OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 28 September 2021

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 28 September 2021

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

6th Meeting 2021, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Siva Anandaciva (The King's Fund)
Professor David Bell (University of Stirling)
Fiona Collie (Carers Scotland)
Derek Feeley (Independent Review of Adult Social Care)
Leigh Johnston (Audit Scotland)
Judith Proctor (Health and Social Care Scotland)
Henry Simmons (Alzheimer Scotland)
David Walsh (Glasgow Centre for Population Health)
Professor Nick Watson (University of Glasgow)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 28 September 2021

[The Convener opened the meeting at 09:00]

Decision on Taking Business in Private

The Convener (Gillian Martin): [*Inaudible.*]—the first item is to decide whether to take in private items 4 and 5, which will be to consider the evidence that will be heard during the stakeholder session and to consider the committee's approach to pre-budget scrutiny. Do members agree?

Members *indicated agreement.*

Social Care Stakeholder Session

09:00

The Convener: The second item is a round-table session with stakeholders in social care, It is intended that it will inform the committee's future work programme discussions. Our witnesses join us online.

I welcome Derek Feeley, who is the chair of the independent review of adult social care; Professor David Bell, who is a professor of economics at the University of Stirling and co-principal investigator—CO-PI—at Healthy Ageing in Scotland; Fiona Collie, who is the policy and public affairs manager at Carers Scotland; Henry Simmons, who is the chief executive of Alzheimer Scotland and co-chair of the Fair Work Convention's social care inquiry; Judith Proctor, who is the chief officer of Edinburgh integration joint board and chair of the chief officer group at Health and Social Care Scotland; and Professor Nick Watson, who is director of the centre for disability research at the University of Glasgow. I welcome you all.

I will ask the first question of Derek Feeley, on the independent review of adult social care, which—obviously—focused on adult social care. Should there be a similar review of children's social care and of the transition period not only from children's to adults' services but, at the other end, from adults' services to older persons' services? Do you have thoughts on that?

Derek Feeley (Independent Review of Adult Social Care): As the convener rightly said, the terms of reference for our review were specific to adult social care. The thinking behind that was that there had been an earlier piece—[*Inaudible.*]—that resulted in a report called "The Promise" that looked at children's services in Scotland, including social care support for children. There was, therefore, a desire not to go over the same ground again.

As we did our work, we had a number of conversations with the team who did the work on "The Promise". We did the best that we could do to identify areas—such as transition, which the convener rightly mentioned—in which there would be some overlap that would have to be taken into account as implementation of our independent review got under way. Additional issues around social work—for example, social workers' case loads often include both children and adults—will also need consideration, in due course.

I think that "The Promise" was published about six months in advance of our report being commissioned.

The Convener: In relation to the review, you did an awful lot of work in reaching out to the people who use the various services of adult social care. Even in these early stages of considering the national care service, do you feel that, through the recommendations that you have made, their voices are being heard, and that there is an opportunity for those people to offer input on formation of the national care service?

Derek Feeley: We certainly did everything that we could do during the pandemic to hear as many voices as we could. The vast majority of what is in our report came from listening to—[*Inaudible*.] One of the promises that we made to the folks who engaged with us was that their reflections, thoughts, ambitions and aspirations would be reflected in our report. Most of the feedback that we got from people afterwards said that we had done that.

We set ourselves some ground rules. We said that we would refuse no meeting—we had more than 200. We said that we would listen more than we talked and that we would make it as easy as possible for people—[*Inaudible*.]—sign language—[*Inaudible*.] Those would not be bad ground rules for the implementation process: refuse no meetings, listen more than you talk and make it easy for people to engage. I am now somewhat on the outside looking in, but my early sense is that the work to implement the report is being taken forward in that spirit.

The Convener: I will highlight a couple of things that jumped out at me as I was going through the report that are completely reflective of my experience, as an MSP, of speaking to constituents about their issues with social care services.

One of the first things that you highlighted was that access to care and support is too complex and too variable around the country. How do you see that being addressed by a national care system? I guess that that point in the report has very much driven the idea of national provision, whereby variability can be tackled and people who need access to care do not have to wade through treacle to get it.

