OFFICIAL REPORT
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 6 October 2020**

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

# Tuesday 6 October 2020

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## HEALTH AND SPORT COMMITTEE
**26th Meeting 2020, Session 5**

**CONVENER**

*Lewis Macdonald (North East Scotland) (Lab)

**DEPUTY CONVENER**

*Emma Harper (South Scotland) (SNP)

**COMMITTEE MEMBERS**

*George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (Con)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

**THE FOLLOWING ALSO PARTICIPATED:**

Professor David Bell (University of Stirling)
Eddie Fraser (East Ayrshire Health and Social Care Partnership)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Humza Yousaf (Cabinet Secretary for Justice)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

Virtual Meeting

# Scottish Parliament

## Health and Sport Committee

*Tuesday 6 October 2020*

*[The Convener opened the meeting at 10:00]*

## Social Care

**The Convener (Lewis Macdonald):** Good morning and welcome to the 26th meeting in 2020 of the Health and Sport Committee. We have received apologies from Alex Cole-Hamilton.

Agenda item 1 is an evidence session as part of our social care inquiry. I welcome Eddie Fraser, chief officer of East Ayrshire health and social care partnership; Annie Gunner Logan, director of the Coalition of Care and Support Providers in Scotland; and Professor David Bell, professor of economics at the University of Stirling.

We will hear presentations from each of our witnesses on the potential for future reform of social care. Each presentation will take 10 to 15 minutes. After we have heard all three presentations, the floor will be open for questions and discussion. I ask members to hold their questions until we have heard from all three speakers. I will invite members to put an "R" in the chat box if they wish to contribute or ask a question, and I will then invite the witnesses to respond.

I invite Eddie Fraser to give his presentation.

**Eddie Fraser (East Ayrshire Health and Social Care Partnership):** Good morning, convener and members, and thank you for inviting me along to speak to the committee. I speak today as chief officer of the East Ayrshire integration joint board, but I think it is important to say that I also speak as someone who has spent the past 34 years of my life working in social work and social care, and I am carer for my son, so I have a rounded perspective on where we are.

Reflecting back on where we were all those years ago, I note that, when I worked in Glasgow, our home helps, as they were then, provided practical support to local people Monday to Friday between 9 am and 1 pm. That has changed a lot over recent years, and while some of the changes have been for the better, some have maybe not been for the better. In particular, there were changes in 2002, when we moved more towards personal care. When we look at the statistics, which show that a high percentage of the care that is provided at home is personal care, particularly for older people, we start to wonder who provides the practical support and where that burden has moved to.

We sometimes see social care as a support for healthcare. That leads to the question whether we are overprofessionalising and medicalising our social care services. If that is the case, are we really valuing social care and acknowledging its purpose? For me, social care is not only about the personal care of a person; it is about their human rights and how they are included in their local community. It is not only about paid hours of care; it is about the things that we do—social supports such as lunch clubs and intergenerational work. We can easily get lost in the question of paid hours of care work.

We have also come a long way with care homes. When I worked in the west end of Glasgow, one of my roles was as a resource worker with a responsibility across eight care homes, and local authority care homes had eight-bedded rooms with curtains between the beds and people sitting on commodes next to each other on either side of the curtains. We can think about how far we have come. On the whole, people now have en-suite single rooms. However, there is still a huge challenge. Is that what we want for the future? Would we want to have a bedroom with a toilet off it, or would we want more space and more normal living?

Putting on my hat as a commissioner from health and care, I ask myself how fair I am being to the care home sector if I cannot describe what we will want in 10 years' time. How can people go out, get a mortgage and build a building if the commissioners are not clear about what we want? That is why planning is so important to what we do.

In East Ayrshire, we have taken a number of decisions over the past 20 years that have got us to where we are. On the whole, people see us as being quite a positive and progressive place, but that has not happened overnight. We took decisions back in 2002 about how we would introduce personal care, and I remember writing a paper in 2005 that said that we were reshaping care for older people. We took a decision back then that, as a local authority, we would come out of the care home market all together and work in partnership locally with Scottish Care to ensure the quality of care that is delivered.

We use management programmes, programmes such as My Home Life and, more recently, through the Care Inspectorate, Care about Physical Activity, and the older people who live in our care homes—they are independent care homes in East Ayrshire—are citizens every bit as much as people who live in their own homes.

We also took the decision at the time that we would focus our care at home in delivery from our council-led services. Again, we have continued to build on that, particularly for older people and adults with particular needs. We still work in partnership with specialist providers, who are much more skilled at doing that than we can be.

There is real change, and we need to look at how we take forward both care at home and care in buildings-based services. That balance of care has really changed, and if it has changed over the past 20 years, we need to look forward at how it might change again.

When I came to East Ayrshire, we had two community hospitals—basically, they were hospitals with geriatric wards where people stayed. We now have very few people—three or four at a time—who are in long-term hospital care for frailty. We have about a dozen people with complex dementias to whom that applies. Everyone else is moved down the line. Some are moved into care homes and even more have moved into care at home.

We have moved the complexity of support along, but we need to ensure that there is not a cliff edge whereby we push that right out and leave it with unpaid carers or people who need support to care. On the whole, it is the right thing to do for people to get support from their family. Those are the people who love them, know them best and can provide support, but it has to be within the family's capacity to do that.

Another area that we are proud of that has been planned strategically—it is something that people have worked at across the country—is how social care and strategic housing investment programmes tie together. It is about ensuring that people get good housing so that their barrier is not getting around their house. We need to ensure that people feel safe in their house. Some of our people who have a challenge with learning disabilities or mental health problems have been given new purpose-built accommodation that gives them a level of freedom while providing them with social care supports in an economic and effective way, and a way that least intrudes on their lives. We get fantastic feedback from the people who get those services.

The other feedback that we get—it is important to say this—is that it costs less to deliver care that way. It means that we can spread the cost around. We have been able to look at doing things differently in a way that prevents us from having to make cuts to services.

In a similar vein, when people first present with social care needs, almost the easiest thing to do is to start wrapping care packages around them, but what happens then is that, at times, we can disable people and not support their level of independence. In recent years, we have changed what we do to what we call our front-door service. When people contact us, we listen to what they ask us for and deliver against that. We also support people to gain the maximum possible level of independence. Put simply, is it better for a person to be able to get their own cup of tea or go to the toilet when they want to, or for them to sit there waiting on a paid carer to come in? If we can give people that independence, that is what we need to do.

Social care is more than paid care, and inclusion is really important. The work that we do in local communities has been some of the most beneficial that we have seen. Seeing our local schoolkids going in and out of care homes before the pandemic and seeing the friendships that they made with older people has been really beneficial. Seeing people going out to tea dances and engaging with people that they might not have seen for years but with whom they worked in the pits or other places has been really positive. Seeing people working together as natural friends is important.

We have groups for people with learning difficulties. The "things tae dae" club gets people out and about and enjoying themselves, and Buns R Us in Cumnock is a service where people bake and cook together and sell their products on. We work together with a range of third sector partners—some of which we deliberately asked to be challenging—and our advocacy and community services. Although those are funded through us, they do not work on our behalf. Instead, they work on behalf of people who use social care services.

