OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 11 June 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

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CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE
19th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Carol Mochan (South Scotland) (Lab)
*David Torrance (Kirkcaldy) (SNP)
Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

David Aitken (East Dunbartonshire Integration Joint Board)
Diane Fraser (North Lanarkshire Integration Joint Board)
Stephen Morgan (Dumfries and Galloway Integration Joint Board)
David Williams (Clackmannanshire and Stirling Integration Joint Board)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 11 June 2024

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 19th meeting of the Health, Social Care and Sport Committee in 2024. I have received apologies from Tess White. The first item on our agenda is to decide whether to take item 3 in private. Do members agree to do so?

Members *indicated agreement.*

Social Care (Self-directed Support) (Scotland) Act 2013 (Post-legislative Scrutiny)

The Convener: The next item on our agenda is an evidence session with integration joint boards as part of phase 2 of our post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013. I welcome David Aitken, who is head of adult services at East Dunbartonshire IJB, and Diane Fraser, who is head of adult social work at North Lanarkshire IJB, who join us remotely. I also welcome Stephen Morgan, who is service director in social work services and chief social work officer at Dumfries and Galloway Council, and is representing Dumfries and Galloway IJB; and David Williams, who is the interim chief officer of Clackmannanshire and Stirling IJB.

We will move straight to questions. What input have health and social care partnerships had in the development of guidance, strategies and standards to improve the full adoption of self-directed support? Who would like to start?

David Williams (Clackmannanshire and Stirling Integration Joint Board): I am happy to start, convener. The Clackmannanshire and Stirling health and social care partnership has an IJB meeting next week. We are going to take a self-directed support policy to the IJB for approval, from which a direction will be issued to both councils to require and support their staff to implement the self-directed support legislation in full.

It sounds like that is happening a long time after the legislation was implemented and a long time after health and social care integration was put in place, but we have some unique circumstances in Clackmannanshire and Stirling. Ours is the only partnership in the country in which two councils have agreed to have a single integration authority. However, the consequence that has been played out over the past eight years is that no singular approach is being taken across Clackmannanshire and Stirling that meets the needs of people with adult health and social care needs. There have been—shall we say?—differing approaches to the implementation of a number of things, not least of which is the self-directed support input.

Since I commenced my interim role at the beginning of December, my approach has been that we need to ensure that there is a “once for Clackmannanshire and Stirling” approach to the delivery of services and that a singular policy is followed. As I said, we are going to the IJB next week with a policy that will be set out.

In fairness to officers in the partnership, there has been a recognition of the position over the past two or three years. An independent review commissioned by the health and social care partnership in 2021-22 identified issues of separateness and disparity. The Scottish Government's SDS finances were utilised to fund a lead officer, who was expected to develop ways forward on that. She did a huge amount of work in that space in 2022-23, before going off on maternity leave. There was then something of a hiatus prior to her returning to her post in December. In fairness to her, she has absolutely flown in that time by developing policy and processes, looking at best practice elsewhere—we have been to East Dunbartonshire to look at what it is doing in relation to self-directed support—and putting in place learning and development opportunities for the workforce across Clackmannanshire and Stirling.

The Convener: For clarity, are you saying that Clacks and Stirling were working differently but are now looking at a joint approach that will be the same right across the two local authorities?

David Williams: They are not doing that particularly, but I will be asking the IJB to put in place a policy that will expect them to take that approach. The IJB will issue a direction to support staff to implement a policy that has not existed hitherto.

The Convener: Over to Stephen Morgan. You do not need to touch the microphone; broadcasting staff will operate it.

Stephen Morgan (Dumfries and Galloway Integration Joint Board): Thank you. It is somewhat different in Dumfries and Galloway. We are quite fortunate that the boundaries for the health board and the local authority are the same, so, when the IJB was set up, social work, adult social work and social care were integrated with almost all health services, including acute services. At that point, we developed policies for self-directed support in line with the 2013 act, but they have not really been properly reviewed since implementation, for various reasons.

In the partnership, we have general managers; we do not have specific professional managers, although there is professional advice, which, for social work for example, comes through me as chief social work officer and is delegated to other people.

We are aware that our policies and some of our practices need to be reviewed and updated. We are currently looking at the new regulations and seeing how they best fit across the region. We are aware that all our staff who undertake assessments are fully trained on what we expect around self-directed support.

The IJB is clearly the governance body, and all decisions around what we do and how we do it are taken through that. Our situation is somewhat more straightforward than that of my colleague.

The Convener: Diane Fraser, do you want to come in?

Diane Fraser (North Lanarkshire Integration Joint Board): Good morning. We are in a different position in North Lanarkshire. We have well-developed approaches to self-directed support. We were probably developing our policies and procedures from around 2010, so it has been a long journey for us. SDS is well established in our policies and procedures in relation to delivering the four options.

Over recent years, we have really focused on the broader offer and looked at how we invest in information, advice, prevention and early intervention work, including through investment in community services. We work closely with our community voluntary services, and we have a different commissioning framework. We have a 10-year framework that was launched in 2021, which allows for more flexibility for those using self-directed support or choosing to have paid care. We have spent a significant amount of time developing that framework, primarily focusing on adults and children. In 2021, we launched a framework that covered all individuals. We have been in a process of shifting from what was traditionally known as a time and task model to annual budgets for individuals. That has all been underpinned by significant engagement and participation.

Over the past few years in our recovery from Covid, we have spent time engaging with carers in developing a carer strategy, as well as with communities and individuals. We are developing community hubs. As part of that process, we have been engaging with a range of communities of interest, as well as different geographical communities, and we are really beginning to understand the gaps in our services.

It has been a long journey for us, and we recognise that there is still lots to do and lots to improve in how we develop self-directed support.

The Convener: David Aitken, do you want to come in?

David Aitken (East Dunbartonshire Integration Joint Board): Thank you, convener. Similar to North Lanarkshire, we have had a self-directed support implementation plan since 2012. The most recent iteration is a three-year implementation plan for 2024-2027. We have developed and sought to apply our asset-based support planning across all services, and SDS is very much established as the framework that sits

behind the delivery of all our children's and adult services.

We have sought to utilise that as creatively as possible—indeed, we have some examples of really highly creative uses of SDS, all of which have a slightly different focus—and we have looked at how we can continue to explore and develop innovation across self-directed options 2 and 3, which have been very underutilised and have not been focused on as much.

Moreover, our SDS business development group, which meets twice yearly, brings together people who use our services, our third sector and all our partners locally to look at how we can roll out self-directed support. [*Interruption*.] Sorry, convener?

The Convener: I am sorry—I thought that you had finished.

David Aitken: I will draw to a close by saying that we commission a third sector provider for our take control East Dunbartonshire service, which is an offshoot of the Glasgow Centre for Inclusive Living. With our advocacy service, the take control service and other third sector partners, we have created a community of interest for self-directed support in East Dunbartonshire, which has been a driving force in our progress towards implementation.

I am happy to take questions, convener.

The Convener: What you have said leads on to my next question, which is about the extent to which the principles of SDS—that is, people having choice and control over how they receive care and support—inform social care delivery in your areas.

Stephen Morgan: That is a really tough question, if I am being honest. I have already talked about the size of Dumfries and Galloway; it is 6,500km^2, with a population of 150,000, most of whom live in and around the Dumfries area. As far as the principles of the legislation are concerned, our social workers and other staff who undertake assessments involve people as much as they possibly can, but when it comes to delivery and support planning, things are incredibly challenging, because of the difficulty of accessing resource and giving people choice.

Currently, 800 individuals access option 1. Virtually zero access option 2—it is not quite zero, but it is virtually zero—and just over 2,200 access option 3. Under option 3, we deliver 46,000 hours a week, but we also have anywhere between 3,000 and 4,500 unmet hours of need, which shows the challenges that we face. It makes it tremendously difficult for people to have the choice that we would want them to have.

