OFFICIAL REPORT
AITHISG OIFIGEIL

Public Audit and Post-legislative Scrutiny Committee

Thursday 14 December 2017

Session 5

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Pàrlamaid na h-Alba

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PUBLIC AUDIT AND POST-LEGISLATIVE SCRUTINY COMMITTEE
31st Meeting 2017, Session 5

CONVENER

*Jackie Baillie (Dumbarton) (Lab)
Jenny Marra (North East Scotland) (Lab)

DEPUTY CONVENER

*Liam Kerr (North East Scotland) (Con)

COMMITTEE MEMBERS

*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Bill Bowman (North East Scotland) (Con)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Monica Lennon (Central Scotland) (Lab)
*Alex Neil (Airdrie and Shotts) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Iona Colvin (Scottish Government)
Paul Gray (Scottish Government)
Beth Hall (Convention of Scottish Local Authorities)
Geoff Huggins (Scottish Government)
Paula McLeay (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

Terry Shevlin

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Public Audit and Post-legislative Scrutiny Committee

Thursday 14 December 2017

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Acting Convener (Jackie Baillie): Good morning and welcome to the 31st meeting in 2017 of the Public Audit and Post-legislative Scrutiny Committee. I ask everybody in the public gallery to switch off mobile phones so that they do not interfere with the committee's work.

The first agenda item is a decision on taking business in private. Do members agree to take items 3 and 4 in private?

Members *indicated agreement.*

Self-directed Support (Post-legislative Scrutiny)

09:00

The Acting Convener: We move on to agenda item 2, which is the substantive item and in which we will take evidence on self-directed support. I welcome to the committee Paul Gray, director general of health and social care in the Scottish Government and—his second title—chief executive of NHS Scotland; Geoff Huggins, director for health and social care integration, and Iona Colvin, chief social work adviser, both from the Scottish Government; and, last but not least, Paula McLeay, chief officer for health and social care, and Beth Hall, policy manager, from the Convention of Scottish Local Authorities.

I understand that the Scottish Government representatives do not want to make an opening statement this morning. I invite an opening statement from Beth Hall, but she does not need to provide one.

Beth Hall (Convention of Scottish Local Authorities): Sorry, but I do not have one. We did not intend to give one.

The Acting Convener: No opening statements, so there is more time for questions from the committee. What joy!

Colin Beattie (Midlothian North and Musselburgh) (SNP): My question is probably addressed more to Mr Gray. You are seven years into what is basically a 10-year project. Is there a formal evaluation as to how it is going across Scotland?

Paul Gray (Scottish Government): We have Audit Scotland's report, and we have done work that is based on the data that is under development. We have a report that, in large part, coincides with what Audit Scotland is saying, and we have further work in hand to evaluate what we are doing. The answer to your question is that we have a report that relates to 2015-16, another such report will be produced next year and we have also commissioned work on evaluation so, yes, we are evaluating.

Colin Beattie: The project does not seem to be going very well.

Paul Gray: One of the aspects is that, at the top line, our data suggests that, of the 208,000 people who are engaged in the system, 26 per cent are making a choice. However, within that 208,000, about 100,000 people receive services such as a home alarm or have a support worker. If you exclude them from the 208,000, it would suggest

that more than 50 per cent of those people are making a choice.

The other part of it—I recently went to Midlothian to sample this—is that, when someone elects to have the services provided by the local authority, it is sometimes regarded as not being a choice, even though they are explicitly making that choice. Just because they are not choosing one of the other options that are on the menu of four, it does not mean that they are not making a choice.

We are in close touch with the authorities that are responsible for delivering self-directed support and the management information suggests that the position on choice continues to improve.

Colin Beattie: Clearly, self-directed care is bound up in the larger picture of moving resources into primary care. If that is successful, to some extent it follows that, as part of that, self-directed care will also be successful.

Looking at the Auditor General's report, there seem to be significant gaps right across the board. In its submission—this is at paragraph 18 on page 12 of committee paper 1—COSLA said that

"bridging finance is a significant issue."

Seventy million pounds was put into this and spent—you have detailed where it was spent—but I assume from what COSLA is saying that that was not enough or that it is asking for more. How are we going to move this forward?

Paul Gray: Obviously I am happy to bring in COSLA here—I am not going to attempt to speak on its behalf—and Mr Huggins will be able to give some detail on how we are moving this forward.

Given your reference to the Audit Scotland report, I would point out its recommendation that the Scottish Government, COSLA and partners work together. I am not disputing the report's recommendations—there is more to be done, and I am not presenting to you a proposition that that is not the case—but whether more money is the answer is a separate question. However, we are taking forward action in response to the recommendations. As I have said, Mr Huggins can give you more detail on that.

Geoff Huggins (Scottish Government): I am certainly happy to do so.

There are two issues here, the first of which is the need to understand where we are in the programme. As you have said, we are seven years into a 10-year programme, but we have to understand the different stages that we have gone through. The programme began with the framing of the intention to legislate, the consultation, the engagement and the process by which—

Colin Beattie: Let me just interrupt you. We are seven years into a 10-year programme. The programme's end date was 10 years after it began. Is it still 10 years?

Geoff Huggins: There has been no change to the end date. I am just trying to set out what is in the 10-year programme so that we can talk about the progress that we have made throughout the period. The initial period was about framing what we were going to do and how we were going to take forward the intention to put self-directed support in place, and the second stage included the time that the Parliament spent framing the legislation, which was taken forward successfully and received good support in Parliament.

We are now effectively in the third phase of implementation in the 10-year programme, in which we are beginning to pilot, roll out and embed the approach in the system. The Audit Scotland report focuses largely on that phase, but it is important to understand that we did not start this 10 years ago with the legislation and the frameworks in place. The 10-year programme also encompasses the need to bring forward the policy proposals and legislation.

It is also important to understand what the £70 million is for. It is not for new services; instead, it is for advocacy and advice, support for local systems to create the mechanisms for taking self-directed support forward and so on. The money for self-directed support can be found in the £3 billion that we spend on adult social care and other social care budgets. Therefore, as far as the application of the resource is concerned, self-directed support is the mechanism for using the resource that is already in the system, and the £70 million is the allocation for transitional support, by which I mean the advocacy, the advice and the support to third sector organisations so that they can adopt the process. That money has been used across the 10-year period; we can say more about it, but that £70 million is not for buying new services. The services are funded through the general allocations, grant-aided expenditure and resources transferred from the national health service to integration authorities.

Colin Beattie: In its submission, the Care Inspectorate says that its findings are

"that self-directed support has not yet had the impact across the country that it aims to achieve",

citing

"lack of training ... poor engagement ... lack of advocacy and support for older people"

and

"overly cumbersome systems and tools".

It also says:

"self-directed support is less well developed in relation to children and young people and this has not been an area of priority focus".

What is happening? Are you really going to fix all that in the next three years?

Geoff Huggins: I think that you should see this as working through a process. A number of things are happening in parallel here; indeed, the Audit Scotland report and other reports have reflected on the fact that, in parallel with self-directed support, we have introduced health and social care integration. As a consequence, there have been significant changes happening in parallel across the system.

When we look at those areas that are working better—and this is reflected in the data, too—we see that some have moved quickly to adopt new approaches to commissioning that embed the idea of self-directed support effectively, while others that have sought to continue with the historical ways in which they commission and allocate care have found it more difficult to embed self-directed support. What we have, though, is a process—and it is a common process—in which some areas tend to make progress faster than others; however, it is not always the same areas.

The teams from the Scottish Government, COSLA, the Scottish Social Services Council, the Care Inspectorate and others are working in partnership with local authorities to take the process forward.

We are about halfway through the implementation phase. We are seeing good progress in some areas and in relation to some of the developments that we might have anticipated, such as greater use of option 1 for the under-65s with disabilities and less use of option 1 for the over-65s with frailty. Things are beginning to fall into place.

The process is designed as a learning process. We could not have understood all of the complexity going into the process, but that is where we are now.

Colin Beattie: Do you agree with the statement in COSLA's submission that

"questions have arisen over the extent to which NHS Boards are meaningfully transferring their unscheduled care hospital budgets ... to Integration Authorities"?

Paul Gray: COSLA has raised those questions, which are to do with what is called the set-aside budget. We are discussing that issue. I have discussed it with chief executives twice in the past month. A few weeks ago, we had a helpful meeting involving COSLA's chief executive, board chairs, the chairs of integration joint boards and chief executives of local authorities, and that is one of the issues that were discussed.

I accept that the issue is under discussion. There are differences of view about how the set-aside budgets can be transferred and whether they should be, but we agree with COSLA that we need to resolve that issue.