It is so important to ensure that we have vibrant communities, as we call them in East Ayrshire, that people can engage with. An interesting side effect of shielding has been much wider engagement of local communities and people, and we need to ensure that we maintain that and build on it.

Without doubt, one of the challenges that we have is recruitment and retention. We need to ensure that people see the social care sector as a valued one, that people aspire to work in it and that the academic parts of people's employment are not seen as more important that the compassionate and caring parts of what they do. Locally, on the whole, we have a female workforce who are earning amounts that are not what we believe they are due. We are considering how we can give people more recognition and make it a job that young people aspire to do. At times, we reach silly positions in which we have youth unemployment in some areas yet we struggle to recruit for social care services. How can we

ensure that we bring those things together and get people into good, local work in our communities?

I will be happy to take questions after the three presentations, and I look forward to giving further detail.

**Annie Gunner Logan (Coalition of Care and Support Providers in Scotland):** Hello, and thank you for the invitation to join the discussion this morning. I am very pleased to be here for this session. This is a pivotal time for social care, and I thank members for their continuing and enduring interest and attention.

I have not given you a fresh paper today, because the paper that we originally submitted back in February is still valid. I went back to it in June and wondered whether any of it would be relevant after Covid, and then I realised that not only is it still relevant, it is now hyper-relevant. I will pull out the key parts of that, with particular emphasis on the bits about commissioning and procurement—because they are of interest to the committee—and then I will talk about how things could be different.

First, I want to say something about what social care in the third sector is, what it does and why it matters; our paper goes into that a little bit. Social care in the third sector is not a service like other public services. We do not cure people, deliver their babies, put their fires out, bring them to justice or get them educated and qualified. We do not generally wear uniforms, and you will not see us in television drama series on Saturday nights.

What we do is get alongside people when they have very significant challenges in their lives and struggle to participate in society as full citizens, and we support them, wherever possible, to make their own decisions and move their life forward as best they can. Where the world makes it very difficult for people to do that because of their age, impairment or whatever, we do what we can to help by ensuring that they are comfortable, are cared for and can have at least some kind of independence and peace of mind in their individual circumstances.

10:15

When you look at what third sector care and support organisations say that they are all about, you do not find much about services; rather, you find things such as,

"Our vision is for the people we work with to live meaningful and independent lives in a world which supports them to achieve their own ambitions";

"Our mission is to enable everyone to live a valued life—the life they choose";

and

"Your way to a brighter future".

The shortest statement that I could find among our membership is simply:

"We support good lives".

It is hard to capture and summarise those organisations' work, partly because what they do to support people in practice will vary according to individual need and preference. That work is not seen as particularly exciting, sexy or critical—certainly not to TV producers on a Saturday night. To have to live without it, however, leads to huge stress and distress for people and when that work becomes the focus of attention, as it has during the pandemic, everybody finds out how important it is.

Over time, a substantial architecture of legislation overlaid that basic proposition of a supportive relationship for people with challenges in their lives. The foundations in modern times were the Social Work (Scotland) Act 1968 and the Chronically Sick and Disabled Persons Act 1970—I am getting a bit anoraky already—both of which conferred very important rights on people with care and support needs as well as duties on public bodies to meet them.

The National Health Service and Community Care Act 1990 introduced the market to social care and, since 1999, the Scottish Parliament has introduced a significant range of additional legislation that refined, revised and modified all those acts.

Over time, we have also codified that basic proposition of a supportive relationship into a set of categories—home care, housing support, care at home, day services, respite and so on—and a set of tasks, generally to serve budgetary and monitoring requirements. Probably similarly to Eddie Fraser, I am long enough in the tooth to have been in front of a predecessor committee, during which we took a lot of time to identify what personal care might be and how it differs from any other kind of care—simply because we had put ourselves in the position of considering making some of it free but not all, so we had to codify what was free and what was not.

Over time, that codification has infiltrated our system to the extent that an awful lot of the supportive relationship that we have with people is now pre-specified as those categories and tasks—the latter often precisely timed, down to 15 minutes in some cases—in detailed contractual arrangements, again primarily for budgetary and monitoring purposes.

The risk is that those arrangements, rather than what people want and need, should now be described as social care. I echo some of what Eddie has said: we can help someone use the toilet, but we cannot run an errand for them; we can help them get dressed, but we cannot clean

out the fridge—even if the errand, or the fridge, is what is really important to them.

That is what people mean when they say that social care has become service led, rather than person centred, which is what we all want it to be. I encourage the committee to see care and support not as a service but as a vehicle through which people who face all sorts of challenges can live their lives alongside those of us who are fortunate enough not to face those challenges. Eddie is absolutely right to say that it is a rights-based issue.

That thought is not original in any way and the independent living movement has put it far better than me. Committee members have probably already been referred to Inclusion Scotland's "Our shared ambition for the future of social care support in Scotland"—I would highly recommend it if you have not.

The paper that we submitted back in February sets out what we think are the key ingredients for making a success of all that: the right policy framework, the right workforce, good critical challenge—we were clear in our paper that there is not enough of that—a diverse range of providers, appropriate use of digital technology, and so on. I am happy to go into any and all of that, but I will not repeat it all again today.

I want to say something about commissioning and procurement, because those are the mechanisms by which the third sector becomes engaged in all those issues. It is worth separating the two. Strategic commissioning is the exercise though which the needs of a population are identified, the desired outcomes for that population are agreed and decisions are made about what kind of care and support needs to be put in place to meet those needs. By its nature, that should be a very collaborative affair.

In contrast, procurement is not collaborative—it is competitive. It involves the codification of meeting assessed needs into detailed category and task-based specifications, which are appended to contracts and put out to tender using public procurement processes that are, fundamentally, no different from any other kind of public purchasing mechanism. That is why we find ourselves looking at documents in which groups of disabled people are described as "lots", and why charities like our members have to bid against each other in order to be awarded a contract to support the people who are grouped into those lots. More often than not—and this is the critical part—such contracts are not underwritten by a financial arrangement that covers the cost of delivering them properly. When up to 80 per cent of a non-residential service is workforce costs, it is clear what will happen when we compete on price. If you ask me—the committee is asking me, which is why I am here—you can trace an enormous number of the critical failures in our social care system, particularly those that have been identified in the past six months, back to that issue. It is the root cause.

A good example that has already appeared on the committee's radar is something that we discovered in the pandemic, which is that many care workers, especially in the private sector, receive only statutory sick pay if they have to self-isolate, which is why a fair few kept turning up to work when they should not have done. However, the national care home contract, which was drawn up by the Convention of Scottish Local Authorities and Scotland Excel on behalf of local authorities, does not allow for any more pay. Many care at home contracts that have been drawn up by individual councils do not allow for more sick pay either. It is not just about bad employers; although they undoubtedly exist; it is much more complex than that.

The position that is taken by central and local government procurement is that fair work is a matter for social care employers to sort out, so tendering processes need to be sharpened up even further in order to root out the bad employers—that is more or less what the guidance says. However, an awful lot of contract values are simply not sufficient to support much more than statutory minimums and plenty of providers get hauled in by commissioning officers and told to shave more off their price.