Third sector involvement in the region is limited with regard to the other options. Our care-at-home market is a mix of in-house and private providers, but private providers have limited reach across the region, with quite small pockets of provision, and the costings can vary. With option 1, people are struggling to find someone living nearby who can take on the personal assistant role, and the difficulty involved in becoming an employer puts people off. We do have some services that assist us; for example, Capability Scotland is a tremendous organisation locally, but its capacity to support is fully used.

Therefore, this is a real challenge for us. As much as we try to encourage innovation and look at different ways of commissioning, the area itself makes things difficult. Pay is another difficulty for those who come into social care; staff can get employment elsewhere, and we see them moving through the care system quite rapidly. It is, as I have said, a challenge. I must be absolutely honest with the committee and say that the situation in which we find ourselves is a difficult one.

The Convener: Emma Harper has a supplementary on this.

Emma Harper (South Scotland) (SNP): Good morning. I wanted to pick up Stephen Morgan's point about the difficulty in becoming an employer and people being put off as a result. Why is it difficult and what would make it easier?

Stephen Morgan: I think it is about the perception of how difficult it might be. Having appropriate support in place for those becoming an employer is great; when we have had services to assist people, they have reported back that it was easier than they thought, and they have publicised that by word of mouth.

Our social work staff and others who undertake assessments are pressed for time when it comes to having conversations about becoming an employer. Moreover, some staff are not skilled in that area themselves, so we need to train them, and we have a programme in place that looks at the skills that our workers need. The perception, though, is that it is difficult.

I should also say that our unpaid carers really help the system move and are a tremendously important cog in the social care machinery in Dumfries and Galloway. We need to support them better than we do by, for example, looking at carer support plans. Without them, it would be even more challenging to support people's care.

09:30

David Williams: Our colleagues in East Dunbartonshire and North Lanarkshire have

highlighted this already, but there needs to have been a cultural shift in relation to the perception and delivery of social work and social care. As colleagues have identified, the move towards a much more personalised approach was first identified way back in the early noughties in "Changing Lives: Report of the 21st Century Social Work Review". It heralded the direction of travel, if you like, in terms of offering much more choice and control for people who are receivers of formal social work services.

However, that was always going to be a journey or require a cultural shift for social work practitioners, social work departments and councils in the main. Some really embraced it early doors, as we have heard, but there are other challenges that are particular to other places. Stephen Morgan highlighted some of the challenges of rurality in Dumfries and Galloway in particular, and I highlighted the example of the two councils that, despite their history of having a shared service, found that relationship almost dissolved with the onset of integration. Certain relationship issues can come into play and prevent the development of provision as expected.

We also ought to acknowledge that self-directed support, which is a fundamentally different way of doing social work stuff, has been implemented at exactly the same time that the system has been facing other pressures that are considered or perceived to be as pressing or to have more priority.

I see that you want to come in on that, convener.

The Convener: I do, because you are telling me about the issues with the system, not how SDS is informing how you develop a social care system.

David Williams: That is a fair point and a fair challenge. I suppose that the point I am getting to is that I am not entirely sure that that has been the outcome in Clackmannanshire and Stirling, based on what I have seen. Indeed, that is why we are taking a policy to the IJB next week.

Very significant work has been undertaken. We have good relationships with voluntary sector providers: SDS Forth Valley, for instance, has been commissioned by the two partnerships in Forth Valley—in Falkirk and in Clackmannanshire and Stirling—to do a lot of that work. We also have early engagement with people who wish to undertake self-directed support.

One point that I would make, though, is that the system needs to accept that the one thing that the self-directed support legislation was expected to bring in—a single route to the assessment of need within a council area—has not happened. We continue to have more than one such route. Some of that is just traditional, and some of it is about having to respond to service demands from within the hospital system, in which the time pressure to get people out of hospital does not provide an opportunity to have a much more considered and qualitative conversation with them.

The Convener: We will come to that later on. Ruth Maguire has a supplementary.

Ruth Maguire (Cunninghame South) (SNP): In some ways, this is quite a difficult question to frame so, if I may, I will just be direct. David Williams, is it correct to say that the decision on how to structure a health and social care partnership is a political one?

David Williams: It is a joint decision between the council and the health board. In Clackmannanshire and Stirling, both councils agreed with the health board on the setting up of the integration authority. Under the Public Bodies (Joint Working) (Scotland) Act 2014, health boards and councils had two routes to do that. One route was to put in place a lead agency, which is what happened in the Highlands, and everybody else went for an integration joint board.

Ruth Maguire: At the beginning of the evidence session, you reflected that we are quite a long way down the road for integration, so I am trying to understand what has gone wrong. Services that had, historically, been delivered jointly were dissolved almost immediately when things were integrated. It will be helpful for the committee to understand whether such decisions are led by officers or by political leadership.

David Williams: I understand that Stirling Council took the decision to dissolve the shared service. It extricated children and family services and criminal justice services from the shared service, and it left Clackmannanshire Council to provide its own children and family services and criminal justice services. At the same time, the 2014 act, which was about adult social work and social care, came into effect. I do not know why a decision was taken to retain a shared approach in that bit of the business when a decision had been taken to separate children and family services and criminal justice services.

Gillian Mackay (Central Scotland) (Green): Good morning, everyone. We have heard continually about regional variability in the implementation of SDS, and the care experience survey that was published on 28 May reveals significant variability in the satisfaction and experiences of people who receive care.

What specific measures are you all taking to address regional disparities in social care? What best practices can be shared in an efficient manner by IJBs and HSCPs that are doing better than others?

David Williams: As I indicated earlier, we have undertaken a significant amount of work to look at how other areas have been working. We have spent a considerable amount of time with colleagues in East Dunbartonshire to look at their approach, particularly in relation to the paperwork and processes that their staff use in order to take a co-produced, joint approach for individuals. We have also taken account of what happens elsewhere while developing the paperwork and processes that our social work staff across Clackmannanshire and Stirling will be expected to use together.

Stephen Morgan: In Dumfries and Galloway, we look at what is available in every community. We have community conversations and carry out community needs assessments, and we try to tie in the strengths of the individual and their family, neighbourhood and community, when that is possible. Doing that is different in Langholm, Wigtown and Dumfries, because there are different levels of population and service delivery. We try to understand what is available in those areas, and we continue to take a place-based approach.

We have an ambitious 10-year commissioning plan, which we call “Right care, right place”, the aim of which is to identify what is available in each area and link people to those services, using the principles of the 2013 act.

Earlier, I mentioned the training of social work and social care staff in relation to the innovation and different thinking that we want to see, because we have a traditional approach to assessment and delivery. When I say “we”, I mean not just the professionals who are involved but the people who receive care in relation to what they ask for. That is how we try to get a level of access across all areas.

The point is that we will not get the same choice in one part of Dumfries and Galloway as we will get in another, and it is impossible to achieve the same level of choice across Scotland, so we have to understand our different communities and what we can do within them to get the best possible outcomes.

Gillian Mackay: Do any of the witnesses who are joining us online want to come in?

Diane Fraser: In North Lanarkshire, it is about how we improve access and ensure that people have information and advice, it is about taking the survey results and thinking about how we work collaboratively with the third sector and with our colleagues in the independent sector, and it is about training. We have been very active in the collaborative and in the community of practice for SDS, and we are looking at piloting training for those at different stages, from the people who give information and advice to the professionals who undertake assessments.

We have also looked at different initiatives as part of our recovery from Covid. We looked at how we could support carers and improve their situation. As Stephen Morgan said, unpaid carers are the backbone of what we do, so we have looked at different initiatives to support carers, one of which relates to hospital discharge. Particularly as we were recovering from Covid, we might not have been able to identify paid care or the choice of care that people were looking for, so we were able to provide financial support to those carers.