Colin Beattie: However, you are still confident that the 10-year deadline is going to be met.

Paul Gray: The set-aside budget is perhaps a slightly separate issue, but we are still working towards delivering what we said that we would within the 10 years. We have got three years to go. The management information that we have suggests to me that there has been progress. Will we be 100 per cent successful at the end of those three years? I am not about to guarantee that, but we are certainly working towards it.

Geoff Huggins: The set-aside budget is for large hospitals, effectively. That is the budget that is supporting the Queen Elizabeth university hospital and the Royal infirmary of Edinburgh.

One of the interesting things that we have seen during 2017 is that a number of the integration authorities are beginning to plan across a range of locations with regard to the provision of services to cohorts such as older people. For example, the Glasgow city integration authority is looking at hospital care, residential care, care at home and housing support, palliative and end-of-life care and its implementation of the carers strategy as a coherent whole rather than as separate issues, which is what would have happened previously. It is now able to ask what the shape of services should be for people in Glasgow who are over 65. That is a big step forward. In doing that, it is thinking about the money that was previously spent on primary and social care and the money that is spent in hospitals with regard to how it can spend that money in a way that delivers the best value for the community from that overall resource. That is quite innovative. It is very much the intention of integration to get into the space of thinking beyond individual silos and services and to start thinking about how we can deliver best value from the spending of public money across the piece.

The set-aside budget has a place within all of that, as the resource that relates to the large hospitals is within the control of the Glasgow city integration authority. Where the money sits is actually less important but, in that context, it is able to consider that as part of the bigger picture rather than having it bracketed off and left as a sort of separate entity.

People go through transitions. Part of the approach in Glasgow is to provide better support at home and to reduce falls, unscheduled admissions, occupied bed days and delayed discharge. Over the past two years, it has been very successful in relation to that last issue in particular, but it has been able to do that only by

looking across the whole picture rather than at individual service areas.

We acknowledge the significance of the comments in the COSLA submission, but we are also seeing progress on the ground in terms of how resource is being used.

The Acting Convener: I wonder whether COSLA wants to comment on what we have heard, as I saw Beth Hall trying to get in. Do you want to say anything at this stage?

09:15

Beth Hall: I just want to pick up on the initial points that were made. It is important to be clear that SDS requires major disinvestment in services to be able to reinvest in new models of support. Transformation funding, which has been mentioned, incurs dual running costs. When we couple that with increased public expectations and the difficulties of making some of the shifts in resource in integration authorities that we have just talked about—not everywhere is experiencing the picture that Geoff Huggins has outlined—it is perhaps unsurprising that we are facing difficulties with implementation. Audit Scotland has found that the scale of the challenge was underestimated and we are therefore facing a longer programme of support but without the necessary resources to make those transformations.

The Acting Convener: So, basically, the key issue for COSLA is the adequacy of resource to allow you to make that transformation. I think that another member will explore that later.

I want to go back to something that Mr Huggins said that left me slightly perplexed. I do not think that legislation has ever been described to me as a "learning process". In my view, legislation is a decision and then there is implementation, yet Mr Huggins seemed to suggest that that was not the case for SDS.

Geoff Huggins: No. I was saying that we are in the third phase, which is the implementation phase, in which we are seeing SDS apply in localities and commissioning systems and for individuals. That implementation phase is the point at which we need to see what is going on, learn from that, make adjustments and move on. The legislation is completed now. We are here today because you are considering the adequacy of the legislation and the implementation of it, but we see the legislation as a completed process. We are in a learning process about how to implement it.

The Acting Convener: The legislation and the rhetoric around it promised transformational change, yet you will have read the *Official Report* of our round-table meeting a few weeks ago, at which people suggested that service-user organisations are disappointed. What do you say to them? With all due respect, if they were happy, that would underline your point that things are not being recorded properly. However, they are not happy, so you cannot blame recording systems for what is a shamefully low uptake of SDS.

Geoff Huggins: There are two or three points on that. First, as reported in the Audit Scotland report, we have had data problems in understanding what is going on, which we are addressing. One component of that is the move from the snapshot survey and additional survey work to bringing the data in respect of social care and SDS into the NHS National Services Scotland source data. That also enables us to link the data to other data to allow us to understand what is going on in the system. The source data is the data that we largely use to support integration authorities. We are addressing issues around the data. We think that the position has been better and that, when we see the data again next year, it will be better again in terms of implementation.

The other element to understand, which is again reported on and noted, is the complexity of trying to do two things at the same time: offering choice and control to individuals, which is a clear objective of the legislation, while at the same time asking integration authorities to plan for populations. Trying to find the fit between planning for populations and providing choice and control to individuals is really quite complex. As I said, the areas that have addressed the issue through their approach to commissioning have done better in that area, whereas other areas have not moved so quickly into that space. There is a challenge in how to meet the needs of individuals within a system while also meeting the needs of a whole population. That is a hard ask.

The Acting Convener: Surely you should have thought of that before introducing the legislation and raising expectations.

Geoff Huggins: Legislation is always framed with a high objective in mind. In the case studies, examples and work that we have seen, we are finding that in some areas, particularly in Highland and other rural areas, self-directed support is a key mechanism by which we deliver care. The fact that something is going to be difficult and hard does not mean that we should not do it.

The Acting Convener: I am not suggesting that, but maybe you should have thought about it in advance.

Alex Neil (Airdrie and Shotts) (SNP): I want to start with COSLA. Reading your original response and the supplementary, I get the feeling that you are putting up the white flag and saying that it is all the fault of the Scottish Government for not providing enough resources and the problem is

part of the underfunding of local government. It appears to be the blame culture rather than trying to address some of the key issues.

As an MSP on the front line, I find that for end users who are coming to a social work department for the first time, their awareness about their rights and obligations is often zilch. My impression is that COSLA's message is all about blame, rather than about how we sort it out and address the issues. Why do we have so many local authorities performing so poorly compared to some of the better ones? What is COSLA doing about it?

Paula McLeay (Convention of Scottish Local Authorities): There is a difference between holding up the white flag and blaming people and stating some facts about the difficulty of the task ahead of us. We have a task of transformational change to deliver SDS, which is not easy for local government. To do it, we need adequate support and transitional funding. Our assessment of the situation is that the transformational funding has not been adequate to meet the scale of the challenge. That is not casting blame, but a fact from our perspective.

If we couple that fact with the responsibility for the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014 and the new initiatives and legislation placed on local government—all of which require evolution and transformation of services, investment and behavioural change—it leads to the reality on the ground, which is the pressure that local government faces in trying to deliver. We would be remiss not to identify that environment thoroughly in our evidence to the committee.

We are not just saying that it is not our fault and that you should give us some money to fix it. We need money, but we also need to ensure that we are working with the Scottish Government—as we are—on the improvement plans, the future implementation and how we leverage the system within the resources that we have and what it is realistic to expect.

We know that that is an improvement journey. We are working to support local authorities to step up to that and implement the changes required. We are working with the Scottish Government on how we support that nationally.

It is a tale of two stories—we will continue to work with the Scottish Government, local authorities and the third sector to ensure that the legislation, as it was envisaged, is successfully delivered. However, the reality on the ground of what is required and the environment that we are in also need to be acknowledged.

Alex Neil: Resources are obviously a big issue. What is COSLA's estimate of the additional resources needed to make self-directed support happen and get things back on track?

Paula McLeay: I had a similar experience to this earlier in the week when talking about care home sustainability. It is difficult to give a specific estimate on the spot when you are asked for a figure of what it would take for the whole of local government to deliver one particular policy and the transformational change that that requires. We are saying that we need to look at the whole pressure on social care—all the initiatives and resources that we have to deliver them—and then ask, together, whether that is sustainable and the expectations realistic. That is a piece of work that needs to be done in the round.

We increasingly find that dealing with the social care budget on an individual and incremental basis is very difficult for local government—and for the Scottish Government. You can adequately say that the carer's bill might cost X, free personal care to under-65s will cost Y and transformational change will cost Z. However, we need to look at the overall budget and the pressures on it and we need to make some choices about where we prioritise our spend and what it will take.

Alex Neil: There was a financial memorandum attached to the Social Care (Self-directed Support) (Scotland) Act 2013 when it was passed, which gave estimated costs of implementing the legislation.

Paula McLeay: At the time we said that the transformational funding had been underestimated.

Alex Neil: By how much?

Paula McLeay: We did not give an amount.

Alex Neil: So how did you know that it had been underestimated? Surely you had done the homework.

