which surprises me so much, because we all have elderly relatives and we all, I hope, will be elderly ourselves, so the issue has an impact on a huge proportion of the population. However, it seems to be an undertone in the press rather than a topic that is discussed as much as it should be.

The Convener: Do you want to bring in Nick Price?

Paul O'Kane: I am interested in any of the other witnesses' comments on the broad question about measuring success.

Nick Price: We must consider the system-wide impacts: the flow through the system, the

recruitment and retention of staff in the sector, the impact on unmet need in the different partnerships, delayed discharges and end-user satisfaction with services. A multitude of elements need to be considered.

Paul O'Kane: Nick, do you recognise that many of the things that you have just said are, at their heart, Derek Feeley's recommendations?

Nick Price: Yes, I guess so, but I also think that, if you had talked to any provider or commissioner before the publication of Derek Feeley's report, they would probably have said the same thing. I am sorry—I might have jumped in there.

The Convener: It is always difficult when people are online. I apologise, and I will bring in Margaret McCarthy now.

Margaret McCarthy: Measuring success is always a difficult issue, because you have to consider whether you measure success by hard or soft outcomes. Therefore, it might depend on how the care service develops. There must be a fundamental shift in how we deliver support in the community—we all know that. We cannot keep delivering what we are delivering just now. The national care service and the bill represent a fantastic opportunity to evolve that and make it happen. The measure of success will be the consistency of people getting the service that they need once the bill is passed.

I look at that in three ways. First, we would have staff recruitment and retention because people will be really excited to join the care workforce—that would be a massive measure of success.

Secondly, service users would get the service that they want when they need it. If service users get what they need at the time, we will not have hospital admissions, so, although discharges might not become a thing of the past, they will not be so hefty a burden for the health sector.

I keep coming back to this, because we have a significant number of unpaid carers. Thirdly, if we get this right, unpaid carers will be able to continue to do their job of looking after their loved one, so hospital admissions and so on will not happen, and the need to put in crisis service will reduce.

Whether we have soft or hard measures at the end of the process is a difficult question, but, if the bill has the detail in it, we should see those measures once it is passed.

Fanchea Kelly: I agree that the fundamentals are that people get the care and support that they need. Early intervention or prevention is hard to measure; again, where we come from on that point is that, if you put an obligation in the bill, we have to find ways to measure those things and make it clearer that we are preventing crisis. Ideally, we would then be making a better use of resources.

The discussion that we have had—you can probably hear it underneath all this—is that we spend a lot of our time on things that we do not see as useful to outcomes, so it would help if we could move towards doing more against outcomes.

I have just talked about the digital aspect; we definitely think that there should be some measure of our looking at innovations that serve Scotland well. Given the amount of investment that would go to that aspect, it is really important that Scotland be seen as a leader in innovation with regard to how the population is served around care and support and, in our terms, helping them to live independently. We would love to see something on that, alongside the normal measures of accountability on the aims. Fundamentally, we are saying that some of the aims might need to change and bring different measures with them.

Emma Harper: We are talking about how to measure success; I have a question for Nick Price on that. You said that, due to the pandemic, the chief of the IJB has developed a way of working, with the Granite Care Consortium, that has actually been successful—we heard that feedback. What the GCC has been delivering has been called a care board model. Do you recognise that, and should we consider harnessing that model as we take forward the national care service bill?

Nick Price: Absolutely. One thing that has changed since the implementation of the GCC is that the providers—this sounds terrible, but I do not mean it to be as raw as it will sound—were heard. We are an equal partner at the table; we have quarterly strategic management team meetings with the chief officer, the chief financial officer and the head of commissioning, who hear from the horse's mouth about what is going on at ground level. That level of engagement, trust and partnership will be critical for how the NCS is constituted.

On measuring success, my only question is about the point at which we start to measure. Where should we draw our baselines? Do we start to measure now? I do not want to be all doom and gloom but—as I said earlier—I have never seen the sector so bad. The gap is widening between the increase in unmet need and the reduction in the care and support worker resource. If we do not start to close the gap now, I do not know what will happen. Something must be done sooner rather than later. We need to gather those metrics now so that, if and when the NCS comes in, we can truly see its impact.