We also have a carer breather initiative, which provides breaks for carers. We are working with carers and the third sector on different initiatives to support people.

In North Lanarkshire, as part of our recovery, we have started to look at the community planning structure, and we have re-established our locality planning groups, which are key because, as Stephen Morgan said, each community has different resources and needs. We are looking for our locality planning groups to support the development of different initiatives across North Lanarkshire.

The key is improving access, so we have taken things back to basics by looking at our enabling approach and at how we can identify early help, support and information. Social work’s role is to provide information, advice and assistance, and we are trying to make a shift so that, when people need assistance, we can provide them with information and advice.

With regard to our SDS processes, we have more than 2,000 people with individual budgets. We are able to demonstrate that we are flexible in relation to those budgets, but despite that, as Stephen Morgan suggested, it is difficult to make sure that people get a choice, because the provision is not necessarily available. Recruitment—which would allow us to provide that support—remains a real issue, particularly in North Lanarkshire.

David Aitken: We touched earlier on how to shift some of the culture in that regard. We very much moved to a position in which we established SDS as the mainstream. It is not seen as something different—it is absolutely the model in which we deliver our services and which we work back from.

We recognise that option 3 is not necessarily a bad choice; it suits many of the families that we work with. We have tried to develop and remodel all of our review and assessment paperwork, so that it reflects the conversational elements that we have talked about. It is about the ability to have good conversations that explore what is possible,

what people's aspirations are, what people really want and what, realistically, we can help them to achieve.

We have implemented asset-based training in East Dunbartonshire. Originally, we commissioned that training, and we have now developed a "train the trainer" focus, which has begun to ripple through the organisation. Again, our paperwork reflects the more asset-based approach that we want to take.

That links to the point that Diane Fraser was making. We are trying to develop community capacity in our local areas. It all fits together; SDS does not sit on its own in that regard.

I talked earlier about the cultural links that we have made across our advocacy service and our carer service, which has recently secured additional money to appoint an SDS carers lead, who works closely with the HSCP carers lead.

Those connections are developing across our independent take control East Dunbartonshire lead agency to support people who are looking to access personal budgets through SDS options 1 and 2, as well as our advocacy and carer services.

09:45

We are trying to draw all that together on a basis in which we deliver quarterly multi-agency SDS training and quarterly single-agency training for social work staff. That is very much delivered in line with the principles of SDS and the reasons why it is important to advance it. We have had innovation and creativity workshops, and we have an innovation and creativity directory, which is anonymised and updated each year and details some of the things that we have been able to do.

It is a matter of pushing that cultural expectation, linking it back with our third sector partners and then linking back to our communities. We have been able to take forward that approach, and it very much links into the 12 standards and our framework. We have taken that approach in East Dunbartonshire, and the assessment against those standards—our own self-evaluation—has very much been a multi-agency-produced evaluation. That has helped, and there is a framework for looking at our practice standards, drawing everyone together.

We have been able to do a number of initiatives. Culturally, as Stephen Morgan has said, it is about shifting things and moving things forward.

Gillian Mackay: How, functionally, has the evaluation and monitoring that you do changed with the change in approach? Are the evaluation and monitoring now much more conversational in relation to some of the softer objectives, rather than getting information on the number of care sessions that have been delivered and so on? Does that help to drive and inform other pieces of innovation and tweaks to the system in East Dunbartonshire?

David Aitken: Absolutely. We have monthly, quarterly and annual performance figures—we could rattle off all the statistics. We also have a quarterly review of all our support plans, which focus on assets and outcomes and on good conversations. That percolates through into our review paperwork, for which there is a similar approach, so we are able to draw a line from our initial assessment paperwork through to our review paperwork.

We monitor and draw out the outcomes that have been achieved from our review paperwork on a quarterly basis, and that has the impact of generating a virtuous cycle that allows us to see where the good conversations are taking place, the difference that is being made and where we have been able to apply that approach. That is very much what drives how we continuously reflect, improve and take things forward by drawing out the good examples of where the system has worked.

Some of the things that we have brought in have been quite random. We have paid for a young adult with additional learning needs to attend a dog-grooming course, because they wanted to set up a dog-grooming business in the future. We have considered arranging tennis lessons for a young adult with autism in order to encourage their participation in competitive tennis. Before any eyebrows are raised, I point out that there is always a context and a background, but we have very much sought to push the boundaries of what people can do through that review and the analysis of the work that we have been able to achieve and of how it has met people's outcomes.

Gillian Mackay: What is the staff feedback on that change in how you do evaluation and monitoring? Is there good, back or indifferent feedback from the staff who undertake the evaluation and assessment?

David Aitken: A lot of that work is led by our self-directed support lead, who monitors and reviews all the review support plans. That provides a fairly consistent approach to how that has been drawn out. They can readily identify specific cases or areas that we might want to look at again in order to improve things. That is an additional part of the monitoring and accountability, so we can see not just the areas in which things are working well but the opportunities to make things work better.

Carol Mochan (South Scotland) (Lab): I am interested in hearing about internal processes; you have already touched on some of that and given

some good examples of where you have started to try to work together, with an understanding that that will take some time.

We have heard some evidence from users and other professionals in the field indicating that that is not happening across the board—work is slow, although it is picking up pace. How will it be ensured that eligibility criteria for self-directed care are higher up the agenda for teams working on the ground, and that action is actually being taken?

Stephen Morgan: You used two words—eligibility criteria—that frighten me in this space, to be honest. The national eligibility criteria are archaic and out of date, and constitute a deficit model, which is the absolute opposite of what we all want to achieve through the Social Care (Self-directed Support) (Scotland) Act 2013.

In my view, it is about giving staff permission to look at what people need in their life, and that has to be measured alongside what an ordinary person would have. If someone is 16 and transitioning from childhood to adulthood, their outcomes and life objectives will be very different from those of an 87-year-old gentleman who has lived his life to the full. We have to be quite innovative in our approaches to different needs.

Carol Mochan: I do not disagree with that at all. What I am asking is how we make that happen. We talk about it a lot, but how do we make it happen for people?

Stephen Morgan: For one thing, we would scrap the national eligibility criteria, if we could. The clerks asked me that question beforehand: if I could do one thing, what would it be?

Seriously, if we were to do that, it would give staff the freedom to work outwith traditional eligibility. It is about building up confidence in our staff locally in Dumfries and Galloway. We are in the process of changing our paperwork and processes and looking at training our staff, and I will do a round of workshops with other leaders in the field to give people permission to think differently. The key is to think differently and not be constrained by what we have always done.

Alongside that, I will assist colleagues in the IJB, predominantly in the health and social care partnership as the delivery arm, to rewrite the policy around self-directed support. We will also look at how we audit that. We recently had an audit of direct payments, which in itself is telling because it was based on the old direct payments legislation. It was a finance-based audit and it was very punitive. While there was innovation around somebody receiving a massage for mental wellbeing and mental health, that was criticised from an audit perspective for not being about providing care, but, in relation to self-directed support, it absolutely is.

It is about changing that narrative. We have heard some excellent examples of how that is happening elsewhere, but we need that to happen locally in Dumfries and Galloway. We have a plan in place to do that, but we need to change the narrative.

David Williams: There is also an issue with accounting rules. It is much more straightforward for councils, in managing the budgets, whether that is through the health and social care partnership or not, to account for the spend that they are embarking on if product is purchased on a half-hourly basis or an hourly basis. However, that approach to the process does not accord with the notion of somebody having an individual budget within which things like dog-grooming lessons can be purchased as part of enabling that person to have a life that they want and choose.

Beyond our social work staff, in our respective systems, we need to think about how we are supported and enabled by the governing bodies. They may argue, “Well, these are the accounting rules that are set by other bodies beyond, and we have to be accountable to the public purse” and so on, but there is a whole system at play, some of which makes it really difficult.