Paula McLeay: We know that it was underestimated, because that has been borne out by the fact that we have had £70 million and that has not leveraged the change—we have not been able to deliver it.

Alex Neil: I am trying to understand the order of magnitude. I realise that, because 32 local authorities are involved, you cannot give me a precise figure. You mentioned £70 million. Should that figure have been £80 million, £90 million, £100 million or £150 million? What order of magnitude are we talking about?

Paula McLeay: When we look at what local government got out of that money—I think that it was £17 million in total—

Beth Hall: Yes.

Paula McLeay: I have not done the sums; it was £6 million plus £11 million plus £3 million. That is not even 50 per cent of the transformational money that was provided to deliver the legislation. That is not adequate to deliver the cultural and behavioural change that is needed. I am more than happy to go away and look, with the Scottish Government, at how much additional resource we need. The conversation has always been, "Here's the resource we have—how do we deliver it within that?" We have argued long and hard that that would not be enough, and that is borne out in the Audit Scotland report.

Alex Neil: There are two issues. The first of those is the overall amount that is needed to make self-directed support work right across the board. I understand why COSLA would find it difficult to give that sum, because that involves the third sector, the Scottish Government's responsibilities and so on.

The second issue is what local authorities need to make self-directed support work. As we have heard, we are nearly three quarters of the way through the implementation period and we are way behind where we expected to be. We can spend a lot of time going over milk that has been spilled over the past seven years, but it is more important that we work out how we can catch up, because at the end of the day, the policy is about making things better for end users.

How much more money does local government need to enable it to catch up and to provide on a permanent basis the level and quality of service that is envisaged in the legislation? I am looking for an order of magnitude.

The Acting Convener: You can write back to us once you have had an opportunity to consider that.

Paula McLeay: I would be happy to go back to local authorities to look at exactly how much we need.

The other issue is that the transformational funding has been—I do not want to say eked out—year-on-year funding.

Alex Neil: I accept that.

Paula McLeay: Given that it is such a significant change, we need the funding to be prioritised in one year to leverage the change, instead of being delivered incrementally, year on year, which will not help us to leverage system change.

Alex Neil: There are a number of points that we can take from the submissions. One of them is that there are a lot of pretty small funds—there does not seem to be a big picture. I accept what you said about one-year budgets.

I have a question for the Scottish Government and COSLA. The discussion has been primarily about inputs—the same is true of the submissions—but what outcomes do we want? One outcome is achieving the percentage of people on self-directed support that was envisaged, but the whole purpose of self-directed support was to improve the outcomes for the end users. Who is measuring that? What improvements have there been? Is there evidence that self-directed support has worked and has been more effective? Has it made a material difference to the outcomes for and the quality of life of the people we are trying to help?

Beth Hall: The reference to outcomes is incredibly helpful. That is where we need to focus. Paula McLeay mentioned the need for us, collectively, to challenge the continued focus on initiative-led budgets and input-focused policy initiatives. The Public Bodies (Joint Working) (Scotland) Act 2014 set out national health and wellbeing outcomes and put them on a statutory footing. Those are jointly owned by local government, the Scottish Government and the Parliament, and we all have a joint responsibility to ensure that the fiscal, legislative and policy landscapes function to support the delivery of those outcomes.

Alex Neil: We accept all that, but I want to know what evidence you have had from local government and the Scottish Government, since SDS was implemented, that where it has been implemented properly SDS is achieving the outcomes that were envisaged?

09:30

Beth Hall: I refer you to the work that Audit Scotland has done on that, in which there is plenty evidence of areas making real progress and innovating. There is constant feedback from service users. I accept that there is also negative evidence.

A range of research is being done by organisations including Self Directed Support Scotland. I have been in discussions with the people there in which they have acknowledged finding high levels of satisfaction with the services with which people were being provided. We also have the social care survey, which reported that 81 per cent of people are satisfied with the services that they are receiving.

The problem is that when we talk about SDS implementation, we focus on statistics around option choice and we attempt to make value judgments about people's choices by using high levels of choice of option 3 as a proxy for poor implementation, although that is not the case;

choosing to continue with council-arranged services is a valid choice.

Alex Neil: I think that the problem is that there is clear evidence that the choices are not being fully explained to people. I am not saying that it is the main or the only reason, but I know from experience as an MSP that one of the reasons why levels of choosing option 3 are so high is that people are not having the other options explained to them properly.

Beth Hall: I think that we need to be careful with anecdotal evidence. It has a role—

Alex Neil: That is not anecdotal evidence—I have seen it. What I say is evidential. I have a case load of people who fall into that category, as do others. In South Ayrshire, where I live, the same is true of people in the third sector to whom I speak. I am not attacking local government. I am just saying that it is not always working at the grass roots as it should.

Beth Hall: I will return to the data. I was drawing a contrast between the research that we have and the scrutiny reports that we have on qualitative experience—which in 81 per cent of cases is positive, according to the social care survey data—and what we get when we look at SDS implementation, focus on the four options and use data on them as a proxy for implementation or compliance. We need to be really clear about and careful with some of the percentages that have been discussed today and in other meetings.

We are in year 4 of the legislation's implementation. The data that we are looking at is for year 2, so it by no means represents the most recent picture. Recording of option choice is new for councils. That comes at a cost if they have to change their information technology systems, so councils, without sufficient transformation funding, have had to make a choice about where to invest. Do they go for the IT systems and the finance systems, or do they invest in changing services and improving support to people?

We need to be really careful when we think about implementation, client compliance and the evidence that we have on them: there are quite a lot of caveats. I think that COSLA and the Scottish Government are aware of that, and we are working together to support improvement.

Geoff Huggins mentioned the NSS source work that links health and social care data. We are also, within the context of integration, working to improve wider social care data, including data about personal outcomes. It is quite expensive to capture that kind of information well, and we tend to rely on Care Inspectorate reports in the interim.

We are also working to improve the data that is collected on carers. A new data specification was issued earlier this year. We are continuing to talk with Government about the costs of making changes to systems.

With regard to what we have seen from councils, the data that we have been referring to today is from year 1 of implementation. Ten councils were not able to break their data down into options that year; that number dropped to four in year 2. As I said, we are currently in year 4, and we will not know what the picture is now until a year and a half from now, because of the data cycle.

Alex Neil: Okay. I want to clarify two figures. First, there is the £70 million transition figure, for bridging finance. Is that purely for SDS and so does not include bridging finance for integration?

Paul Gray: That figure is for SDS.

Alex Neil: Is it purely for SDS?

Geoff Huggins: The £70 million covers some of the implementation costs for local government, and the cost of providing local advice and support to individuals, so it is purely about the mechanics.

Alex Neil: But if it is related to SDS—

Geoff Huggins: It is purely about SDS.

Alex Neil: So what is the bridging funding for integration?

Geoff Huggins: I do not think that we have offered bridging funding. What we have offered, and what has come through each of the last two spending reviews, has been additional resources for integration authorities from the NHS budget to support integrated care. Up to 2017-18, the current year, the figure that has been transferred from the NHS into the integration authorities is £357 million, which is in addition to the historical figure of £100 million, which was the reshaping care for older people resource, and to the £30 million for delayed discharge. We can see that the additional resources that have gone in over the past three or four years have been quite significant.

Alex Neil: On Beth Hall's point about SDS, which also applies to integration, you have a period of transition in which you are, in effect, funding two systems that are running in parallel, because you have to disinvest in the old system but cannot until people move into the new system. Does the £300-odd million include funding for making that double run until you can make the transfer?

Geoff Huggins: It is perhaps important to think about what the different funding streams support.

Alex Neil: That is what I am asking about. I would like a straightforward answer, Geoff: does the funding stream of £300-odd million support the

bridging aspect of running two services at once until you can switch to one? You are setting up a new service, and sometimes people cannot be taken off an old service all that quickly.

Geoff Huggins: The additional transfers that have gone into integration budgets are largely for the costs of direct service provision—the cost of packages. The money pays for the person who goes into someone's house or the cost of a residential care package. The associated £70 million resource is largely for the mechanisms by which people actually access packages—the process of assessment, the advice that is offered to the individual and work that is related to that process. The resource that is in the integration authorities, to which almost half a billion pounds has been allocated, is largely for provision of direct care.

What you are saying—it is one of the broader questions in this—is that, as we see new approaches being developed, such as the work on the carers legislation and support that is in place for that, there would be a transition from old systems to new ones. Part of the challenge is that, quite often, that has been presented as a need to continue to run the old system and have the new one. We need to get beyond that mindset and to see the full transition.

Paul Gray: I wonder whether the committee wants a response from us on outcomes.