In any other kind of market, suppliers, which is what many of us have become, would take their business elsewhere, but in publicly funded social care, the public sector is the only purchaser in town. It is the opposite of a monopoly, where there is just one provider; it is a monopsony. Very few charities support self-funders. That is not the business that we are in, so we have only one purchaser.

For a hard-pressed public authority, the proposition of being able to control costs because its suppliers have nowhere else to go is initially very attractive. The public authority just lets the market do what it does: the providers compete with one another and bring the price down for the purchasing authority. Eventually, however, the public authority will run out of road, because a price-driven market in a monopsony under severe financial pressure will eventually see the quality providers exit the market. That is what we began to see pre-Covid.

So how could things be different? We have been working with our members on some alternatives to a competitive market in social care. We call them our big ideas. Fundamental to those ideas is the actualisation of self-directed support. We never liked competitive tendering much, to be

honest, but the introduction of self-directed support is what tipped us over the edge, because we could not see how people could possibly be supported to exercise choice and control on their own behalf in a system in which all the choices about the support available to them had already been made for them by the procurement processes. Those two thoughts cannot be kept in one head at the same time.

Sustainability and the appropriate use of resources are also fundamental to our thinking, so we came up with four tests for any alternative to competitive tendering in the market environment. Does it shift power? Does it increase choice and control for individuals? Does it improve accountability and transparency? Does it improve social care sustainability? Having set those tests, off we went.

We are still working on our big ideas and at an appropriate moment—very soon, I hope—we will share them with the committee. For now, I can say that they include things such as alliancing, which is a particular type of contracting arrangement in which commissioners and providers collaborate with each other as equal partners in pursuit of a common endeavour, sharing risk and agreeing, rather than competing, on who does what and with what resource.

Those ideas include suggestions such as agreeing at a national level a suite of sustainable rates for different kinds of support, which everybody signs up to. Then, if we must have a competition locally, let us have it on quality, not price. When I refer to a sustainable rate, I mean a rate that will cover, and continue to cover, the cost of a properly rewarded and supported workforce, following fair work principles.

Those ideas also include a suggestion that we go back to grants, instead of contracts, again to stabilise our organisations and our workforce and, critically, to link the amount of grant, and its conditionality, to the meeting of individual need and outcomes, as required by self-directed support.

Therefore, our big ideas are just that: ideas. However, if I may respectfully say so, the national care service is just an idea. These are all half-formed things that have not yet been tried and which need a lot more fleshing out to see how they will work in practice. However, we know enough about what does not work to be able to give at least half a mind to what might work. That is the territory that we now need to enter. We are up for that. I hope that you are up for that. I will stop there and leave more time for discussion.

**The Convener:** That is great. We will discuss that shortly but, first, I invite our final witness, Professor David Bell, to give his presentation.

**Professor David Bell (University of Stirling):** Thank you, convener, and thanks for the invitation. Annie Gunner Logan has ably discussed the issues around the way in which the existing service could be redesigned to give greater choice and control for care clients. I will focus more on the size of the sector and how it might change over the next 20 years or so. I sent a paper to the committee in February, and I have added a further paper, which the committee got at the weekend. That paper added some evidence from the pandemic, which has focused attention on several difficulties that the social care sector faces.

In principle, our attention is on adult social care, but I will focus on elderly care, which comprises about 91 per cent of all adult social care. Two important statistics from my paper to bear in mind are that, in the next 20 years in Scotland, we can expect an increase of 68 per cent in the over-80s and around a 74 per cent increase in those with severe dementia. I am happy to expand on those.

My focus in both my February paper and this paper has been on finding sufficient resources to deal with the increase in demand and thinking about how to fund these services in a way that is reasonably fair. My recent paper shows the size of the care sector, which employs more people than the NHS yet gets a fraction of the attention that the NHS gets.

10:30

As both earlier speakers emphasised, there is an army of unpaid carers. The Scottish Government estimates that 690,000 people out of a population of 5.4 million are unpaid carers; admittedly, that is unpaid care for all age groups and not just for older people. Although I am an economist, I have some recent experience of being an unpaid carer for my wife and my mother. The social care sector is hugely important; it is also, as both earlier speakers said, extremely complex, because it involves actors from the public, private, voluntary and unpaid care sectors.

My argument is that Scotland made a move, which Annie Gunner Logan referred to, towards the introduction of free personal care in 2002 but has not done much strategic thinking since then. That has been exacerbated by the austerity that we have seen over the past decade. Much of the difficulty around the commissioning of social care has been due to the fact that local government spending in Scotland fell in real terms by 13 per cent—well, effectively 14 per cent—between 2012-13 and 2018-19, whereas spending on the national health service increased in real terms by 7.1 per cent. That was a decision that the Scottish Government made, but it reflected the same sort of—in fact, perhaps even more severe—cuts on local government that were experienced south of

the border. As local government is the principal funder in the monopsonistic market for social care, that puts huge pressure on the ability of local government to fund the sector.

I did not include it in my submission, but I did some off-the-cuff research in the past couple of days around Perth and Kinross, which is my local area. The minimum hourly wage is £8.72 at the moment. A care assistant job was advertised at Four Seasons Health Care at £9.51 an hour, compared with an Aldi store assistant job that was advertised at £9.40 an hour, so the care assistant would make 11p per hour more than the store assistant. Care assistant is a job with a lot of physical and mental pressure, so 11p an hour does not seem like the sort of margin that might attract a lot of people to the sector. A registered nurse, on the other hand, earns around £16 an hour, so there is a big difference there.

Audit Scotland has been looking at the laudable aim of linking health and social care together through health and social care partnerships but has argued that, thus far, progress on that has been limited—again, local government continues to be squeezed, which makes things difficult. In a sense, local government and the health service have two different approaches altogether to running systems.

That was the background against which the pandemic hit us. As you can see from table 1 in my submission, which comes from a paper that I jointly wrote with a number of others from all over the UK comparing care home deaths in different parts of the UK, Scotland lost more than 5 per cent of current care home residents, with their deaths registered as being Covid-19 related, which was a very bad outcome. In terms of excess deaths, Scotland comes out marginally better than England; the excess deaths table on page 4 covers deaths that have been registered as Covid-related but focuses on a comparison between current deaths and averages over the past five years. Both those figures reflect the huge difficulties that the sector faced because it did not have enough personal protective equipment or enough access to testing. It is fair to say that the system buckled under the strain.

Discussions about a national care service are a distraction. We face a very large increase in the likely demand for care and that demand will not be met without a significant addition of resources. The question that has been addressed, but not answered, in England is how to do that fairly. Fairness has many dimensions. There is a gender dimension. Unpaid care is typically delivered by women and most care workers are also female. There is a generational fairness argument about whether future generations should pay for this generation's care.

There is also an argument about income—at what point do you set the floor above which people are expected to contribute towards the cost of their own care? Alternatively, do you pay for care from a general increase in taxation or from taxation that is aimed at a particular group of people who are likely to benefit from long-term care, or do you use some sort of insurance system? The record of those around the world is not a happy one.