Within that, there is an issue about the way in which organisations providing care are encouraged and supported through procurement to put in place support provision in exactly the same way. It is more straightforward for providers to respond to the building of care packages if somebody requires X hours or half hours or whatever per day for an individual to do X, Y and Z. The system does not always easily create the environment where there is a greater degree of flexibility—greyness, if you like—which is what is required around the boundaries to enable supported people to have the life that they want and to choose the options that they want.

Carol Mochan: Does what you are talking about require a culture change, or does it require training or legislative change? What do we need to do to make that happen?

David Williams: It is probably a little bit of all three. I do not know the detail of what legislative change would be required in that space. I am not an accountant, so I cannot make this judgment, but there is something about being able to account for how the money from the public purse is spent, and that equates to best value. What does “best value” mean? For people who need services, best value must mean that they get choice and control over their lives and over the services that they get through the individual budget that is made available to them. Their understanding of something called best value, which guides councils, might be completely different from what the system expects. There is a range of things that

we need to do that probably link to culture and a shift in the understanding of what we are actually trying to achieve.

Diane Fraser: To supplement what Stephen Morgan said, eligibility and our performance measurements do not necessarily sit with SDS or what we are trying to do in SDS, which is to promote choice and control. In North Lanarkshire, we are working with Healthcare Improvement Scotland to develop a human learning systems approach to our work. I suppose that the issue is how we shift that and make the culture change that is needed across the system. David Williams highlighted that in talking about the way that his organisation audits its work through quarterly reviews of support plans. It is about learning from individuals and staff to make improvements. I support Stephen Morgan's point that eligibility and performance currently do not necessarily sit well with the promotion of self-directed support.

Ruth Maguire: I will move on to talk a little about the processes that support individuals and how individuals access health and social care partnerships. How do you ensure that your communities know how to access care and support? Also, importantly, how do you help them understand that self-directed support is the means by which their care and support will be arranged? David, you have nodded, so I will come to you first.

David Williams: That is almost the most important thing that needs to be in place, and we have a lot of work to do in that space in Clacks and Stirling. We are working with partner organisations such as Self Directed Support Forth Valley, which is a voluntary organisation, and through our locality groups and the community planning partnership on the way forward on accessing support and services. There is something about communication and about publicity materials and all those kinds of things. We have quite a distance to go in that space in Clacks and Stirling, but I expect us to be able to get there, because that is what is required.

Stephen Morgan: In Dumfries and Galloway, we use multiple methods. There are advertisements in general practitioner surgeries, local halls and so on, all of which point people towards our single access point. If someone needs an assessment for social care, or by an allied health professional, they come to a single access point. It is about community and systems knowledge so that, if someone sees an occupational therapist, physiotherapist or general practitioner, that professional will know the system and point the person in the right direction.

The system is multifaceted, but we have developed it so there is a single access point. We had thought about doing that pre-pandemic and then we were kind of forced into it—thankfully—during the pandemic. It has been quite successful in getting people to the point of assessment and conversation sooner. After that point, it is about how to work with a person to access their support options. It really is multifaceted.

10:00

Ruth Maguire: Thank you. Do any panel members who are online wish to come in?

Diane Fraser: I want to re-emphasise what others have said about information and advice. We currently commission the Glasgow Centre for Inclusive Living, which David Aitken described. That is one of a range of services that can support and provide advice to individuals around self-directed support in North Lanarkshire.

The issue is how we improve access, and I think that a system-wide response is required for that. It is about whose responsibility it is. However, particularly in health and social care, that can be a range of people. The GP is the first person to meet individuals, so can the GP provide that basic signposting to individuals? It is about how we begin to embrace SDS across health and social care, so that people feel that they have the right information to share with individuals when they talk about social care, and they feel comfortable sharing it. As I think somebody said earlier, social care is not something separate; it is not a different entity. It is about how we deliver social care SDS. There is definitely a culture and leadership issue that we need to address, as well as the need for that systems knowledge.

It comes down to a collaborative approach. In North Lanarkshire, we are working with the third sector, the independent sector and communities. Our community hub development is absolutely key to that. At one hub, we are able to engage with more than 600 people. We are beginning to tell them how we are able to deliver social care and a whole range of other services that sit alongside social care including accessing SDS. We are working with housing colleagues and working on tackling poverty so that we can improve people's outcomes, finances and housing, and then we are looking at how we can support social care. Self-directed support is embedded through that collaborative approach.

Ruth Maguire: David Aitken, East Dunbartonshire IJB seems to be quite far along on this journey. Do you have anything to share with the committee on how you make sure that communities know how to get the support that they need?

We cannot hear you. Sometimes, having folks online can be a bit like a bad séance. I will move on and we can come back.

David Williams: Can I come back in?

Ruth Maguire: Yes.

David Williams: Thank you. One of the things that I took on board from work that I did in Tayside in 2021-22 in relation to mental health, following on from David Strang's work there, was the value of a self-advocacy group called the stakeholder participation group. I was very impressed with the level of ownership that that group had of the issues that people had, which it wished to convey and work with. Next week, we will ask the IJB to support the development of something similar in Clackmannanshire and Stirling.

It will be about the recipients of self-directed support and their carers and families from across Clackmannanshire and Stirling being supported to work together. They will have access to the most senior leadership in the health and social care partnership, with a view, and an opportunity, not just to influence but to reflect their experience. The group will also, at one level, be a conduit, because people who are in local communities are the people who can talk about accessing services. That works by word of mouth, as much as anything else, so there is something in there about the preparedness to engage.

Ruth Maguire: Okay. Self-directed support and that different way of working will be about achieving outcomes for the individual and will be asset focused—I have heard that phrase quite a few times this morning. How do health and social care partnerships manage that against risk? I give the example of someone who has been assessed as requiring greater intervention but who wishes to have less of a service, if that makes sense.

Stephen Morgan: Risk assessment is a key element in a social worker's psyche; it is one of the main things that we do around human intervention. When we have a good conversation with people, we not only start with strengths and build from there, but we identify and mitigate the risks in the support planning. If anything significant is identified, such as a high risk of falls or of financial abuse, we have other pieces of legislation that we can use if we need to.

It is almost like a spider's web: we make our way through the journey of someone's life and then try to pick the best piece of legislation for the circumstances. We can deliver that. I am absolutely confident that, in the different parts of Scotland that I have worked in and from speaking to colleagues across the country, that balance of risk is done well.

In the specific context of social care delivery in relation to self-directed support, it comes down to prioritisation. If we have to make that choice, we are more likely to prioritise someone who is at more risk of harm because of their living circumstances.

Ruth Maguire: That is helpful.

I am also interested in what provisions are in place for when individuals move between local authority areas.

Stephen Morgan: If someone who has had a social work assessment under the 2013 act and receives a package of care moves to another local authority area, there is a period of 12 weeks in which the new authority will continue to deliver those services. The situation will be very different depending on whether option 1, 2 or 3 was chosen, so we would work together in anticipation of what the package might look like. After that 12-week period, the original host authority's responsibilities lapse and are handed over. However, if someone with option 2 moves from elsewhere, a new assessment is carried out, because they are starting over.

I suppose that those are the differences in life. If you live in one part of the world as opposed to another, you will have different experiences.

Ruth Maguire: Does anyone else want to respond to any of those points?

David Williams: Yes. I think that Stephen Morgan has addressed the question. An aspect is recognising the difference of approaches and the different support systems that are available in and across 32 different local authority areas. That relates to the issue of variability in delivery and in experience, so we have to acknowledge that, as well as the portability of individual budgets. That goes back to my earlier comment on accounting and how that works in practice. There is a point at which the involvement of one authority needs to stop and another one picks that up, which can present challenges.

Ruth Maguire: I have one final question, if I may.

The Convener: I think that David Aitken wants to come in.