Alex Neil: Yes, please.

Paul Gray: I am happy to continue or to go on to outcomes, as the committee wishes.

Alex Neil: Could I finish my questions about bridging?

The Acting Convener: There is a line of questioning to be concluded, and I think that Paula McLeay wants to come in as well.

Alex Neil: I will, if I might, go back 20 or 30 years to the switch over from the old Victorian mental health institutions to care in the community. One of the reasons why that was handled so successfully over a period of five years or so was that bridging finance was provided by the Scottish Office to the relevant authorities to cover the period in which they had to run two systems in parallel until they made the transition. They could not empty the hospitals on day 1, any more than we can now empty acute services of people who do not need to be there. They ended up having to fund the existing system until they created the facilities—in that case, care in the community—to allow emptying of the hospitals. My question is whether the £300-odd million includes the equivalent of bridging finance.

Geoff Huggins: It is important to think about what happens at the point at which somebody exercises choice in respect of SDS, which is the intention.

I will use the example of an individual receiving care as part of a care-at-home package with a number of hours of care each week, following a council assessment of their needs. If, having taken advice using the supported advice resource, they have been assessed through the SDS mechanisms and decide that they want instead to exercise option 1—to take on the budget for and to commission their own care—they would be given the budget to do that and the care package that the council was providing would simply stop. There is not a period in which a person would receive both the service from the council and SDS.

Alex Neil: My question was about integration and the £300 million. I was making the distinction between the £70 million for SDS and the £300 million. COSLA has also raised the issue of bridging funding. For the third time, does the figure that you referred to include, in effect, bridging finance for integration?

Geoff Huggins: No. The resource that has been allocated to integration authorities is additional resource to meet the costs of policies such as the living wage, as well to meet the needs of demographic change and to provide additional services.

Alex Neil: In that case, could part of the pressure that COSLA refers to in its evidence be addressed by bridging finance for integration, given that you will, in effect, run two systems until you make the final switch over to the new system?

Geoff Huggins: I am sorry: I am not sure what two systems you are talking about.

Alex Neil: We are trying to empty the acute hospitals. We reckon that about a third of people in acute hospitals do not need to be there. Geoff Huggins may remember that one of the main purposes of integration was to get those people out of the acute sector and into the community. You cannot empty the hospitals on day 1—it will take years to do that. You need the money to create the facilities in the community before you can empty the hospitals. Is there not a need for bridging finance to do that? It is a simple question.

Geoff Huggins: I understand that; it is quite an interesting analysis. That is an interesting question, on which there are different views.

Our experience is that when we create additional services in the community, people access them. If we do that while we continue to have hospitals, people also continue to access hospitals. In effect, we increase the overall service provision that is available in a locality. I am not sure exactly within that how, after we have decided to increase the amount of primary care

and social care—which is now being taken up by the community—that will take us to a point at which we are able to close our hospitals, which continue to be full.

The model of bridging finance works very well where you are able to identify a clearer closure plan for a—

Alex Neil: It does not need to be about closure. The hospitals are under huge pressure. That is why COSLA signed up to the integration policy in the first place. One of the driving forces was to get people who do not need to be there out of hospital. Does Paul Gray want to answer the question?

Paul Gray: My view—I want to be respectful of my COSLA colleagues and to let them give their own view on the issue—is that part of the proposition that lies behind integration is that the demographic trends—trends in multimorbidity and trends in respect of the ageing population—mean that the demand on hospitals continues to grow. My judgment is that the process is more about ensuring that we can meet the demographic trends by having services elsewhere that mean that the people who do not need to be in the hospital can be cared for elsewhere.

Alex Neil: Exactly.

Paul Gray: As the committee will know, there is significant investment in primary care. That is intended, over time, to build up the general practice function. The British Medical Association is considering—and voting on—a contract. All that is part of the progress that we seek in shifting the balance of care.

I understand Mr Neil's clearly made point about bridging funding. At the moment, the money that is being put in through the processes that Geoff Huggins has described is not being described as bridging funding. Is that clear enough?

Alex Neil: Additional money is going to primary care and—quite rightly—a lot of the money that is going to social care is to meet the living wage commitment. On top of all that additional money, is there still a need for bridging finance for integration?

Paul Gray: I suspect that COSLA would argue that there is. I also point out that, in terms of the overall transformation that we are seeking to make, more than £100 million has been assigned to transformation. The budget will be published later today, so COSLA will have an opportunity to see what is being proposed for next year. We are putting money into transformation; I am not claiming that we are presenting that as bridging funding.

09:45

The Acting Convener: Okay. Perhaps we could hear from Paula McLeay before we move on to our next member.

Paula McLeay: All the money that is currently being put into integration is to pay for services. It does not account for demand; it accounts for spend on services—the living wage and provision of care at home. It is to stand still. To be clear on the matter, there is no transformational funding in the budget, no transformational funding has been provided for integration and no money has been provided to support the shift in the balance of care.

The purpose of integration is to shift the balance of care and the balance of resource. We have not seen that happen, so there is a question to answer about how we support people to invest in community and social care and move the money and people from acute care into the preventative services. We are clear on that. Geoff Huggins is right that there are two ways that we can do that: we can manage the change with additional resource or we can make some fairly brutal choices about shutting one end of the system to invest immediately in the other. At present, there is no money for managing the transition.

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): I will stick with evaluation for a wee minute. Paul Gray's paper tells us that we are appointing

"an independent evaluator to lead on research work"

and so on. However, it also says that we are gathering evidence to tell us

"how to evaluate the impact of Self-directed Support".

Does that mean that we are not actually evaluating the impact now but finding out how to evaluate it as a result of that work? Have I understood that?

Paul Gray: There are three parts of the research. Do you want me to go over that?

Willie Coffey: No, I can read it. It just says that we are gathering evidence to allow us "to evaluate the impact". That tells me that we are not evaluating the impact at the moment and will do it later. Will you explain that, please?

Paul Gray: Points were made earlier about outcomes. Part of the task is to design a process in which we can work with people who use the support and the people who care for them. That is why we have appointed the organisation that will support us on that and are working with disabled people's organisations in particular so that we can tailor the evaluation to produce meaningful results for the services.

Willie Coffey: When will we know that? We are seven years into the programme. I know that we cannot evaluate a scheme the minute we set it up

but, seven or possibly eight years in, we might get an idea of the impacts, positive or otherwise.

Paul Gray: As the committee might already be aware, we will have progress reports in February, April and June 2018 and a final report by August, so evaluation is happening not far in the future. Local authorities already evaluate for themselves the impact of what they are doing. We have been reminded that anecdote is not evidence but, nevertheless, I take time to go and meet people who benefit from the service. I also accept the points that the convener made that some individuals and organisations remain disappointed with the uptake and provision of self-directed support.

Perhaps Iona Colvin can say something about the impact and outcomes.

Iona Colvin (Scottish Government): I do not want to go back over the options. I have been in the chief social worker adviser role for the past nine months and part of that time has been spent going round the country talking to colleagues about what is happening throughout the country. It is a mixed picture, but many authorities feel that we should not judge them on the numbers of options and the numbers of people who choose option 1 or option 2.

The key to that is how well some authorities have embedded this within their assessment, so it is not a case of having an assessment there and a self-directed assessment over there; it is all one process. Midlothian, Highland, North Lanarkshire and East Ayrshire have been pretty successful at that. Part of the key is not having two assessment processes but having one assessment process, which looks at people's individual needs and at the outcomes that they would like to see. It is about working with people, which is something that social workers are trained in and used to doing.

It has been difficult to gather that evidence because it is based not just on how many people take the different options but on individual experiences of care, on whether their outcomes have been differently articulated and on whether they feel that they have met those outcomes. There is a lot of individual evidence and all the authorities are looking at that in making their assessments. The job that we are trying to do is about pulling that together in a meaningful way that reflects the fact that people are having better outcomes, because there is more focus on talking to people about what outcomes they are looking for, and more focus on achieving those outcomes.

I was recently talking at a conference in Airdrie, in North Lanarkshire, that had the title "Being Human"—an interesting conference and an interesting title. I have also spoken to many people in North Lanarkshire about their experience of self-directed support, and I can clearly see the difference between a traditional care package, where somebody would come into your house four times a day, and having an individual carer and being able to direct when you have contact with them. There were a number of service users—people who have lived experience—talking at the conference about the difference that that has made to their lives. It is a fundamental difference to their quality of life and their outcomes. We are trying to capture that and feed that in, as well as trying to assure you that we are taking a consistent approach across the country.