12:00

Emma Harper: I have a wee final question. Nick, you said earlier that, when your chief officer put forward ideas, people were nervous about them. I know that it is difficult to accept and adopt change; some folk are total change agents, while others need a lot of coercion. Do we need to harness your chief officer's approach, given that a lot of trust was required to deliver the change that was necessary for the Granite Care Consortium and that you are now leading the way? Indeed, I have heard that you are now working with Dumfries and Galloway Council with regard to the lessons that it can take from you on how to deliver things in the south-west of Scotland. I am interested in hearing about the change aspect.

Nick Price: With any change, it is all about having trust in the lead change agent and, indeed, in their credibility. I have known Sandra MacLeod for quite a long time and worked with her beforehand, so I knew her, got her vision and understood where she was coming from. I think that people were reticent because they were looking at retendering the whole care-at-home service right at the start of the pandemic. Some of the consortium's board members did not meet face to face until a handful of months ago; we did all our tendering and our meetings through Teams. If we can achieve what we have been able to achieve in such circumstances, there is no reason why we cannot achieve the same at national level.

The Convener: James Dornan has the final question.

James Dornan: Most of the stuff that I was going to ask about has already been covered, but I just wonder whether any of the panel members have been involved in the co-design activities that have been held to date. If so, how did you find them? If not, would you be keen to be part of them? What would you like to see from those activities?

If you do not mind, I would like to start with Fanchea Kelly.

Fanchea Kelly: Are you talking about co-design with health and social care partnerships or co-design with the communities?

James Dornan: No, I am talking about the NCS.

Fanchea Kelly: We have not been involved directly in work on the NCS, but we have had a chance to make submissions and so on. I think that, at local level, there is still quite a lot of confusion about how you can get involved with co-design and how that can be taken forward.

From our experience of working with the health and social care partnerships through, for example, housing contribution statements and strategic planning groups, we know the processes, and we would like this work to build on the best of that—to use a phrase that was used earlier. Given our role, we would love it if there were more opportunities for co-design work on housing and digital support in neighbourhoods and communities.

The Convener: I want to go round everyone on that question. Have you been involved in the co-design work that has taken place so far, and how would you see yourselves being involved after the bill is passed and once the co-design process begins?

Margaret McCarthy: Like Fanchea Kelly, we have had limited involvement with the health and social care partnerships on this particular matter, but there is an appetite across the country for more involvement. We need to be at the heart of the co-design process. There is best practice to draw on across the country; there is, for example, the Granite Care Consortium, and we, too, work with Dumfries and Galloway.

The reality is that we are already starting that process and are testing changes to a more co-designed way of working. I would therefore welcome more involvement in the process that we are talking about, and, as I have said, it would be good if we could look at and try to echo practice around the country.

Peter McCormick: Similarly, I have not been involved in any co-design work on the national care service, but we already work with the local health and social care partnerships as well as the health boards and will continue to do so.

Going back to the trust element that we talked about earlier, I think that different partnerships in different council areas are working in quite different ways, and not all of that work is happening on the basis of trust. Although we all work together regularly, it does not feel as though we are always brought in; instead, it feels as though we are brought in only on occasion. In fact—and there will be a number of reasons for this—we can sometimes feel blindsided by certain changes that have been made and which no one ever spoke to us about.

Of course, everyone is busy, and one of the difficulties for the sector is that, from a time point of view, it is quite challenging for one provider or another to be constantly involved in this work. If the various umbrella organisations such as Scottish Care could co-ordinate things, it would help, but I go back to my earlier point about trust. We need a process that is on-going and constant, not something that we dip into and out of.

Nick Price: I have not been personally involved in co-design work for the NCS, but there are a lot of experts throughout the country who are involved in care-at-home services and I encourage those

individuals to be involved. I am sure that GCC representatives will happily give up their time and get involved, too, and Scottish Care and CCPS will absolutely do so.

The Convener: I thank all four witnesses for giving their time this morning in what has been a very helpful session. As I told the other panel of witnesses, it is great to hear your recommendations and ideas about what you want the bill and the national care service to look like.

At our next meeting, which will be on the afternoon of Monday 5 December, the committee will continue its scrutiny of the National Care Service (Scotland) Bill with two more evidence-taking sessions. I should also say that it will be an external meeting in Glasgow.

That concludes the public part of today's meeting.

12:06

Meeting continued in private until 12:25.

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