I am not contradicting anything that the two previous speakers said, but Scotland must address that strategic question. There will be an increase in demand. Whether that is met in care homes or by care at home, there will be an increase in the demand for care services for older people.

**The Convener:** Thank you to all three witnesses. I remind colleagues to put an "R" in the chat box if they have questions. A number of colleagues have already done so; if anyone else wants to do that now, that would be helpful.

My question is about the workforce issue, which came up in all three presentations. Eddie Fraser said that professionalising the workforce is not the way forward as it takes away from the correct focus. Eddie, how would we ensure better recognition and recruitment of workers if we do not create a career path and offer qualifications?

**Eddie Fraser:** I am sorry if I was not clear about that. The workforce is professional, but I worry that we are medicalising it, which is a different thing. We have staff across the social care sector who go into people's houses every day and deal with some of the most challenging situations. They are skilled communicators and they are skilled in compassion and in supporting people who are distressed. They have worked hard for years to show that this is a professional workforce.

However, when you look at a job evaluation scheme and try to translate those values and skills into a monetary value and a score, that all seems to fall down and people start to look at qualifications.

In those schemes, it is about how we value compassion and communication with members of the public. We use terms such as "challenging situations", but it is not about that—as Annie Gunner Logan said, it is about getting alongside someone and getting to know them. A family carer, or someone who has provided care for a long time, can often de-escalate situations or make people feel at ease. That is a professional skill, but sometimes it is not a skill that is valued when we look at our pay schemes. I am not talking down working in Lidl or Aldi, but why do we pay people working there the same? How should we look at the skills that are involved in social care? Often, our social care workers are out there on

their own, and they have to take decisions on their own, and yet people who work in other buildings, and who get direct support all the time, get paid more.

I do not think for a minute that we do not have a professional workforce, but we should not go down the line of moving them away from some of the social care skills to more medical or health-related skills. As I said before, I have been meeting a whole group of personal carers, some of whom go back as far as I do in doing home-help work, and they all worry about who will get the shopping, tidy the house or do other things that are important to some older people. That is why I am saying that we should not be pushed into a medicalised model of social care.

**Annie Gunner Logan:** [*Inaudible*.]—this point. It is a bit of a mess, I have to say. On the one hand, we have an agenda, which we have supported, as have the committee and the Parliament, for a professional workforce with a status that accompanies that. That is why we have the Scottish Social Services Council and a qualifications-based register, and why we regulate social services workers. A lot of that is about status. At the same time, we do not want to pay for that, which is what I think Eddie Fraser is saying.

As a perceived solution to some of our resource issues, we have introduced a middle ground between unpaid carers, who are mainly family members, and professional care workers. In recent times, there has been quite a lot of talk about using volunteers more—there are personal assistants, who are completely outside the regulatory framework, and there are microproviders, which are hovering around somewhere in the middle.

At some point, we need to nail down what we mean by a professional social services workforce. We all support that, but there is a fuzzy bit in the middle, where we are trying to suggest that some of the work can be done by non-professionals, but we are not very clear about what we mean by that.

I come back to Eddie Fraser's point about the divide between people working in Aldi and people working in social care—there is an 11p an hour difference between the two. In social care, there is quite a big difference between social care workers who are employed by councils, who are on a very different set of terms and conditions, and social care workers who are employed by the organisations that are commissioned by councils, who are often a long way down with regard to pay and conditions. We already have a two-tier workforce inside social care, never mind between social care and other fields.

**The Convener:** Thank you. There are a number of questions from colleagues.

**Emma Harper (South Scotland) (SNP):** There are loads of questions birling in my head right now. My first question is about the professionalisation of care. Nurses give insulin and medication, and social care staff do some aspects of medication delivery, depending on the med. There is a wide range of social care, which includes cleaning out a fridge, or a nurse coming in to give insulin and also putting the kettle on.

How do we ensure that the workforce is professional? How do we bring all that together to ensure that there is proper funding and proper terms and conditions?

10:45

**The Convener:** David Bell, you raised the financial issue. Where do we get the money to pay for and reward quality staff?

**Professor Bell:** Eddie Fraser and Annie Gunner Logan made good points about valuing the aspects of care provision that are difficult to put into a job description and about the issue of how far we might seek to professionalise the system.

I can answer only from personal experience. I had district nurses and social care workers in my house two or three times a day earlier this year. They worked very well together. The care workers earned my undiminished admiration. They were council workers covering the whole of Perth and Kinross. At 9 at night they would go from me in Auchterarder to someone else in Kinloch Rannoch. That was their next call. I thought, "Really?" Even if they are earning a bit more than workers in Aldi, that kind of responsibility deserves more recognition than it gets.

**The Convener:** Annie Gunner Logan, do you have any thoughts on how to deliver that?

**Annie Gunner Logan:** Emma Harper has eloquently described one of the challenges of integration. If you have a nurse and a social care professional, where are the boundaries between the two? The project of integration looks too much at the structural aspect of how we organise all that, rather than looking at care at the front end.

I agree with David Bell. Integration has always been there in practice at the sharp end. The problem is with how all that is supported and codified at a higher level—I have lost my thread a little.

I was going to talk about the inclusion of unpaid carers. There is a good example of that now if you look at what is happening in care homes. Staff, tradespeople and managers come in and out. The only people who are currently excluded from care homes are family carers, yet in other circumstances in the pandemic we rely almost

completely on family carers. The committee will have heard from Inclusion Scotland and others that there are people who have had their home care support either pulled completely or significantly reduced, precisely because there was an unpaid carer or somebody who could assume that role in the house.

We have taken fundamentally opposing views of the value of family carers in those two different areas of care. In home care, we have relied on them to take over almost completely when the state has withdrawn; in care homes we have told them to keep out. I know that that is about infection control, but it tells you something about our paradoxical view of who is there to provide care.

**Donald Cameron (Highlands and Islands) (Con):** I have a question about integration, which David Bell touched on in what he said and in his submission. The narrative that we are used to hearing and have all accepted since 2014 is that we should think of health and social care as one.

We have integration on the ground through health and social care partnerships and the Cabinet Secretary for Health and Sport is responsible for the Government's health and social care directorates. To talk of a national care service seems to reverse the integration process and to make us think of health and social care as distinct parts of the system.

Does Professor Bell have any reflections on that? You have said that the progress of integration has been slow and has led to the possibility of rationing. Do you think that we should plough on with integration? Is there a contradiction between integration and the idea of a national care service?

**Professor Bell:** The important point here has to do with the most effective way to use resources. The provision of more resources to social care will take some of the weight off the health service. It is difficult, however, to draw conclusions about that matter as yet. In my paper, I pointed out that the provision of data on social care has been quite a problem. The pandemic will be a catalyst for the Scottish Government to considerably improve on the social care data as far as it is available.

Ultimately, we have two organisations that could jointly ensure that we provide the best possible care and health outcomes for the Scottish population, but the modus operandi of each is quite different. Local government is a democratic organisation with a budget that has been limited in recent years; the NHS has a more generous budget but is organised with much more professionalisation in the sector.

On a democratic point, local government would become a relatively limited level of government—even more than it already is in Scotland—if social care were taken away from it after already losing the police and the fire services. Arguments could be made around the learning that passes from one authority to another, which probably happens to some extent. It seems to me that the idea of a national care service is not the big issue at the moment, but that we should really start to address the issue of resources for the two sectors.