Derek Feeley: There is an old saying that goes something like, “Every system is perfectly designed to get the results it gets.” Our current system is perfectly designed to get us variation. As you rightly said, one of the major drivers for our recommending a national care service was to remove some of that variation.

People whom we spoke to who received social care support described it as a postcode lottery. Removing that somewhat was definitely part of what we had in mind when we recommended a national care service, but we also wanted to see social care being held in the same regard as the national health service. We wanted parity with the NHS, we wanted to clarify some of the accountabilities, and we wanted to give a national assurance to ministers, Parliament and the public about the standard of social care in Scotland. We felt that it is important enough to have national strategy, funding and direction.

We wanted a national care service to be a vehicle for fair work. We wanted to be able to set national improvement priorities. Furthermore, there are some real pockets of excellence in social care support in Scotland, but we wanted to have a way of more easily spreading those across the whole country and of scaling them up, so that everybody gets the benefit. That combination of things was why we recommended a national care service.

The Convener: I will point to another couple of things that resonated. A lot of people said that the threshold for accessing support is too high. I really liked the quotation that says that a care system

> “should be a springboard not a safety net”.

That absolutely encapsulates the issue. Will you give us a little more information on what you heard on that and put in the report?

Derek Feeley: I cannot take any credit for that quotation. That was said by a young man with learning disabilities, who shared that perspective with us at one of our meetings.

People described how they found the process of assessment and eligibility to be “complex” and “bureaucratic”. One young lady described it as “brutal”. Over recent times, as resources have become stretched, eligibility criteria have been ratcheted up and up. Now, the only way for someone to access social care support is if they have a real crisis in their life. It is often too late by that time.

We want simplification of the assessment and eligibility process, and standardisation across the country, so that no matter where someone lives they could be sure that they can access support. We want to get more people into the system of social care support, and we want social care to be seen as being not just for crises, but as something that is preventative and proactive, and is available to help people to live the kind of lives that they want to live.

I am sure that Henry Simmons could speak about this, but I will mention one of the things that we heard from his organisation, Alzheimer Scotland. It did some really great work on taking more preventative approaches to supporting people with Alzheimer’s, but it was incredibly difficult to scale it up across the whole country. There were lots of opportunities to simplify the process of assessment and eligibility and to make it easier for people to access support—and, with a bit of investment, to get more people into the system earlier.

The Convener: I would like to open this up to other panellists. If any of you wish to come in on any of these issues, just put an R in the chat box function in BlueJeans.

The catch-all opening question that I would like to ask all of you is this: what do you see as being the most pressing issues for social care that the committee should consider, and which perhaps need to be tackled through the reality of a national care service?

Fiona Collie (Carers Scotland): I want to feed back quickly on what Derek Feeley said about children's services. We often hear from carers that transitions are a particularly challenging time. There is a wider picture of children with additional support needs and complex needs. There are issues around how they access the support and services that they need; around employment levels of carers and the difficulty of juggling work and care, and—[*Inaudible*.]—forward, how we incorporate children's rights in—[*Inaudible*.]

Certainly for carers, I would reflect that the idea of the system being unduly complex and being there for people only when they are in crisis—[*Inaudible*.]—that they have had to have, they have had to fight for support to be given to the person whom they care for.

It probably does not surprise you that I would say that the most pressing need in relation to the development of the national care service now lies in supporting unpaid carers. We know that there has been an increase of about 400,000 in the number of people who have taken on caring roles during the pandemic, which has had significant effects on their mental health, physical health and incomes. We think that there are some real opportunities in relation to the national care service, in particular around the right to a break.

There is also the wider question of having a social care system that is a springboard rather than a support. If we provide the right support for a person who is currently being cared for, we can, in effect, provide the same support for carers to enable them to manage their caring roles and their lives alongside that.

09:15

There is certainly a need, as part of all this, to look at what carers need, and at the choices that a person has available to them when they become a carer. A question that we never, or rarely, ask is whether someone would have become a carer, or a carer at the same level, if the right services and support had been available to their child, parent or spouse. Too often, we take that choice away.

In general, we are very positive about the opportunities that the adult social care review and the current discussion are opening up in bringing to the fore the value of social care and the support that carers provide. It enables us to look for ways in which we can make support more consistent and easier to access, in order to prevent many of the impacts on carers' physical and mental health, as well as impacts such as losing employment and the impact on their income.