I acknowledge the point that was made earlier, which was that people need to be offered self-directed support as part of an option and that sometimes that is not happening. That is the bit that we need to focus on together, and we are working with COSLA on improving the current situation and people's understanding of the process, to ensure that people are aware of it and that it is discussed appropriately with them. There is also the question of how we can gather the evidence to show you that people have a different experience of care because of that.

The general experience is that there are lots of things going on across the country. The issue is how we can get to a point where it is consistent and where we can learn from one another collaboratively and improve the processes, practices and outcomes for people. That is part of the discussion that is going on just now. Paul Gray and I have also been looking at the skills that are required, what the future workforce looks like and how we can ensure that we have a workforce that is fit for the future.

Willie Coffey: I was going to ask our COSLA colleagues about that. You mentioned East Ayrshire. We have taken some evidence from East Ayrshire and, as it is the local authority for the area that I represent, I know what is being done down there and I am pretty impressed. What can Paul Gray and Beth Hall tell us about the picture across the local authority landscape? One of the questions raised by Audit Scotland's work was about what is being done locally, so what is data gathering telling us about the impact and how does that feed into the independent review that Paul Gray is carrying out? Presumably it will join up.

Beth Hall: I highlighted some of the things that we know are going on with data at local level when I spoke about councils improving their systems and increasingly being able to record whether someone has chosen option 1, 2, 3 or 4. We want to make further improvements around the impact that that choice is having in terms of whether personal outcomes are achieved. That area is more difficult, for a number of reasons. It is very

qualitative. It is an output of a conversation between a service user and their care manager.

We absolutely want to avoid a tick-box approach to measuring whether an outcome has been achieved that does not really capture what has been going on. For example, if there is a young person with learning disabilities and one of their personal outcomes is to improve their social circle, how do we measure whether that has happened? How do we capture it? How does a council, a commission or an IT provider make their data capture system capable of doing that? Over what time period would it be reasonable to expect that personal outcome to be met? How would we ensure that those very nuanced things were being dealt with in the same way in every single area so that we can sit at the national level with comparable data?

We all have this ambition around personal outcomes, but a lot sits underneath that. That is not to say that we are shying away from that ambition or saying that it is too difficult to achieve; it is just that there are issues with the scale and length of time that it would take.

Willie Coffey: Are all the health and social care partnerships doing their own thing in how they evaluate it? Are they doing 32 different things?

Beth Hall: No. We have work that we do jointly with Scottish Government in the integration space, which looks at having a core set of consistent data that can tell us about what is going on in the system.

Our recent focus there has been around social care data, where we feel that there is a gap. We have been working together to address it.

Returning to SDS for a moment, we need to challenge ourselves and ask a more complicated question than whether the data on SDS implementation is telling us that we are halfway or three quarters of the way there. SDS is an approach to delivering social care, as Iona Colvin stated. It is not a separate thing. For me, this is about the whole system and what we know about it. We need to approach that by challenging ourselves to look at inspection evidence on how other personal outcomes are being achieved. That evidence includes scrutiny reports such as Audit Scotland's, the integration data that I just mentioned, the social care survey data that we have and developments such as the new national care standards, which are much more person centred and outcome focused. It is about how we look across that whole system. That gives us plenty of work to be getting on with.

Paula McLeay: I would add to that two points about outcomes. There is the extent to which implementation of SDS and the outcomes that it can achieve are being merged with an overall dissatisfaction with how much resource there is to meet people's needs in the system, because we have raised expectations and we have done it in a period of austerity. One issue is to what extent those things on the ground are being felt by individuals and transferred to a feeling about whether SDS is being successful for them.

I would also say that, in the round, we as a country are not as good as we would want to be at measuring outcomes. We are still measuring inputs. We have had a review of targets and indicators across health and social care that indicated that we are still measuring inputs and are measuring them without any counterbalance in that measurement and performance system that looks at whether they are achieving things for people and how we articulate that. That is an issue that we collectively recognise and want to address, but it is not easy.

Geoff Huggins: Maybe we could also make the connection between what Paula McLeay said and what was in Sir Harry Burns's review. It is very interesting. Mr Neil earlier asked about whether outcomes are getting better. It is difficult to say whether they are getting better, because historically we did not track them. If we are looking to compare what is going on in 2017 with what went on in 2010, the data for 2010 that we would want to compare with is not there. We have not looked at it in that way. We are also asking different sorts of questions. The questions that we are asking now are ones that we would not have asked in 2010.

One of the key components of SDS is personal control, which is the idea that someone is able to determine how their care is delivered and takes a personal benefit from that sense of control in their life; they will feel that they are not subject to some arbitrary or external system making decisions about how they live their life. That sense of control is a key component of someone's wellbeing and quality of life. How we measure it is a whole new idea—not just in Scotland but more generally.

10:00

At the moment, we are doing work in Dumfries and Galloway on the implementation of the dementia outcomes work that we have done with Michael Porter's international consortium on health outcome measures. That takes us into questions about people's sense of safety and of control and using that in local health and care systems to see how those systems can understand whether they are producing benefit. It is remarkably hard work. It is very easy for us to know how many people went through a hospital door, but it is a lot more difficult for us to know how their experience was when they went through it. That is not just at the point when they might press a button to answer

the question, “Was your experience good today?”, but perhaps when they think about it two days later or when they can see how it has affected the rest of their week. Those are quite big issues because, ultimately, they are about how we feel about ourselves and how we live our lives.

Building new systems in a space that allows us to track whether the more human outcomes—rather than clinical ones—are achieved is a whole new challenge. It is one of the really exciting parts of Sir Harry Burns’s review, in that he maps out that that is the direction in which we need to go. Alongside activity data and population data, we also now need to be able to understand people’s experience of care and the degree to which it supports them in matters such as their sense of safety, control and wellbeing—things that, historically, health systems would not have seen themselves as being about.

You might ask why it is taking so long to develop an evaluation strategy. Part of the challenge around it is that, while we can look at different tools that people use to say whether they have achieved their personal outcomes, simply aggregating them and saying that, for example, 74 per cent of people achieved them does not really tell us whether the process generally gives people exercising options 1, 2 or 3 a greater sense of control over their health and wellbeing. There are some really quite deep questions that we need to answer.

As Paula McLeay has reflected, this is also happening in the context of a range of other changes in the system and in people’s lives more generally, in terms of their expectations and experience, such as social isolation and the changing demographics in society. We are not just tracking a single thing as we move through time but tracking it while other things are changing. That takes us into some very complex evaluation of how we attribute benefit or disbenefit to any particular intervention in that space. It is also why we need to move away from simple statements such as that something used to be 74 per cent and it is now 76 per cent. There is just so much more going on there.

Willie Coffey: My last question is about the final point that Audit Scotland made, which was about the joined-up nature of the service. How do we make sure that we have a picture of what the whole service looks like, and in particular where SDS fits into the health and social care integration side? Last week, I was chatting to some Ayrshire general practitioners about the new GP contract. They were bemoaning the fact that there are multiple integration joint boards even in a single health board area. For example, in Ayrshire and Arran there are three. All over the place, there are multiple joint boards in health board areas. The GPs were finding it difficult to deal with such situations, so how on earth do we ensure that the whole system joins up and fits as correctly and appropriately as we want it to?

Geoff Huggins: That is an interesting question, because general practice is a good example of a very local service. As we begin to build and to think about the new contract, and the wider primary care team connection to social care, we are beginning to see better connections to social care. We are also looking at issues around palliative and end-of-life care as we make connections across the piece. Those happen in very local systems of care, although they are in the framework of a national contract. We see that when we look at the data on activity and how people engage with services. They are really quite localised systems of care, in which people’s experience relates to perhaps two or three services. GPs will tap into voluntary or statutory services based on proximity. That means that, when it comes to understanding local care systems, a lot of the work that we have been doing on data, through the list officers and through NSS source, to track how people move through the system becomes significant. Using the data in NSS source, we can now understand the different pathways that people take through the system and what that means for service configuration.

Some of the work that we have done has been in Ayrshire. We have looked at the paths by which the over-65s, who are high users of service, go through the system, which has given us a lot of knowledge about the two tracks that they follow. One is a frailty and fall track and the other is a dementia and psychogeriatric track. Until we had the data to understand how they went through the system, it just looked like a lot of episodic care. Part of the challenge for clinicians in the system is that they see the person in front of them, but they might not recognise that, in that area of Ayrshire—East Ayrshire or North Ayrshire—there have been 20 people going through the same thing that month. The data enables us to think differently about how to approach those people as a cohort in connection to hospital and specialist services, and also the support that is offered to primary care.