**Annie Gunner Logan:** Mr Cameron has made a really interesting point about seeing health and social care services as one. Far be it from me to contradict a member of the committee, but I am not sure that the project of integration was about that, although it certainly was about seeing the resources for each service as "losing their identity"—the expression used at the time—so that there would not be "health money" or "social care money", but that all of it would go into the pot, which we would then spend on whatever we wanted or was appropriate.

The integration project meant that the boundaries between health and social care would be much more fluid and seamless, but it was not about seeing them as one thing. The NHS is a monolithic state-run one-provider business; social care is a market.

The NHS also does not have the same imperatives on choice and control that social care does through self-directed support. The NHS is free at the point of use, whereas a lot of social care is still chargeable. They are therefore distinct areas.

From the point of view of the person who needs them, that distinction can be drawn quite clearly. If someone is knocked down by a bus, they will not want to spend the next two weeks choosing how the services of an accident and emergency department will be delivered to them. There is an urgency to acute health and medical needs, which means that the system will take over—and we are all grateful that it does so. In the social care system, though, people who need support at the point of entry will often need it for the rest of their lives, so the idea that they might not have any choice in or control over that is completely the opposite view.

However, I am not sure that it is right to think that integration is simply about seeing those things as being indistinguishable from each other; it is about their resourcing needing to be put in the right places.

**The Convener:** Members have a couple of follow-up questions on costs and benefits and on resourcing issues. We will hear from David Stewart first, followed by Brian Whittle.

**David Stewart (Highlands and Islands) (Lab):** I, too, thank all three witnesses, whose evidence

has been extremely useful. All of them might wish to contribute to answering my question, which is about the bigger picture.

I start from Eddie Fraser's point that the key issue is about human rights. My particular interest is in developing a human right for people to die at home. If that right were to be established, it would have to be resourced, a bit like free personal care is. That might change the balance of people going into hospital and, to a secondary extent, into care homes. We all know that statistics—[*Inaudible*.]—wishes, and the right to die at home is at the top of the list. However, the reality is that most people die in hospital. We must ask how we can turn that around.

I will give an excellent example, which might help. In my patch, Albyn Housing Society and NHS Highland were involved in the provision of fit homes, which are barrier-free houses that can be changed—for example, a sink can be lowered if a person suddenly becomes wheelchair bound. They also have a technological aspect, in that if people are not moving around at home, that can be picked up by carers and NHS staff. That seems like a missing link in our care system that we might be able to develop, and which would enhance people's lives. That goes back to Eddie Fraser's point about whether simply providing en suite rooms is enough. Using the fit homes approach, people would still have their own homes, but would also have the technology that makes such a difference.

Such an approach would not be the answer to everything, but I would be grateful for our witnesses' views on how we might change our strategy on social care so that it would better reflect the rights and wishes of individuals across Scotland.

**Eddie Fraser:** I will address that shortly, but first I point out that the whole approach comes down to whether services work well in local communities.

Integration was said to be all about providing integrated services from the perspective of the service user. For me, all the structural stuff that we might go into is a diversion from that principle. In recent years, many of our policies have been about respecting people's rights through approaches that we might call anticipatory care planning or lots of other terms, but they are essentially about people putting down on paper what they want to happen in certain situations. Our task is to ensure that those wishes are then adhered to when people find themselves in those situations.

I am involved with community nursing and social care teams, and I have responsibility for primary care across NHS Ayrshire and Arran. The question is how all those services can work together around a person or local community or, in the case of children's services, around a school, and still take full account of what people want.

That ties into lots of other things that we do. Getting people out of hospital when they do not need to be there, and back into their own homes, gives them much more choice about where they die. Often, if a person stays in hospital for too long that choice is taken away from them.

There are lots of side issues to that, such as where a person will stay from that point onwards. We need to ensure that different types of services are available at the very end of people's lives. We might ask what a general practitioner should do when they go into the house of someone who is at the end of their life and who lives alone. Should they call an ambulance, so that that person then goes off to hospital? Alternatively, should they walk out of the house and leave them to die alone? In the example that I have here, the GP sat with the person until they died.

11:00

For us in local services, it has been a real driver to think about what a different service might look like. In the example that I gave, if the GP could not have sat in the person's own home for all that time, and there was no family member who could have done so, who could have helped them to stay there at the end of their life rather than dying in an ambulance or sitting in an emergency department? I consider it a failure for us all if we reach the point at which a person wants to stay at home but they are not able to do so.

Of course, I understand that if a person had a much longer illness there would be a question about how we could be there for 24 hours a day, seven days a week. That would be a challenge. However, there are many examples in which partnership working between families and services can deliver such outcomes. We simply need to speak to people—saying, for example, "If the family can do three nights, we can do four"—and to work together.

That is where the integration approach comes together. Actually delivering such services, even at that level of intensity, is cheaper than a person going into a bed in an acute hospital ward, where they do not want to be. I know that we need to work through all that other stuff about the system, but I have a real belief that doing the right thing around people enables us to deliver our wider strategic aims. I believe that we can demonstrate that. If you look at our budget you will see that, in the past couple of years, we have come in with an underspend. Since integration, the only year in which we have overspent was one in which we had a specific issue around our children's

services—not those for adults or older people—yet we continued to delivering good-quality services.

Ensuring that we have good integrated services in the community is what helps to keep people at home and to get them back there when they need to be there. It therefore addresses that issue of their rights in relation to what they want to happen.

**The Convener:** That is a hot topic. Perhaps we could hear from Annie Gunner Logan, followed by David Bell.

**Annie Gunner Logan:** The issue that Mr Stewart has raised will be music to the ears of a number of our housing association members. The ideas of barrier-free and smart housing really need to be injected into the integration process with some urgency.

We are all talking about how long we have been involved in the business; I remember when a certain Sam Galbraith was the relevant minister. His view of integration, although it was not called that back then, was that it should involve health, social care and, specifically, housing. This time round, some of our members, and also the Royal Institution of Chartered Surveyors and the Scottish Federation of Housing Associations, had to work quite hard to have housing reinserted into the planning structures around health and social care integration; it was seen as absolutely critical to do that. It would be really helpful if the committee could use its influence to keep making that point. Housing has been slightly sidelined in all this, yet it is critical to the kind of support that Mr Stewart mentioned.

**Professor Bell:** I endorse what Annie Gunner Logan has said on that point. It seems to me that we need to have a serious think about the accommodation solutions that we are likely to need in 10, 15 or 20 years' time, and to consider how much change that would require to our existing housing stock or, indeed, whether that would need expanding. Then we must ask who would invest to make that happen, and on what terms.

Such an analysis would have to take into account demographic change. The Office for National Statistics has said that, in 10 or 15 years' time, there will be 80,000 women aged 80 and over who have had no children. However, so often, we rely on the children of the oldest of our old people to provide unpaid care for them.