David Aitken: Thank you, convener. I just want to highlight that people's needs change. We must ensure that we are promoting to people that they should live as independently as they possibly can. Their needs are not static. Therefore, when someone moves to another area, that can represent not just a challenge for the individual—we have recognised some of the structural impositions in that regard—but an opportunity to restart, re-evaluate and really begin to reassess what is important to them and what they now need. I would frame the matter in a slightly different way, in that a move represents another opportunity to look at needs. As I said, people's needs are not static—they change over time—so it

is important that we reflect and provide the opportunity to consider them again when somebody moves.

Also, we, too, have similar tensions around financial stewardship against rising demand and so on.

Ruth Maguire: We have heard quite a lot this morning about systems and things from the perspective of those who deliver support to citizens. We spoke about accounting rules, stuff around eligibility criteria and performance that can get in the way of that innovative way of working. If we were to ask one of your citizens who is receiving support about your system, what do you think that they would say was in need of changing? What would they say should change to make services fairer, more equitable and better for them?

Stephen Morgan: I was trying to point to the screen to see whether anybody wanted to come in first. I tend to end up hogging the mic, as it were.

In Dumfries and Galloway, that will vary significantly, depending on where you are. For example, when I visited one of my social work teams, they explained what it was like for them. They told me that, when they finish an assessment, they feel as though there is no choice for people and, sometimes, no care is available. Therefore, in that part of the region, those citizens will be saying, "We want care to be available on our doorstep." Whether that is done through them employing somebody themselves or that is done through the council or the HSCPs, they just want things to be available because, in some parts of the region, that care is not there. Others would say, "We had a good choice and we were able to make that choice," so the picture is really varied.

David Aitken: One of the challenges that we and people who have access to a personal budget are increasingly experiencing is recruiting personal assistants locally. That is beginning to be felt, and that was mentioned earlier. We have people with big ideas and things that they want to do and achieve, but they often have to return to option 2 or option 3 because of the lack of availability of personal assistants.

I also accept that, for employers, some of the financial regulation around this is not simple or straightforward and it can be a challenge, which is why we have support agencies to help people with that. However, it would be unrealistic not to acknowledge that that can be a barrier and that some people look at and decide that they do not want to take forward those options because of the potential complexity. We have tried to streamline the process and to have a greater focus on electronic means of providing information, with online video explanations and so on, including details about our auditing processes. However, it can still be quite a big ask for people to take that on.

Diane Fraser: As David Aitken and Stephen Morgan said, there are issues to do with provision, particularly with regard to personal assistants, and the availability of appropriate resources. However, in North Lanarkshire, one issue that people have fed back to us relates to agreeing individual budgets and the speed at which such decisions are made. We have taken on board that feedback, and we are devolving budgets to localities so that decisions are made closer to the person. We hope that that will improve the speed of decision making.

David Williams: The number of people in Clackmannanshire and Stirling who have chosen options 1 or 2 is so small that I hope they are quite content with what they have got. The lack of engagement in relation to that probably reinforces that. However, the very significant number of option 3 packages of support that have been put in place possibly underlines quite a lot of what I have alluded to, which is that not enough people know about self-directed support, the systems are clunky and we need to have a consistent approach—all those kinds of things.

The Convener: Paul Sweeney joins us online.

Paul Sweeney (Glasgow) (Lab): Thank you, convener. I want to discuss variability across criteria and particularly—stakeholders in previous sessions highlighted this issue to us—the ability to carry over packages of care across local authorities and so on. What practices and procedures do you have in place to examine cases where there have been complaints, how do you learn from those and do you benchmark against each other? Will you provide us with a bit more understanding of how you act as an ecosystem across local authorities to try to maintain consistency in eligibility criteria?

David Williams: I am happy to come in on that. I note that I have not been in attendance at or a member of the chief social work officers group for quite a while. However, I would expect that all chief social work officers in Scotland come together routinely. I would expect that the issue of variability will continue to be one of the main areas of discussion in relation to the implementation of self-directed support. Stephen Morgan and other colleagues have referenced issues to do with eligibility criteria, the transfer of cases and learning from complaints. That might not happen in the formal setting of chief social work officers, but there is a network, and I would imagine, and expect, that to be engaging in that.

Paul Sweeney: There is a forum of chief social work officers. Is there a specific—[*Interruption*.]

The Convener: I am sorry, Mr Sweeney, but David Aitken wanted to come in here, too.

10:15

David Aitken: I highlight that there is a self-directed support practice network for all SDS leads in Scotland. That national group very much tries to draw together some of the strands that Mr Sweeney mentioned, including the variances in eligibility. Our chief social work officer national network does that, too. There are forums to look at that.

Elements around our eligibility criteria, the establishment of risk-based criteria and the sound stewardship of public money also come into play. The arrangements have been mentioned in relation to when somebody moves to another area and the portability of care for 12 to 13 weeks. The support would be reassessed in the new area, taking into account local variance and differences in service provision. That provision will vary significantly from, say, Dumfries and Galloway to an urban environment in Glasgow or Edinburgh. There are those processes, with many common threads, and support is provided by the national networks.

Paul Sweeney: Will you provide a bit more detail about how the network manages those cases and how the case reviews work? Is there a robust formal mechanism or is it more of an informal discussion about the experience? I am curious as to whether there are specific rigorous protocols for saying, "This case wasn't handled well; here are the counter-measures and how we improve across the service". Is there something as robust as that, or is it more a general discussion and chat that takes place between senior social workers?

David Aitken: The national group will be very much that community of practice whereby the development and sharing of learning and experience takes place, as well as being a forum for reflecting on what is working well in different areas and drawing together best practice so that it filters through the country.

In our individual HSCP and local authority areas, we will have our own processes for managing and looking at established complaint arrangements. In preparation for today's meeting, I spoke with our SDS lead directly about how that is managed in our area. The SDS lead directly reviews all the complaints that come in that have any focus on the provision of support packages or that have any link to self-directed support, and they review each separately to the main complaint response lead. We have established an additional process with our SDS lead to give a two-layered approach to any complaint that we receive on our SDS delivery.

The Convener: Stephen Morgan wanted to come in.

Stephen Morgan: It was to make the same point, convener.

Paul Sweeney: I also want to understand how you use the data that is being collected to drive improvements. Can you point to any examples of where you have said, "We've seen this problem arise, this is how we have addressed it, this is how the service has now improved to deliver better support"? We have had a lot of feedback about the approach being reactive and risk-based rather than focused on good outcomes for a person's wellbeing.

There was a suggestion that annualised budgets are a way forward in respect of improving provision and providing the extra capability, scope and agency for individuals to direct their own care. I throw that in as one example that I have heard in recent discussions with stakeholders. Can you point to any other examples where you have identified opportunities for improvement and are looking to make improvements but maybe not been done so yet?

David Aitken: I can certainly give you the example of our auditing process, which has been recognised as quite challenging and which people have recognised as being rigorous. Originally, we had six-monthly auditing processes. We took that approach to protect people as much as anything; after all, where substantial sums of money are involved—our average budget is about £17,000 annually—we need to ensure that that money is spent appropriately.

However, we have moved to a much more flexible position in response to feedback not only from people who receive self-directed support but from people in the field. The latter recognise that some people find the management of all this fairly straightforward and are able to look at it without great concern or anxiety, but they also recognise that others find it more of a concern. Consequently, we have developed a much more personalised and flexible approach to our audits. We run workshops that involve legal services, strategic commissioning and people taking on self-directed support option 1. As I mentioned, we have uploaded explanation videos—[*Interruption*.]

The Convener: We appear to have lost Mr Aitken.

David Aitken: —in respect of all the people who are taking on this role.

The Convener: We lost you there for a moment.

David Aitken: I apologise. Am I back now?

The Convener: You are back now. You might want to repeat what you were saying.

David Aitken: Thank you. I will just conclude, as I am not sure what was lost.