The size of integration authorities varies quite considerably around the country from 22,000 people in Orkney to around half a million in Glasgow. However, there are the 100-odd localities within those where a lot of the very local planning needs to take place, as most people’s experience of healthcare services is local.

Willie Coffey: That is very helpful.

Liam Kerr (North East Scotland) (Con): Does Beth Hall want to say something? You looked as though you wanted to come in.

Beth Hall: Thank you. I want to pick up on some of the points that Geoff Huggins has made. We need to be really clear that integration is about more than IJBs. There are services that sit outwith IJBs in local government and community planning that can support the success of integration. Community justice and children's services are not always integrated, so housing has a huge role to play and other local government services such as leisure and environment have a massive contribution to make towards the prevention agenda. When we talk about shifting the balance of care and about early intervention and prevention, we tend too easily to have a narrow focus. It is not just about shifting from acute care to community health and social care; it is also about a shift further upstream to preventative services that sit within local government.

I mention that because it is relevant to SDS. Geoff Huggins talked about control and empowerment, and we must remember that, at its core, SDS is about more than services to meet needs. It is about moving away from the deficit model, so it is not about needs and the services to meet them, but assets and outcomes and how we achieve those. That means that we are into the space around building individual and community assets. A good SDS conversation is about the outcomes that we want to achieve and all the resources that might be available to help achieve them, which includes individual strengths, carers, family and the wider community. We will not be genuinely successful in delivering the original vision of SDS unless we can move into that space.

You can imagine what I am going to say next. There are concerns about it becoming harder and harder for councils to do all that they do to tackle inequalities and build stronger communities. Although money is going into health and social care to allow us to stand still, as Paula McLeay highlighted, there is a corresponding reduction in wider local government stuff. I worry that we have very narrow conversations about the shifts that are required, which, if we are thinking about sustainability over the longer term, is a mistake.

Liam Kerr: I will come back to that point. First, I have a brief question for Paul Gray. Willie Coffey asked about data capture. In a previous session, we heard from Inclusion Scotland that different local authorities capture data in different ways, but that is now coming together and we are trying to sort it out. Why was that not done at the start? Why did no one plan properly?

Paul Gray: If we wait until everything is perfect, we will not do anything at all. However, a more constructive answer—

Liam Kerr: Is that an acceptance that there was a failure to plan, Mr Gray?

Paul Gray: No. We started with what we had. That is a key tenet of improvement, and it runs through our improvement science approach. You must start with what you have, otherwise you never start anything. I am not saying that there was a failure to plan; I am saying that, on the basis of experience and learning, we have built the systems and made them better. We improved the data collection to give us a set of data on 2015-16 but we were able to put that out as data in development. We have developed it further and continue to do so. Also, as COSLA colleagues have said, we are talking about choices that local authorities must still be allowed to make about where they invest.

Liam Kerr: But they incur costs. We talked about the IT system. If the system develops and the local authority says, "Hang on, we need a whole new IT system," a cost is attached to that.

That takes us back to the point that Alex Neil made, and I have a question for Paula McLeay on that. Alex Neil asked you about the financial memorandum and how much more money is needed to make self-directed support work. You were fairly clear that £70 million was not enough. Alex Neil pressed you and asked how much would be enough, but you did not seem able to answer that question. To be fair, at some point, the Scottish Government is going to say that it thinks that you need £70 million and you will say that you need more. The logical question is, "How much?" and you do not seem to be able to answer that. Is that correct?

Paula McLeay: The £70 million was allocated incrementally, year on year, so we did not consider what it would cost if we wanted to refresh our IT systems and when to amass that money, although we could do that.

Liam Kerr: Who did not consider that?

Paula McLeay: I do not think that we considered it as part of the financial memorandum.

Liam Kerr: When you say "we", do you mean COSLA? Who was the onus on to make that judgment?

Paula McLeay: It is on everybody—it is on the Parliament, the Scottish Government and us. We accept that we did not, at the outset, consider whether there was a need for a total refresh of our IT systems and what that would cost.

I do not want to go into what data we have, because, if we pick off one element, we miss the fact that the funding in the round for social care is really challenging. However, Audit Scotland's recent report on social care said that, in order to stand still, we need 16 to 21 per cent more in social care budgets by 2020. That gives us a ballpark figure for what it really would require. We

have not broken that down and taken a system-wide look at whether the spending on historic statutory pressures has kept pace with demand, whether the individual additional policy requirements and pressures that have been put on us are sufficiently funded and whether the overall prioritisation that we make across a shrinking budget is able to deliver on expectations. I accept that we need to do that and put more robust figures on it.

Audit Scotland has considered what it would take to stand still, but we obviously want to evolve and we want new models of care. Part of the purpose of integration is to be more sustainable, not just to keep growing our services to meet the demand. Bearing that in mind, Audit Scotland produced a figure of 16 to 21 per cent by 2020.

Liam Kerr: That is useful. I have a degree of sympathy with that. What happens later today may be more challenging. However, it is fair that the Scottish Government would ask how much you need to make the system work. To my mind, the Government needs to be presented with a figure. However, that then begs the question whether Paul Gray accepts that not enough money is going into the system. Do you accept that the financial memorandum was wrong, Mr Gray? If so, who got it wrong?

Paul Gray: No. The financial memorandum is necessarily an estimate that is made at the time. I am never resistant to the argument that more money would help, but that would be true of almost anything in the world. I would certainly welcome any more detailed proposition from COSLA of what it thinks would help, at what rate and to what specification.

Nevertheless, we have put £70 million into this. I will not read out my written submission, but I invite the committee to look at it, as it sets out where that money has gone, how it has been distributed and what it has produced. If part of the learning is that we need to make some choices—as Paula McLeay has fairly stated, this is about choices—and if we choose to put more money into self-directed support, we will be choosing not to spend it on something else. We would have to decide that self-directed support is more of a priority.

10:15

Liam Kerr: The panel has been fairly clear. This is obviously generalising, but I hear from COSLA that we do not have enough resource. However, to paraphrase slightly, Paul Gray said that he doubts whether more money is the solution, and he has just said that there may be other things that need to happen. Who is right, and what is the solution? What will happen?

Paul Gray: There are many components to the solution, but I will try to keep this relatively short and simple. The work that COSLA, Iona Colvin—who is our chief social work adviser—and our workforce colleagues are doing on workforce is part of the solution. Education is also part of the solution. I will not read out our written submission, but it says that the support in the right direction programme annual report tells us how many people were supported and that the innovation fund annual report tells us about the number of people who had improved knowledge and awareness of approaches and so on. Those investments in helping people to understand the system and what it can do are important. Investments in the workforce are important.

The data that we gather from our evaluation will help us to decide what to do next. From the report, the evidence that we have gathered and the visits that we have done, we are clear that there are still people who are not clear enough about the choices that are available to them and the basis on which they might make them. Our task is partly about helping the workforce to explain the choices and partly about making the choices more clear.

Liam Kerr: That sounds like a resource issue. It sounds as though cash will need to be injected into the system to deliver the various things that you have just talked about. If that is so, is the Scottish Government making an assessment of what needs to be done, how much it will cost and, therefore, how much more money needs to go into the system?

Paul Gray: As I have been trying to set out, it is largely an issue of explaining and educating. As I said in response to Mr Coffey, we are carrying out an evaluation and we will reflect on what it tells us. However, I would like to have that evaluation before I decide what to do about the matter.

Paula McLeay: The point that I have been making is that, if there is no more money, we will need to make some choices, and those will be political choices. At present, we have legislative pressures, which I will list for accuracy. We have SDS, legislative pressures on children's and young people's services, the Public Bodies (Joint Working) (Scotland) Act 2014, the Carers (Scotland) Act 2016, the Community Justice (Scotland) Act 2016, the Community Empowerment (Scotland) Act 2015, early years services expansion, the Scottish living wage, the commitment to 800 additional mental health workers, nursing and social care staffing pressures, free personal care for the under-65s and the extension and implementation of the living wage in relation to sleepovers.

At some point, we will have to make choices about what we are prioritising in the system and what we are de-prioritising. We cannot continue to

add on more with shrinking budgets and expect the ends to meet. That means reduced eligibility, reduced numbers of people getting services and, eventually, reduced quality of care as a consequence. We want to work against that and deliver improved outcomes. We want to work in partnership to deliver integration, the shift in the balance of care and health and wellbeing outcomes, but the stark reality is that we are continuing to load the system with more new commitments when the overall resource is shrinking.

Liam Kerr: That is a persuasive argument. Paul Gray, how do you answer that?

Paul Gray: I answer that by saying that I will wait for COSLA's proposition.