**The Convener:** We have one other question on accommodation and housing, from Emma Harper.

**Emma Harper:** We have heard that, in other countries, students who are studying medicine, nursing, physiotherapy and so on are accommodated in older persons' housing complexes. Should we be looking at doing that in this country, to incentivise young people to participate in older persons' care in exchange for housing as they go through their university studies?

**Eddie Fraser:** The principle of intergenerational support is right, but in areas such as Cumnock or Auchinleck, we do not have all that many student villages, although we have lots of young people. Seeing people working together and the mutual benefit that it brings is right. Whether we take the step of financially incentivising that in some way is interesting and should be explored. As I was saying before, we can explore how we can help our younger folk financially and at the same time ensure that older people remain included in communities. The issue in rural areas is that if a person is going to leave their family home, they want to stay in their very local area. We have good social care services and increasingly, we have good technology-enabled care. There has to be added value for a person to leave their house. For us, just now, that tends to happen when a person requires high levels of support and they move to what we call very sheltered or high needs housing, which also has a social aspect that the person cannot get at home.

The same principle could be delivered in different ways, depending on the setting. In a very urban setting, the model that you described could be delivered, but in a more rural setting we need to think about inclusion in local communities.

**Annie Gunner Logan:** I have seen the model that Ms Harper is suggesting and it is very attractive and has huge benefits. That model speaks to me more of the kind of thing that Eddie Fraser was talking about right at the beginning of the meeting, about how we should focus on not social care, but a society that supports people at all stages. That model is what we call, in the jargon, prevention and early intervention.

However, if we are talking about the point at which older people are assessed as requiring care services, it would be too much for a student to take on and we should not expect them to—at that point the older person will have challenging and complex needs that must be met by a professionalised workforce, rather than by a student living in their house. As I was saying, we have codified social care to be a thing that we will now pay for, rather than building the kind of community that would support people. The model that Emma Harper refers to belongs in the latter category.

**Brian Whittle (South Scotland) (Con):** Good morning Eddie, Annie and David. It is always good to see you and you always make us think far too much. I should declare a slight bias, in that Eddie Fraser works in the area that I represent and I am very aware of the work that he does.

All of this starts with an attitude or an approach that is, in that much overused phrase, person centred. However, for my money, the approach that Eddie Fraser's team are taking seems to be the right direction of travel. East Ayrshire has very low levels of delayed discharge and Eddie is talking about people having input into their own care packages and the inclusion of community activity and is very aware of what the third sector is doing in vibrant communities in East Ayrshire.

My first question is for Eddie. What is the cost of that kind of approach versus the long-term cost benefit? That relates to what Annie Gunner Logan was saying about pressure on providers and needing a sustainable level of quality service, which in turn feeds into David Bell's point about resource. David Bell, did you look at the whole system approach of NHS social care in relation to ill health in Scotland? What would be the impact if we tackled the ill-health element, particularly preventable conditions, and shifted some of that resource towards the start-to-end-of-life approach that we all want to take? I know that there was a lot in that, but I hope that I have condensed my questions well.

**Eddie Fraser:** None of this happens on its own: it has to be planned over time. There has been a shift in where we support our older people and people with mental health and learning disabilities: we have consistently moved that support further down towards the community. Over the last 18 months or so, we have reduced the overall acute bed nights of delayed discharge by about a third—that was pre-Covid. At this stage, no money has followed that, but we are moving in the right direction and it is the right thing to do.

We had a community hospital on our patch that still had Nightingale wards and so was not the standard of care that we would aspire to for our older people. In a neighbouring partnership, there is a hospital in Cumnock with single rooms, so if people need the service it is still there. However, on the whole, we were able to take resource out of the hospital with the Nightingale wards and shift it towards the community. When a person needs to go to a care home, a lot of support is required. We know that getting people home from hospital earlier means fewer people go to care homes, so the number of people in our care homes has gone down and the number of hours of social care have gone up. We can push the flow down the way. There is evidence of that in the most recent statistics.

Having moved that flow down the way, I am able to do things like fund the third sector and take some resource and make sure that I am funding advocacy and the Council of Voluntary Organisations East Ayrshire when it does connect work and other things. Our link worker scheme—we call them community connectors—in the GP practices is delivered through the third sector. We have been able to take resources and push them down into the community.

The most important part of all that is that the person's voice is heard much more clearly—the person gets choices about what they want to do. The vast majority of the time, the cost of providing what people want is less than the cost of an institutional response that pushes their care back up towards hospitals and care homes. That is not to take away from the need for any of those parts of the system—there is an absolute need for all those parts—but is to ensure that people get very person-focused support and that we use our allied health professions to keep people as independent as possible. It does both things and is a win-win: it gives the person a better life and it costs the public purse less.

**Professor Bell:** I agree with Eddie Fraser. Getting better outcomes for older people is helped by the move out of hospitals and care homes and into the community. It is quite difficult to quantify that, because we have not really collected enough information on the outcomes from social care. One of the focuses of the data work that I hope will be carried out by the Scottish Government is collecting information from people receiving care and their relatives or unpaid carers on how they see those developments in relation to what was perhaps an older model of provision. However, it is quite difficult to establish beyond doubt that the system has been working.

11:15

The health budget is approaching almost half of all public sector spending in Scotland, so we might be doing much better in linking healthcare and social care, but other parts of the health budget seem to be continuing to grow. The pandemic will perhaps shed some interesting light on changes in people's habits and how those will affect their health outlook. From speaking to colleagues in England quite a lot, my impression is that, other things being equal, the outcomes in Scotland, particularly in relation to social care, are somewhat better than they are in England.

**Sandra White (Glasgow Kelvin) (SNP):** Good morning. I thank the witnesses for their evidence, which has been enlightening and helpful. I have a couple of points to make to which witnesses might want to respond. I am the convener of the cross-party group on older people, age and ageing, and we get a lot of evidence on care homes and how older people are cared for. You can correct me if I am wrong, but it seems from today's evidence that there is a lot of emphasis on the health of older people but not enough on their wellbeing, particularly in communities. There also seems to

be a diverse range of providers that tend to be vying for contracts, as has been mentioned.

We are moving on with health and social care partnerships and IJBs, which are great once we get people working together. However, do you agree that, while social care is still connected to health and possibly its budget, the legislation leads to an awful lot of bureaucracy, which slows things down? Should we consider that when we look at social care for older people? I throw those points out there.

**Eddie Fraser:** What you have said is exactly what I tried to reflect at the start of the meeting. Sometimes, we focus too much on health—we see people as conditions and think that we can cure them, instead of asking what they want and what is most important to them in their lives.

I talked about the change from "home help" to "personal carer". The danger is that personal carers will be pushed into what ias almost a nursing assistant role. When we ask people what they want, we hear that they want their house to be tidied or to get a bit of shopping, rather than waiting for the delivery van to come; self-directed support legislation should be able to provide that, to an extent. There should be agreement about need and a person's resources, and there should be freedom to deliver on that.

Last year, the Care Inspectorate looked into self-directed support. We were proud of our work in some areas, but there are lots of areas in which a lot of development is needed; it is still very much focused on the adult world rather than the older people world. Older people are often quite happy to say to the workers, "You just arrange it for me." I worry that the service will then become too traditional, instead of being more inclusive and focused on wellbeing.