One example that I can give you is our auditing process, which we have developed in response to feedback from people and from practitioners. We are ensuring that we make information available through online videos and workshop sessions to anyone who is taking that on. The system allows you to learn and take things on, but it requires providing opportunities to bring people together locally within community groups. We have twice-yearly meetings that involve workshop development sessions with stakeholders, people who use services and the third sector, and we try to draw all the experiences together in order to learn about and develop our processes. We want to ensure that people who use SDS are very much at the heart of directing what we can do better.

Paul Sweeney: Are you looking specifically at improving the pooling and annualising of budgets? Is that workstream being taken forward in those forums?

David Aitken: Budget pooling, where it works, has been a feature for a number of years, but there are challenges in relation to bringing multiple needs together, and there has to be some core outcome that people want to achieve collectively. However, it is something that we have sought to introduce not just in the past; we are seeking to do that currently and are continuing to take that forward. That all comes back to how we have established SDS as our mainstream service provision in East Dunbartonshire.

Paul Sweeney: Does no one else have anything to add?

The Convener: It does not look like it.

Paul Sweeney: Okay. Thanks very much, convener.

David Torrance (Kirkcaldy) (SNP): Good morning. Commissioning, tendering and procurement are different processes that are often undertaken by different teams. How do you ensure that the commissioned services meet the principles and requirements of SDS and are affordable?

David Williams: Over the past two or three years, the Clackmannanshire and Stirling IJB has put in place what we have described as a commissioning consortium. In essence, it is a co-produced approach to responding to particular needs across each of the communities in Clackmannanshire and Stirling, with carers, supported people, those with lived experience, the third sector, social work professionals and provider organisations coming together to look at the best and most appropriate response to the issue. We have implemented the concept across Clackmannanshire and Stirling in provision for people with dementia and as an approach to alcohol and drug issues, and we are also looking at it for palliative and end-of-life care provision across Forth Valley.

It is expected that self-directed support will go right down the middle of all that and provide an opportunity to look at things differently, say, from an asset-based point of view. In other words, what do we already have available to address any or all of those conditions—if I can use that term—as we look to develop the commissioning framework for provision in particular areas? Such an approach is healthy. For a start, it takes us away from the traditional purchaser-provider model, which has probably got in the way of implementing self-directed support as we would want, given its focus, as I said earlier, on the hourly rate and how that is taken forward.

As for the affordability element of your question, when we focus on assets and strengths as a basis for moving forward instead of taking a negative approach—that is, somebody has this or that disability and therefore requires a certain level and type of support—we can look at maximising the totality of input. We tend to think about money when what we are actually talking about is resource. Each of our communities is rich with resources that we have not tapped into, because of our fairly narrow and traditional focus on and approach to service provision. It is very much about risk enablement rather than risk aversion—indeed, it is that sort of risk-averse response that is costing too much money, because it means that we tend to overprescribe stuff.

I will give a different example altogether. We will all have seen care-at-home packages that provide support for older people in their communities and their own homes a minimum of four times a day, at breakfast, lunch, tea and bedtime. That is not an asset-based approach; it is just overprescribing, and it is probably more costly than it needs to be.

Stephen Morgan: The point about commissioning and procurement being separate is key, especially for us in Dumfries and Galloway. The health and social care partnership has a strategic commissioning team that commissions all health and social care, including internal commissions; a direction will then be given to the council to procure the social care element; and the council's procurement team will procure the services.

To be honest, I would say that that model maps what we have always had, to a degree. There could be further development by having a specific

focus on the principles of the 2013 act when we look at what we commission for social care. We have not really focused on that before.

I have already referenced our "Right care, right place" strategic plan. Clearly, it is all about putting the right care in the right place, but it also looks at the whole system of community health, acute health, and social care. Sometimes, integration is absolutely the right thing, but we still have to focus on certain specific functions and principles in order to get it right. We still have some way to go locally but, as a health and social care partnership, we have started having community conversations and asking people what they want and need in their areas. We will then look at what we need to commission and how we procure that.

The term "affordability" has been used, but I prefer to call it "value for money". If I overspend in social care but, in doing so, keep people away from the hospital doors, the overall cost savings might be considerable, but I have still overspent my social care budget. That is okay, though, if I actually get it right and can round things off at the end of the day. For me, it is more about the community needs assessment, the individual needs assessment, outcomes and making sure that we put the money in the right place. That sounds really easy, but I have already acknowledged that, in Dumfries and Galloway, we still have some way to go with regard to the procurement of social care in particular, and we are starting to have those conversations internally as a partnership, as well as with our communities.

David Torrance: Are there any barriers such as cumbersome processes or governance arrangements that make the effective commission and procurement of services difficult? If so, how would you overcome them?

I am seeing blank faces. Does David Williams want to come in?

10:30

David Williams: There is an issue with regard to the continuing priorities that social work and social care services need to respond to. There is a view—and an approach—that that provision is prioritised by the Government and health boards and that that takes us away from focusing on being more proactive, preventative and forward thinking, in the way that we want to be, in delivering services. As Stephen Morgan highlighted, we need to recognise the need to shift the dial to being more planned and considered. We spend too much time in our industry and business dealing with the urgent at the expense of the important. If we were able to focus a little more on the important, we would probably have a lot less of the urgent to deal with; the urgent is where the costs are.

Therefore, we need to provide the space and the opportunity to shift that culture. The mechanics are there—the integration joint boards and the public bodies legislation were expected to do that, and they should be able to achieve that. There are examples of really good practice across the country in that regard, but we need to be supported by the Government, councils and health boards to do much more of that, and that is a real challenge.

David Torrance: How effectively do staff across health, social care and procurement work together to ensure that the right services are commissioned and procured?

Stephen Morgan: I think that I already alluded to the need to do better at that in Dumfries and Galloway. In health and social care, the staff function well, but when your procurement team sits elsewhere the connections can be a bit challenging.

If I may, I will touch on your point about the cumbersomeness of commissioning and procurement. That depends on the size of the commission. We will delegate X thousand pounds to individual types of staff, so a social worker can authorise procurement of, say, £2,000, a senior social worker can authorise procurement of £10,000 and so on. That will vary across a local authority. Therefore, at an individual level, you have to be brave enough to use appropriate guidance with regard to how you look at that.

If we are speaking about larger commissions of hundreds of thousands of pounds, the bureaucracy that is in place is appropriate to protect the public pound, to a degree. I am not a fan of bureaucracy all the time, but it is essential when we are looking at considerable sums of money. It is about finding the balance between the individual level—the delegations to staff in health and social care—and commissioning at the whole-service level, which requires that rigour.

David Williams: I have already articulated the real challenges in Clacks and Stirling with regard to joined-up working; we need to be in a materially different place. With regard to your question, we have probably got quite a long way to go in responding to that issue.

The Convener: David Aitken and Diane Fraser want to come in. Please be brief.

David Aitken: I will reiterate Stephen Morgan's point about large commissioned services. We need to work through the protocols in place in order to protect and safeguard public money and to ensure that we get the arrangements right. On SDS, we are trying to move our commissioning to

a lower level and develop a preventative fund, with budgets being devolved to a lower level—to localities—in order to remove some of the complexity. That will be an on-going feature of our work.

We have brought together our finance and legal colleagues and those in our strategic commissioning team as part of our SDS community of practice, so that they have a much greater understanding of the needs of people who are looking to direct services, particularly in relation to SDS options 1 and 2.

Diane Fraser: We have a similar process to the one in Dumfries and Galloway that Stephen Morgan described.

I want to highlight complex care. When individuals present with both health and social care needs, that is a barrier to commissioning. We do not necessarily take the same approach across health and social care, so we need to consider how we support people with complex needs at home.

Emma Harper: We have heard lots this morning already but I am interested in how we look at training for all different types of staff, whether it is the people who are auditing the finances or social workers, and at everybody who is involved in training and education.