The Acting Convener: Before I bring in Monica Lennon, I have something to ask. On page 3 of your written submission, you talk about distributing 40 per cent of the £26 million of funding over 2010 to 2018. When did the allocation of £70 million start? Was that in line with the legislation in 2013? Are you counting funding against that total that arose much earlier?

Paul Gray: Yes. I will give you a precise answer, but I will give it to you in writing.

The Acting Convener: I am happy for you to write back to me.

While you are doing that, can you break down the £70 million? I might be wrong about this, but what I heard from Paula McLeay was that you seem to think that you got money from the £70 million in tranches of £3 million, £11 million and £6 million.

Paula McLeay: Yes. It was £11 million in the year before implementation, £6 million in year 1 and £3.52 million thereafter, and we now have resource that covers one staff member and a development budget of a few thousand pounds, depending on the size of the authority.

The Acting Convener: Adding those figures up did not get me to the figure that is cited in your paper, but that might just be my maths. You are saying that you have distributed £35.5 million to local government. Clarification of the distribution of the £70 million, over which years that was done and to where would be helpful. I am happy to have that in writing.

Monica Lennon (Central Scotland) (Lab): In response to an earlier question, Geoff Huggins mentioned rural areas, but I cannot recall exactly what you said. Could you remind the committee?

Geoff Huggins: In areas in which it is difficult to provide social care because of workforce challenges, we have seen creative and innovative use of self-directed support as a mechanism for securing care for people. An example of that is Boleskine Community Care in the Highlands. In an area in which the health board, the provider of social care in the area, was finding it difficult to recruit, it was able to work with the people who required care to access and buy care from others who lived in the community. That enabled it to bring in the component of control and address the question of supply.

In areas in which it has been challenging to provide care in traditional ways, SDS has enabled people to secure care that would otherwise have been difficult to deliver. It also shows the degree of customisation that can be allowed and the degree to which it reflects people's lifestyles and work patterns in such localities. The person who is the postman could be doing four hours of care work a week as part of a portfolio career in the locality.

That enables people to maintain their lives in communities where they want to live instead of having to move elsewhere to receive care, which is valuable and important.

That is the sort of creativity that we want to see generally, and we are beginning to see it. However, it has come about because of a series of particular pressures.

Monica Lennon: It is good to hear about innovative approaches. The area that I represent is not rural; it is predominantly urban. When Jess Wade of Self Directed Support Scotland was here, a couple of weeks ago, she talked about rural areas and some of the challenges that you have acknowledged. From what she told us about what her members have reported, it does not sound like a great picture on the ground. She said that, because there are few service providers in rural areas, people are being directed to option 1 when it might not be appropriate or when they do not want it. Do you recognise that? What is being done about it?

Geoff Huggins: It is genuinely a challenge that all the facilities that we want are not available everywhere. In that context, trying to find creative solutions is part of the way forward.

We see across the country, and perhaps more in rural areas than in other areas, that the workforce is not always available to offer care, including personal care. Our objective is to support councils and integration authorities to secure that workforce, but, ultimately, we cannot compel people to work as social care workers. That is a genuine challenge.

The examples that we have seen are quite creative. We use our facilities and our engagement with integration authorities to share those examples and to talk about them with people in Argyll and Bute or in Dumfries and Galloway so that they are aware of what is

happening. Equally, there are challenges in other areas—particularly in rural areas with high employment, such as Orkney, where it is difficult to secure people to work in the sector. I acknowledge that there is a genuine challenge, but we are working with providers and commissioners to find a way through that.

Monica Lennon: I will probably return to best practice, but, for the moment, I will stick with the evidence on self-directed support. Jess Wade said that there is a disconnect in implementation between central and local government. She told us that she believes the legislation is sound, but she questioned the extent to which it is being followed. Does the Scottish Government share that frustration?

Geoff Huggins: In my earlier response, I talked about the challenge of both providing individuated support based on choice and control and commissioning support for populations. That is a genuine issue, not a made-up issue. When I think about the care needs of the people of East Ayrshire, I need to think about the overall workforce needs, the pattern of care, the residential care needs and what facilities might be offered around end-of-life and palliative care. If I am also trying to answer the question of what I would do to support particular individuals in exercising their control within that, the picture becomes quite complicated. We are not seeing a disinclination to take the work forward; we are seeing the genuine challenge of people trying to do both of those things at the same time.

That is a real challenge, because we are thinking both at the whole-population level and at the individual level, as there are good reasons to do that. Increasingly, the work that we do on integration and on data tells us about the interaction between a relatively small group of individuals—around 100,000 people in Scotland—and the whole health and care system. Those 100,000 people use roughly half of all the resources that are used in health and care, so offering them choice and control to support them to live safely and independently is valuable at a system level. However, it can be difficult to strike a balance when there are expectations of standardisation and uniformity.

We are often asked why we cannot say that everything is the same everywhere or why we cannot guarantee that things are happening in the same way. It is expected that SDS will happen in very different ways, to reflect what people request, and I guess that is a continuing challenge.

Monica Lennon: We have heard a lot today about challenges. SDSS's perspective is that it is difficult for the Scottish Government to give strong direction to local authorities on what needs to change and improve, and Paul Gray has talked about issues around explaining and educating. Is there a leadership problem? Is the Government fit to address that challenge?

Geoff Huggins: The key focal point for leadership around self-directed support in local systems is the integration authorities, which have a commissioning role in setting the framework. My team and I meet with each of the integration authorities at least once a year. Some we meet more frequently and we regularly meet the chief officers. As part of that process, we are identifying with chief officers, in both local and national meetings, the opportunities that self-directed support offers in respect of the particular challenges of delays in social care delivery preventing admissions. We are working with key leaders on that.

Monica Lennon: Given that the evidence shows that provision is really patchy, do you ask the chief officers at those meetings why good referral pathways are not consistent?

Geoff Huggins: We do. We address the issues that come out of the data.

Monica Lennon: What do they say in response?

Geoff Huggins: They identify the degree to which they are working in those spaces to make improvement. This is an improvement story. You start from where you are and you make improvement to deliver better-quality outcomes.

Monica Lennon: What would the top three reasons be for why provision is patchy and why good referral pathways are not always in place?

Geoff Huggins: Generally, what comes out of the conversations is how chief officers have prioritised different parts of their activity over the recent years. They will have been doing different things. As Paula McLeay identified, there is a range of expectations for improvements. We have seen within systems that different improvement expectations are being addressed in different orders. We tend to identify why it would be that, for example, providing better support to carers at an early stage will help integration authorities to achieve their overarching, broader strategic outcome objectives in terms of sustainability and quality.

10:30

Monica Lennon: Could you pause for a second? Paula McLeay ran through a long list of legislative requirements and statutory duties, and she said that there might be a need to deprioritise. Is the Scottish Government giving any direction to local authorities that there are some areas of delivery that can be given lower priority?

Geoff Huggins: The issue comes back to what is going on in local systems and the different degrees of maturity that exist in those areas. In some areas, the work that we did on implementing the living wage was significantly more straightforward because of work that had already been done. That meant that it was less of a burden for that work to be done. Some areas have significantly more developed engagement with and better supports for carers in their areas. It is clear that, across the country, not everyone is doing everything really well, but nobody is doing everything really badly. It is a case of looking to see how those things fit together.

It is also important to remember that not all the measures are intended to produce additional resourcing burdens. The intention in providing good-quality support to carers is to enable them to feel more safe and secure and to provide the care that they want to offer to their loved ones for a longer period of time. That has benefits to the carer and the individual, but also to wider sustainability.

Monica Lennon: It is clear that you have examples of innovation and good practice. Given that we know that good practice exists, why is there no urgency on the part of the Scottish Government and local authorities to do more to shine a light on that good practice and to ask other people to pull up their socks and get on with it? You know that good practice exists, so why is that not becoming the standard everywhere?

Geoff Huggins: Again, it comes back to the nature of the situation. I mentioned Boleskine Community Care. Although that is a great example in that area, I would not expect the same service to be delivered in the centre of Edinburgh; I would expect a service to be delivered that was appropriate to the locality. That is the improvement challenge. It is a case of using the facility and the framework that are there under the carers legislation or self-directed support, or in another improvement area, but making sure that a localised approach is taken. The knowledge that others have done innovative things does not mean that people should simply drag and drop what they have done to their locality.

People expect individuated care. Just because the people in the Boleskine example have found that service to be very valuable, that does not mean that people in another area of the country will find it equally valuable. That illustrates the degree to which the change process is not simple and straightforward.