For a period, we got lost in respect of professionalising social care, in terms of where lunch clubs and other things fitted in. Long ago, I was responsible for going around lunch clubs, and things became very complicated in relation to environmental health—needing different colours of chopping boards, different knives and so on—so, many places chucked the lunch clubs, because organising them was too difficult.

In fact, when we talk to faith groups and community groups, we see that the lunch clubs have never gone away. It is important that we go back and engage with them, and make that level of social inclusion part of social care. It is not necessarily just about providing the key parts of social care; it is also about ensuring that people can access that care. Such provision is as important for people's wellbeing as healthcare is.

**Annie Gunner Logan:** Sandra White put her finger on it: we should be in the business of wellbeing. However, many care services that are delivered to older people are currently very far from that. Many councils commission or provide care in 15-minute slots—I do not know whether East Ayrshire Council does that—which is a sign that we are not at all interested in wellbeing. It is interesting that the third sector is not in any way active in that type of provision. Only a handful of CCSPS members are involved in that type of activity, because it is not a model of care that most of our members wish to provide. They do not see how they can be alongside people and fulfil the mission of their organisation by visiting 10 people, one after the other, and spending only 15 minutes with each person. That is nothing to do with wellbeing.

Eddie Fraser is right to highlight that we need to think not just about paid care, but about the community activities that go on around it. Unfortunately, we find in times like these, when cash is strapped, that such things are sacrificed first. It has always been that way. One of the big aspects of integration was to be that we would focus on early intervention and prevention, but we have signally failed to do that, so I would like to see it pushed further up the agenda again.

I will give one example of how our procurement system mangles the concept of wellbeing for older people. You might remember that, years ago, we used to have meals on wheels services. When a person could not prepare their own food, someone would bring a meal to them—they would visit, have a chat then go away. The procurement and efficiency response has been delivery of frozen meals once a week, stick them in somebody's freezer and leave them to it. That is not wellbeing—it cannot possibly be—but it is a nice and efficient procurement solution. That is where our heads have gone, and they should not be there.

I absolutely agree with Sandra White about the level of bureaucracy that is involved, which providers are finding is a huge challenge in the context of additional Covid costs. The committee will know that the Cabinet Secretary for Finance has released multimillions of pounds through social care partnerships to help organisations to keep the show on the road. However, I am sorry to say that, in some areas, some of our members have not yet received a single penny of that support, despite having made substantial financial outlays on additional staff costs, personal protective equipment and so on. Even where the money is flowing, organisations are being asked to fill in 20-page Excel spreadsheets—in some areas, they are asked to produce payslips for individual workers—in order to evidence their spend before they are able to access any of the money.

All that speaks to me of the absolute absence of trust in the system. We have overlaid the system with all these bureaucratic processes that it pleases us to call "following the public pound", as if third sector organisations, which have been partners of the public sector for decades, are suddenly going to nab the money and run off to Rio with it. It is a huge issue, and it is what lies behind all the contracting and procurement processes: we simply do not trust each other to do the right thing.

If we are going to have a competition, let us have one to find out who is trustworthy, and let us all collaborate with each other properly without any 20-page spreadsheets. In that way, we can get on with it and make the best use of resources in a collaborative way, working with each other as equal partners, not standing on each other's shoulders and not trying to ensure that nobody runs off with the spoons. That is what I would like to see.

**The Convener:** [*Inaudible*.]—have framework agreements between Scotland Excel and the Care Inspectorate made any difference in improving the commissioning and procurement of services?

**Annie Gunner Logan:** The most recent national framework for care at home and housing support has not yet got off the ground. Scotland Excel made a sensible decision to put the brakes on a bit when the pandemic hit, because there were more important things to do than start tendering.

I would say, however, that a framework agreement is, in the context of workforce issues, one big zero-hours contract. People bid to go on to the framework, but there is no guarantee that any work will come out of it. How can people plan a workforce on that basis? Framework agreements were supposed to be the solution to the winner-takes-all competitive tendering processes that we had before, in which one provider would run off with the whole thing and everybody else would be left with nothing.

Framework agreements do, at least, rank people, so that they can call off different bits of work under the agreements. However, the problem is that they offer no stability to providers, which means that providers cannot offer any stability to their workforces. A sure-fire way to undermine all the stuff about recruitment, retention, fair work, workforce instability and uncertainty is to introduce a framework agreement.

**The Convener:** Thank you. There is a last brief question from Emma Harper.

**Emma Harper:** [*Inaudible*.]—the dementia question to Professor Bell. In one of your submissions, you say that between 2020 and 2040 there could be a 74 per cent increase in the number of Scottish residents with dementia. That is a huge number. My understanding is that dementia is very wide; there are 15 different types. Diagnosis seems to be more efficient now. There are levels of dementia from stage 1, which has no impairment, to stage 7, which has severe impairment. Have you analysed the detail around dementia? For example, people with irritable dementia might need to be supported in care-home accommodation while others might need less support, which can be provided in their own homes. The numbers look pretty stark and jumped out at me when I read your submission.

**Professor Bell:** The numbers come from what I think is the best source of forecasts for the United Kingdom as a whole—the run from the London School of Economics. I have known that group of people for a while, but I was not involved in the modelling work and have forgotten who funded them. I think that the Economic and Social Research Council provided most of the funding under a project called MODEM—modelling outcome and cost impacts of interventions for dementia.

I gave an overall figure of a 74 per cent increase, but there are subdivisions for mild, moderate and severe classifications. Under those, a 49 per cent increase is expected in the number of people with mild dementia, which could be dealt with in people's homes, a 31 per cent increase is expected in people with moderate dementia, and a 104 per cent increase, to 74,000 people, is expected for severe dementia by 2040. A high proportion of those people would probably need some form of non-domestic accommodation, which is one of the principal drivers of my concern about having accommodation in place to deal with changes in the distribution of care and care needs over the next two decades.

We currently have around 30,000 people in care homes and 50,000 people receiving care at home. The estimate for the number of people with severe dementia by 2040 is quite scary, but it is based on estimates of prevalence by age group. Prevalence goes up very sharply with age. That is a function of what will happen for people in my age group, in particular—the baby boomers—as they get older, and especially as people live longer, well into their 80s and 90s, which is when prevalence of dementia is significantly higher. That is based on National Records of Scotland projections for each age group. That is the background.

11:30

**Emma Harper:** Annie Gunner Logan spoke earlier about the quality of the service. We hear about self-directed support, but we do not know how well it functions across all local authority

areas. Where is it working well, where is it not working, and why does it work well?

There is a further issue. The third sector has been phenomenal during Covid. It is predominantly volunteers who support the third sector. Are you suggesting that we just give folk a pot of money and let them get on with it, without the 20-page Excel spreadsheet scrutiny? How do we then trust people to support our older persons in the community?

**Annie Gunner Logan:** There is a lot of research on self-directed support, some of which we have done ourselves and some of which has been done by Audit Scotland. We will send you all the links to that research, which will clearly set out for you where it is working and, critically, where and why it is not working.

On trust, I thank you for mentioning the performance of the third sector, which has been absolutely magnificent during the pandemic—although, I would say that, wouldn't I? The key to the future of social care lies in finding out why the third sector has been magnificent, and in helping those in the sector to do more.