I am very familiar with Dumfries and Galloway, Stephen, and my background is that I am a registered nurse. How do you ensure that staff in all the different parts of Dumfries and Galloway—the local authority or the national health service—get education on the self-directed support legislation? I am looking directly at you, Stephen, so go ahead first, please.

Stephen Morgan: It is just about getting on with it. I will give you an example. In children's social work and social care in Dumfries and Galloway, we implemented the Signs of Safety approach, the principles of which are very similar to those of the 2013 act. We bought a training package and delivered it to social workers, teachers, health staff, children's reporters and children's hearings staff. In a concentrated effort, we trained thousands of people. We have never really done that for our multi-agency partnership staff for the social care act, but, as I have already said, we will. We will have to bring people together in specific groups if that is easier—although multi-agency groupings would be better—say that "These are the principles and what we want to do," and just deliver that training.

In relation to finance and auditing staff, my chief internal auditor would say, "We will audit what you tell us to audit; we will audit the systems that you have in place." For them, it is therefore not so much about training, but about ensuring that the intent of the legislation is clear in our policies, so that when they come to audit us around the activity, they are auditing the spirit of the legislation, as opposed to the financial drivers.

We need to concentrate the training on the people who are on the ground working with the public—the "backroom staff," if I can use that term. They will just follow the process, so we need to ensure that it is spelled out clearly.

Emma Harper: When you google "self-directed support", loads of information comes up from Alzheimer Scotland and In Control, for example. We now have a toolkit that people can use to help them to understand what self-directed support is. How do you deliver the education then? You said that you bring in groups, so is that done online? How do nurses know that self-directed support exists? In the cases that I have worked with, the people do not know that they are getting self-directed support, because if they get it through option 3, a local authority delivers it. Does that matter? They know that they are getting care so does it matter whether they know the technological language?

David Williams: Yes, it does, for a range of reasons. I go back to that whole integration thing. It is about bringing two workforces together, from a health board and a council, or two councils in our case, to work in a more joined up, collective way. You have to be able to do what I described earlier—that is, to focus a bit more on the important and less on the urgent. Communication, learning, development and training are important and will be at different levels.

There is a difference between awareness raising and enacting the policy, which probably applies as much to the staff groups that are not directly engaged in the assessment of individuals who enter the system through self-directed support options. However, it may well be worth looking at bringing together more focused groups with social work staff on the trickier questions, such as appreciative inquiries, which we are looking at, as we enable our social work staff to become more consistent with the aspirations and ambitions of the self-directed support legislation.

Giving space and time to pressured members of the workforce, whether they are in hospitals, are district nurses in the community or are social work staff, requires a change in the leadership expectations of what we want to be able to provide. We need to demonstrate a will to do the right thing, rather than simply going along with what are perhaps the more traditional ways of doing business and hoping that people pick up on these things as we go along. An intentional approach to delivering on the policy is required.

In Clacks and Stirling, that work began a couple of years ago and it is being driven by a policy on self-directed support that we will be taking to the IJB next week for it to own the issue and issue directions to respective councils.

Stephen Morgan: If I may be slightly controversial, I do not think that it matters to the person who is receiving the care whether they receive self-directed support or social care. That is certainly true of the people who I have spoken to. Before 2014, people received care, which is what they come to services for. We use the phrase "self-directed support" all the time, and sometimes we use it inappropriately when we are referring to the social care act. The four options for self-directed support are merely part of that. For the people who receive our services and our support, it is important that they get what they need.

On the question of how we provide training for different groups, I think that we first need to concentrate on those who undertake assessments and care and support planning, because they will have the front-line contact in relation to social care, so we should start there. They should have intensive training on having good conversations, for example, and innovation around support planning.

Some of our nursing colleagues might be undertaking those assessments, which is great; we should include them. If those nurses are in an acute setting or a community setting and they do not undertake those assessments, we should make them aware that they can use the toolkits from In Control. We can make them available online, so there will be a hybrid model for the delivery of training.

For the assessment and care planning elements, my preference is that our teams do that training in person, so that the richness of the training can come across, as well as the trainer's enthusiasm. We might bring in experts. I would suggest that we can use the many experts that we have internally, as well as those who are most committed and most innovative, to train the rest of the staff.

Emma Harper: I have a question for David Aitken, who is online. You talked about video learning as a method of teaching people. Is that delivered in multiple languages, including British Sign Language, in Scotland? During Covid, a lot of the instructions on hand washing and wearing face protection were provided in eight or nine different languages. Is education delivered multiculturally and in multiple languages?

David Aitken: We have moved to develop video learning for audit, but that is only one part of our training and the accessibility elements of it. I doubt that we have established our training in the level of detail that you have mentioned at this point, but our self-directed support lead is looking at identifying whether there are any gaps in accessibility. The whole approach is to build accessibility and choice in to every service—that is framed in the principles and it is central to them, as well as the culture of how the policy should work. Our self-directed support lead is central to taking that work forward.

The Convener: [*Inaudible*.]—witnesses to keep their answers concise so that we can get everyone in.

10:45

Emma Harper: David Aitken, you talked about innovation and allowing social workers to have good ideas, and you used the example of dog grooming. How do we ensure that social workers who are making assessments can choose to be innovative?

David Aitken: It is the choice of the person how they wish to have their outcomes met. It is about how we work in partnership through talking and developing conversations that bring out what people need by asking question such as, what do people need to live fulfilling lives? What is important to them? How can we work with people to identify what they want?

We have to have a cultural position, and the structures behind it, that promotes approaches that might sound off the wall in order to meet people's assessed need. It is cultural, and it is also about the elements that you have to support that. However, it is the person that drives those conversations. It is very much their choice about how the needs that have been identified within their assessment are met.

Paul Sweeney: [*Inaudible*.]—previous line of questioning, but I want to ask how clearly the culture of self-directed support is embedded across staff and what formal training and programmes are in place to inform staff about the full range of the options available? Is there a formalised process of continuous professional development courses such that staff have protected time available to undertake training to understand the latest developments in self-directed support and how to improve the services?

We talked about senior social workers discussing continuous improvement. Does that also take place at a lower level within health and social care partnerships? Any insights there would be useful.

David Williams: I will give a brief answer. I have suggested that we have a long way to go in most of the areas that Mr Sweeney alluded to, but we are on the case.

Paul Sweeney: Do other members of the panel want to come in with any insights or thoughts?

Diane Fraser: We are looking at training as part of the work that we are doing with the community of practice. We are involved in a national pilot looking at three levels of training. Locally, we have training built in for our staff, including for our newly qualified social workers and our experienced workers. It has been clearly identified—including at last week's committee meeting—that we need to look at social work education and how we begin to develop and embed SDS through that.

David Aitken: We have quarterly training at a multi-agency level and individually for our social work staff. However, more importantly, we have training and learning that can be delivered across the partnerships that we have established with our advocacy service, our carers service and our independent SDS support service. It is about joining those elements together and much more widely broadcasting, publicising and developing training and learning across the wider system.

Paul Sweeney: Panellists have expressed that this is an area for improvement and further development. Could you suggest what your ideal structure and position would be? What would good look like if you had unlimited resources available to design a good training system for social workers?

David Williams: On an unlimited budget and with unlimited resources, I would probably want more social workers and social care staff to be given the space and opportunity to have those good conversations. The workloads that social workers have and the pressures that they are under from all sorts of angles mean that they rarely have the opportunity to develop a good relationship with somebody who wants to move forward with their life and to have the opportunities and choices that we all take for granted. It is about capacity and the availability of adequate levels of staffing to do that as well as we would like to.

Paul Sweeney: Do you think, Mr Williams, that there is a vicious circle of stress levels and time constraints that inhibits there being the space to undertake improvement, or even just to contemplate how you might improve the service? Basically, is the very fact that that resource is not there inhibiting reform and improvement?