Monica Lennon: Yes, but do you understand that people who do not work in the system and who are not in the political bubble that we are in find it quite frustrating that although best practice will often be cited in a report as an example to look at, it does not seem to get rolled out. Why is there no urgency?

Geoff Huggins: I think that there is a clear urgency around implementing SDS. As well as the Scottish Government's commitment to developing innovation and continuing the funding to support the change, there is the work that we are doing with chief officers and the work that is being done through the SSSC, NHS Education for Scotland and the Care Inspectorate. Through us, through COSLA and through the national agencies, there is a clear commitment to promoting and taking forward SDS. A key component of that will be the improvement of the data and the gathering of data that demonstrates the degree to which outcomes are being improved.

As Audit Scotland suggests, SDS is a major challenge to implement, and we are working through that.

Monica Lennon: I want to bring the discussion back to the experience of service users. We have heard in evidence that reductions in the level of service in some authorities are causing anxiety for some service users about how their support will be reviewed.

What impact is the diminishing resources of councils and integration authorities having on the flexibility and choice that are available to people?

Beth Hall: You talked about service users seeing services diminishing. Earlier, we spoke about some of the difficulties in disinvesting from old models of support and reinvesting in new ones. I certainly picked that up from the Audit Scotland report. I also noticed what was almost a dichotomy and was certainly a tension in terms of feedback from service users. On the one hand, you had people who were quite anxious about that move away from traditional services and who want things such as day centres to be retained and are nervous about self-directed support, because they see it as being about a reduction in service and they are aware that it is being implemented at a time when local government resources are being greatly reduced; and, on the other hand, you hear from individuals who feel that they have not had the level of control, choice and innovation that they would expect from SDS.

Councils will be struggling with some of the themes that Iona Colvin mentioned earlier. People will make different choices when they come out of a day centre, for example. For the sake of argument, if two, three or four people choose to take a direct payment, the costs of running the day centre do not reduce by that amount. Both costs must be met. The direct payment must be paid to the people who have come out of the service, but the service costs must still be met. Where that becomes difficult, councils have to make difficult

choices about whether they are going to close the community-based day centres that some people still want to use in order to be able to afford to offer the SDS options that they are required to offer. Similarly, as I noted earlier, two different views can be at play in relation to councils' role in engaging with communities. All of that must be reconciled, and all of the issues will be different from area to area, because there are different configurations of services in different areas.

I think that those issues account for some of what you are hearing from Self Directed Support Scotland. Quite a lot is going on in relation to those issues. We have started to talk about some of the bigger whole-systems issues today. I realise that we do not have masses of additional time but, in order to deal with those issues, we must ask some pretty fundamental questions about how you get the flexible workforce that you need, how you get the investment to the right place and how you balance the competing resources, given that there will not be enough resource to deliver all the initiatives and legislation that Paula McLeay outlined. There will inevitably be a bit of competition over that too-small resource. There is a lot going on under those issues.

Monica Lennon: When there is a competition, there are always winners and losers. Who will the losers be?

Paul Gray: If you are asking me what choices local authorities are going to make, I would say that I am not able to answer on their behalf.

I would be reluctant to characterise the process as involving winners and losers. We risk losing sight of the fact that local government has come a long way on self-directed support. The number of people who are engaged in it is increasing. I will not read out long extracts from the self-directed support strategy that has been published but I will draw attention to the fact that, over phases 1 and 2, it was noted that there is a greater understanding of SDS, that there is a greater use of local facilities and so on. There is a list that you can read for yourself—there are lists under outcome 2 and under outcome 3, and all of the lists are based on the evidence that we have. The management information that will form part of what is published in due course shows that uptake is increasing.

I am not diminishing the difficulties or failing to acknowledge the pressures that COSLA colleagues are describing, but we are seeing a system that is improving. The workforce and the public are gaining an improved understanding, although the understanding of the public—who are the most important part of all of this—is not yet as good as we would like it to be. I want to leave with local government the matter of the choices that it is legitimately entitled to make, but I would not want to come away from this conversation with the sense that SDS was somehow failing—it is not; it is improving.

Monica Lennon: Let us try to end on a positive note. What more can the Scottish Government do to work with COSLA and to help local authorities to improve and to achieve best practice? We know that best practice exists, but how do we get that rolled out a bit quicker?

Paul Gray: I have indicated that we want to wait for the evaluation results. I want it to be clear that that evaluation is being overseen jointly by not only COSLA, other local government colleagues and ourselves, but most importantly by people who represent service users. We want to learn from the evaluation; we want to learn from what this committee may say.

What can we do? We have resources available through our i-hub programme, which supports improvement. That is, I think, the point that Ms Lennon is making about ensuring that where there is good practice it is spread. Like Geoff Huggins, I hesitate to use the word "rolled out", because rolling out what happens in the Black Isle to Falkirk would never work, but there are components of good practice that we can continue to support everyone involved in this system in developing.

Another thing that we can do—this was not done in preparation for this committee, but it has turned out to be helpful—is to continue to meet the representatives of care organisations and with the people who experience the service, because there are quite powerful testimonies and they are not all about what is working. I have acknowledged the Acting Convener's point about some who feel quite strongly about what they are not getting from the system as well as what they are getting from it. We can continue to learn.

If we were to adopt a proposition—it would not be my intention to do this—that we should somehow move into a mode of telling local government what to do, that would not be an effective way to run this.

Monica Lennon: I make it clear that that is not what I was recommending.

Bill Bowman (North East Scotland) (Con): Who is in charge of the SDS project?

Paul Gray: The integration partnerships are in charge of delivering it. To suggest that one person is in charge of it would be—

Bill Bowman: It would be helpful to know who is in charge. You can interpret "who" how you like. I asked in a previous session about the chain of command. Who is at the top of the chain of command?

Paul Gray: In that context, Mr Bowman, as I am the chief executive of the national health service in Scotland, I am at the top of the chain of command. SDS is not delivered by a single agency or body.

Let me be straight. I could certainly say that, yes, I am in charge, but that would not be true. I am the accountable officer for the budget that comes from areas for which I am responsible, but money is directly assigned to local government and therefore each partnership is responsible for the delivery of self-directed support in its area.

Bill Bowman: Does a partnership model work?

Paul Gray: Better than almost anything else.

Bill Bowman: That you have tried?

Paul Gray: There are few things that are not delivered better in partnership—I am fundamentally clear about that. It is not easy. It would be much simpler, but much less effective if somebody—it would not matter too much which of us along this panel here—could give instructions and say what is going to happen next and in what order. However, that would completely ignore the fact that, as Geoff Huggins, Paula McLeay and others have explained, the systems are delivered in localities that are very different. A single all-encompassing edict would simply not work.

10:45

There is a ministerial steering group jointly chaired by the Cabinet Secretary for Health and Sport and COSLA's lead spokesperson for health and social care, Councillor Peter Johnston. Therefore, governance is in place that oversees integration partnerships. That is joint governance, and deliberately so.

I may not be giving you exactly the answer that you are looking for, but that is the answer as it currently is.

Bill Bowman: I would differentiate between giving instructions and leadership. You have heard from COSLA that it is not happy about everything. For example, it suggested that more money might help, but your response was that you would await its submission. I think that I have suggested to you before that you have a passive management style, in that you delegate and let things happen. Could you be more proactive in these matters and show a bit of leadership?

Paul Gray: I do not think that any leader would sign up to a proposition that they had not seen. I am happy to wait for and receive that. If you have deduced that I have a passive management style, you have not seen it all.

Bill Bowman: I wait to see that. Being proactive and waiting for something before you act are different things. Anyway, you have told me what I need to know.

Can I pick up on one further small point, convener?

The Acting Convener: Yes, but very quickly.

Bill Bowman: In response to, I think, the Acting Convener, you spoke about the 40 per cent of money that was spent. You have referred to various funds in your submission. You say that money has been "invested" in two funding streams:

"£2.9m has been invested"

in the support in the right direction fund and

"£1.2m has been invested"

in the innovation fund. What does "invested" mean?

Paul Gray: Spent.

Bill Bowman: Spent. Could you not just say that? If you use the word "invested", that suggests that you are creating something for your balance sheet.

Paul Gray: Mr Bowman, at the risk of agreeing with you, I agree with you. It is clumsy drafting—it is not a word that I particularly like. The money was spent.

Bill Bowman: I do not think that it is only you who falls into that—I will not say "trap"—usage.

Paul Gray: I agree.

The Acting Convener: On that note of agreement, I conclude this evidence session. I thank the witnesses for coming along this morning and providing us with very interesting evidence.

10:47

Meeting continued in private until 11:30.

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