On bureaucracy, I get the point about following the public pound—I understand all that—but it would be good if we were able to enjoy the same kind of trust from our local authority partners as they enjoy from the Scottish Government. Local authorities get sums like £50 million and £1.1 billion, but I do not think that they had to fill in a 20-page spreadsheet to get that. All that we are asking is for the same kind of trusting relationship down the way as applies back up the way. That is it, really: we want to be equal partners.

**The Convener:** This is the final question, and I ask witnesses for one-sentence answers, please, rather than a paragraph. The Scottish Government is currently undertaking a review of social care. What is the top thing that the Scottish Government's review should focus on?

**Eddie Fraser:** The review should try to understand the value of social care in relation to the people who require it, rather than seeing it as being only about health conditions.

**Professor Bell:** The review should understand that this is about wellbeing—getting the two sectors to work harmoniously and thinking about where care needs will be into the long term, in 20 years.

**Annie Gunner Logan:** The most important thing is the rights of people with care needs. Secondary to that is the importance of collaboration and partnership in ensuring that those rights are realised.

Most fundamental is that I really do not want the review to start from the position that all social care is broken, because it is not. There is fantastic social care out there, and we need to figure out how to do more of it, rather than chucking out everything good that is already happening.

**The Convener:** I thank all our witnesses for their contributions. It has been a stimulating and wide-ranging session. A number of you mentioned items on which you are able to send information to individual members; I ask that you send that to the committee, too. It will fit in with the work that we are doing on social care and on budget issues, which we are also working on.

Thank you all very much. We look forward to our next round-table discussion after the October recess.

# Subordinate Legislation

## Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 15) Regulations 2020 (SSI 2020/288)

## Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 16) Regulations 2020 (SSI 2020/301)

11:35

**The Convener:** The second item on the agenda is subordinate legislation, and consideration of two affirmative instruments. As in previous weeks, the regulations relate to coronavirus and international travel, and have been laid under section 94(1) of the Public Health etc (Scotland) Act 2008. They have already come into force. When regulations are introduced urgently, ministers have 28 days to bring them to Parliament in order for them to remain in force. It is for the Health and Sport Committee to consider the instruments and to report to Parliament accordingly.

I welcome, from the Scottish Government, Humza Yousaf, who is the Cabinet Secretary for Justice; Jamie MacDougall, who is the deputy director of the test and protect portfolio; Anita Popplestone, who is the head of police complaints and scrutiny; and Robert Mitchell, who is senior policy officer in the population and migration division.

Committee members would like to consider the instruments together, if that works for the cabinet secretary. When we reach the correct point, I will invite him to move the motions on the instruments jointly.

We will take questions from members in a moment. Cabinet secretary—could you start by recalling the update that you gave us on sharing of data at our last meeting, and further updating us on that, as it relates to travellers who are entering Scotland?

**The Cabinet Secretary for Justice (Humza Yousaf):** Good morning, convener. I hope that you and all the other committee members are keeping safe and well.

I will give you an update. When I was asked about the matter the last time I appeared before the committee, I apologised because we had been unable to meet the previous deadline that I had set. I can inform the committee that in tomorrow's published statistics—they come out weekly from Public Health Scotland—the data referring to the number of positive cases that have been linked to international travel will be included. I have all fingers and toes crossed that they will be in tomorrow's data set.

**The Convener:** That is good to hear. I have a question from Brian Whittle. I remind other members that if they have questions for the cabinet secretary or his officials they should put "R" in the chat box now.

**Brian Whittle:** The cabinet secretary will be aware that a little bit of concern has been expressed about checking that people who are travelling from international destinations and who should be quarantined are not quarantining, and that the checks on them are not up to the level that you had expressed. Are we ensuring that at least 20 per cent of people who are coming into the country are being checked? Can you give us an update on what impact international travel has had on current levels of Covid, which are on the rise?

**Humza Yousaf:** I thank Brian Whittle for his question, which I will answer in a few parts. If you think that I have left anything out, please come back to me.

The latest statistics are published by Public Health Scotland weekly, so the member will have the information on the most recent week, which runs to 27 September. Of people who entered the country, 1,291 were contacted out of the 11,217 who were required to quarantine. That figure of 1,291 is far higher than the 450 figure that I referenced previously, and I am pleased about that.

The member will also know from correspondence that I have sent and from my verbal updates that we were recruiting 25 additional contact tracers. I am pleased to say that they have been recruited. The intention is that 2,000 people will be contacted each week. Progress is being made, and next week's statistics will be the test of whether we get to, or close to, 2,000. I hope that we do.

It goes without saying that the caveat is that, as the number of positive cases unfortunately rises in Scotland, there might be times—as, I am sure, the committee understands—when contract tracers have to be put on to contacting people who are symptomatic and who might test positive for Covid. However, as far as possible, the 25 people whom we have recruited will be ring fenced for contacting people who need to quarantine. I hope, therefore, that we will get up to that 2,000 mark in next week's statistics.

On the follow-up, to give Brian Whittle some more reassurance I say that Police Scotland's latest published figures again show that all 181 referrals were followed up. Eighty-six were followed up by the central team, which is known as the C3 resolution team, and 95 were investigated

by local teams. I hope that that gives Brian Whittle some confidence. If he has more questions, I will be happy to answer them.

**Emma Harper:** I will follow up on an issue that was raised the last time you attended committee. Are people who are arriving in Scotland at our airports and sea ports being encouraged to download the Protect Scotland app? Can you provide a wee update on that, and is it happening?

**Humza Yousaf:** The short answer is yes, people are being encouraged and the app is being advertised. I hope that the messaging has been quite clear that people should download the app, regardless of whether they are in the country for a holiday, for business or another reason.

I know that Emma Harper has a particular interest in ferry ports. Again, regardless of whether people are entering via—[*Inaudible*.]—or through airports, the message should be the same: people should download the Protect Scotland app. We are communicating that message regularly, and have done some marketing alongside that.

**The Convener:** Thank you. Emma—does that answer your question?

**Emma Harper:** It does, thank you.

**The Convener:** Excellent. There are no more questions from members.

Are members content that we take motions S5M-22792 and S5M-22855 together? No one disagrees.

**The Convener:** I remind members that they cannot now put questions to the cabinet secretary; this is simply the formal debate. Given experience, it might have been quite a brief debate.

We move to the next stage in the process. I invite the cabinet secretary to speak to and move motions S5M-22792 and S5M-22855, in his name.

**Humza Yousaf:** As was the case previously, convener, I am happy to proceed without opening remarks, given that we have had an opportunity for questions and answers, and the committee is well versed in why the regulations have been introduced.

I move,

That the Health and Sport Committee recommends that HS/S5/20/26/M The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 15) Regulations 2020 (SSI 2020/288) be approved.

That the Health and Sport Committee recommends that The Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 16) Regulations 2020 (SSI 2020/301) be approved.

*Motions agreed to.*

**The Convener:** That concludes that item of business. I thank the cabinet secretary and his officials for their attendance.

11:44

*The meeting continued in private until 12:01.*

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