David Williams: That is a fair point; there probably is a vicious circle. The more pressures and stresses that social work staff are under, the less capacity they have emotionally and in terms of time to be able to take on the things that need to be done, so what you say is fair.

It is not fixed simply, because the demands on the services and on the social work staff—from handling adult support protection inquiries and hospital discharges to implementing aspirational and life-changing opportunities such as self-directed support—are immense, and the priorities of social workers and the system will tend to always focus on those who are in most need and the most vulnerable.

Paul Sweeney: I appreciate that; thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practising NHS GP.

I would like to ask a number of very direct questions, if I may, and I would like everyone to respond to them. In this year's budget, do you have a funding gap, and what is it? David Williams—I will start with you.

David Williams: Yes. We have set a budget through the IJB, which required us to identify somewhere in the order of £10 million of savings. We have identified and put in place proposals to deliver that. Essentially, that is all about implementing change such as we are discusssing, which we think will materially improve the financial position. Inevitably, though, there will probably be some continuing financial pressures, because it was not possible for everything to be put in place by 1 April to deliver what we wanted.

Sandesh Gulhane: Okay. Stephen?

Stephen Morgan: Yes—in relation to social care for adults and older people, we have a £5.5 million pressure on the budget this year. That care is being partly funded by reserves, but £5.5 million still needs to be found in the coming year for social care alone. On the health side of things, the amount is significantly higher.

Sandesh Gulhane: Thank you. Diane?

Diane Fraser: We are similar: we are overspent. We have mitigations to bring us within budget, but at this stage we are seeing within the system continued pressures, as have been already described, particularly in complex care.

Sandesh Gulhane: I am sorry—I asked what the number is.

Diane Fraser: It is £5 million.

Sandesh Gulhane: Thank you. David Aitken?

David Aitken: [*Inaudible*.] pounds, which we have mitigated to approximately £5 million at this point, so the answer is yes.

Sandesh Gulhane: Thank you, everyone. David Williams spoke at length about budgets being tight. Have you ceased to fund care requirements for people other than those who are in the "critical" or "severe" categories?

David Williams: No.

Sandesh Gulhane: Has anyone on the panel ceased funding for people who do not meet those two criteria?

Stephen Morgan: We have not ceased funding. However, the ability for some people to find care is limited. I mentioned earlier that we carry between 3,000 and 4,500 hours of unmet need for care at home for older adults alone. That is replicated across the system. We have not ceased to do anything, but people find it difficult to find care in our local area.

Sandesh Gulhane: Okay. I assume that the answers from the witnesses online are also no.

Have a significant number of cases been downgraded—that is, they have been changed from more need down to a lower need—in the past year?

David Williams: They have not, that I am aware of. That is not something that we would endeavour to do. It is not social work practice to identify significant levels of need then to underassess what those needs would be. The assessment is the assessment: if somebody has significant levels of need, they need to be provided with support to meet that.

Stephen Morgan: I would say that the opposite of what you suggest is the case. The complexities of people's conditions, their multiple morbidities and the issues with which people are living longer mean that their needs are increasing. From a social work perspective, we are clear that the assessment is the assessment: it is clean and it identifies what the person needs. That might be the wrong language, but I will use it in this context. If we cannot meet a need, we have to mark it as being unmet. We cannot downgrade things to make the figures look better and, from and ethical and principled perspective, we certainly would not do so. That would go against our values, about which I am passionate.

David Aitken: I can advise that we have not stopped funding the provision of care packages where there are critical and substantial needs. Where we have identified an assessed level of need, we have a duty to provide services to meet that level of need, and we have continued to do so—albeit in a much more challenging environment in which we are having to look at where we can develop community capacity to meet what might well be, as Stephen Morgan highlighted, quite considerable elements of unmet need.

Sandesh Gulhane: Stephen Morgan, earlier we spoke about people who move between health board areas and thus into different IJB areas. When they get assessed by a social worker in one area, how much of that assessment is carried over into another one? Obviously, there will be differences, but how much is repeated?

Stephen Morgan: The initial local authority shares its assessment with the receiving local authority. We then try to meet the need either in the same way or, given that situations across Scotland are different, in a different way. We then have 12 weeks to undertake our own assessment, and that assessment might well change the position.

Earlier, David Aitken made the point that needs are not static and, depending on someone's community, neighbourhood, housing and the supports that they have, the outcome of their assessment might be the same, but the way that the services are delivered might be different. That is why there is the 12-week period for us to carry out a new assessment to see how someone's outcomes can be met differently in a new environment.

The point at which there is the move can be the crux in terms of how quickly something can be put in place. However, to be honest, that is not so much an issue for older people, because they tend not to move as much as younger people. It is a more significant issue for younger adults with complex learning disabilities, health needs and so on. If there is an issue from a health perspective, the clinicians will deal with that, and the social care elements will be provided. However, the new assessment will take place to look at the new environment.

Sandesh Gulhane: David Williams said that, if he had an unlimited budget and unlimited resources, he would certainly want more social workers. In our previous committee meeting, we established that the average life expectancy of a social worker is around six to seven years—

The Convener: You should clarify that you mean that the length of their career is around six to seven years.

Sandesh Gulhane: Of course. Having such a turnover is challenging, in terms of the workforce.

A lot of bills that are coming up will require social workers; for example, implementation of the Children (Care and Justice) (Scotland) Bill requires 500 social workers. How are you going to meet that need?

11:00

Stephen Morgan: I thought that you said that the life expectancy of a social worker was 67 years, hence my shock.

The "Setting the Bar 2: Taking the wheel" report showed us that about 16 per cent of social work graduates who qualify do not even enter the

profession, and that a considerable number of those who do so leave within six to seven years. Those of us who have been around for longer tend to stay in the system.

There are lots of things that we have to do. We have to look at the way that social workers are educated in our universities. One of my sons, Travis, is about to graduate from Robert Gordon University in Aberdeen, and he is already considering not entering the profession, for whatever reason. Some of that is about experiences of university, how he was taught and how well equipped he feels, and part of it is about the type of placements he had. He had excellent placements, so he will probably stay in the profession. I really hope that he does.

We have to train people differently and we have to take a different approach to how we offer placements. We have to take a significantly different approach, and I believe that it should be a national one. Localisation and local decisions are important, but in respect of education for social workers and how we train them on the job, we need a national approach. We have a protected year for post-qualification social workers, which needs to be extended. Furthermore, the support that social workers get from senior social workers and other line managers needs to improve significantly.

We do not have vacancies and capacity issues only in relation to front-line social work staff—there are issues across the profession. We need to think about introducing bursaries in order to bring in different types of people, as we do for nurses. I was lucky when I studied to be a social worker many years ago, because the funding system was very different. Many social workers now come from middle-class backgrounds—that was not my background, although it is my son's. Having bursaries would bring in people from a wider cohort of society, which would provide richness in the people who come into the profession, because people will want to be in the profession for different reasons.

Sandesh Gulhane: I can see that time is short, so I will end my questions there.

The Convener: Our witnesses have indulged us by staying a bit longer than they had committed to.

I have one final question; perhaps the witnesses can write to us with the answer. We are 11 years on from the passing of the legislation and seven years on from Audit Scotland's review of self-directed support. Throughout the morning, I have heard that we are on a journey involving cultural changes, that there is a cultural shift and that we need cultural leadership. I would be keen to hear from the witnesses how they are shifting the culture, given that we have had the legislation for some time. As I said, perhaps you could respond in writing.

I thank our witnesses for attending the meeting and for staying on a bit longer than planned. I am sure that you are all busy and that you have other things that you need to attend to.

Next week, the committee will continue phase 2 of its post-legislative scrutiny of the 2013 act, with an evidence session on monitoring and evaluation.

11:02

Meeting continued in private until 11:23.

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