I will leave it at that for the moment—I am sure that I will want to chip in with other points as we go along, but I wanted to make those points first.

The Convener: Members will want to dig deeper into a lot of what you said, in particular around unpaid carers, but first I will come to Professor Bell.

Professor David Bell (University of Stirling): Hi, convener—

The Convener: Hello—we can hear you perfectly.

Professor Bell: Did you want me to come in?

The Convener: You put an R in the chat box, so I imagine that you want to come in. If other witnesses want to come in as well, they can do so. It would be great to hear from you all about what you think the main issues are.

Professor Bell: I have a quick comment in response to the first question. I am not in a position to talk extensively about children's services, but one of the reasons for focusing on adult social care at present is that we know that there are particular issues coming up to do with the increase in life expectancy among older Scots. There has been a bit of a hiccup during the pandemic, but it is likely that life expectancy will continue to grow post pandemic, whereas we know that the number of children is declining.

I am looking at projections that my colleagues at the London School of Economics produced on the number of people with severe dementia in Scotland from 2019 to 2040. The number is expected to increase from 36,000 to 74,000 over that period, which is an increase of more than 100 per cent. Given that we currently have only about 33,000 care home places in Scotland, it seems to me that that issue merits significant attention from the Scottish Government. The review is, perhaps, the first part of that process.

The most pressing issue concerns people, including staff and—as has just been mentioned—informal carers. If we look at any estimates of the costs of long-term adult social care, we see that a huge proportion of the costs are associated with what we call informal or unpaid care. That involves people having to give up time that they might otherwise use for leisure, work or whatever. That constitutes the largest of the costs, because much of the support in adult social care is non-medical support. That cost has been so squeezed in the past decade or so because of the squeeze on local government funding. Health budgets have been less squeezed during the period of austerity. The squeeze on local authority funding has pushed up thresholds for access to services, which has had consequences in terms of council contracts with care homes and the terms and conditions that care homes can offer their staff.

I suspect that, post pandemic, that will be a real issue. A lot of people are already leaving the social care service because of the adverse effects of the pandemic. Conditions for care workers, which were already not very good, have been made more difficult as a result of their experiences during the pandemic.

The Convener: Professor Nick Watson wants to come in.

Professor Nick Watson (University of Glasgow): There is certainly a need for a review of children's social care. In addition, we have recently done some work around transition, and there are a lot of problems with that. I am focusing more on young people in transition. A big problem is that when we look at transition, we look only at the immediate post-school environment, whereas we need to look at the situation for young people until they reach 30. A lot of the evidence suggests that, for disabled people, transition can be delayed anyway because of the strictures that are put on them. The European Union is currently looking at transition services for young people up to the age of 29. If we are focusing on transition, we need to expand it outwards.

I thought that the Feeley review was great. However, one problem that I see from reading the report—I will be interested to hear what Mr Feeley has to say about this—is that it seems to present two different futures for social care. On the one hand, it suggests that good social care is the product of people power, the co-production of services and a diversity of approaches that are adapted to meet the needs of the locality and the needs of each service user. On the other hand, it calls for centralisation and standardisation, and institutional power, through a national care service.

Those two approaches seem to be in tension with each other and, as I read through the report, I really struggled to see how they could be reconciled. The former is about the transfer of power to those who receive care and support and those who provide informal care and support, and a call is made for informal care to be blended with more formal care provision, so that care becomes relational. However, in the latter approach, power is placed in the hands of a national care service, with a care workforce, and care becomes much more transactional.

It is also difficult to see how the third sector will fit in with those roles. One issue that emerged from our research on the experiences of disabled people during Covid, both in Scotland and in England, concerned the role of the third sector. In comparison with the state sector, the third sector is agile and flexible, and able to adapt the way it works very quickly. It was therefore able to meet the needs of disabled people where the statutory services could not. There are lessons from that around health and social care integration. Both in England and in Scotland, ministers looked at healthcare and took their eye off social care. That is not a criticism—ministers did not have the bandwidth to be in charge of both health and social care, with the demands that were placed on them at that time—but social care slipped out of consideration.

I would like to hear from Mr Feeley about how he envisages those two tracks working, how they will be pulled together and how we will keep the vibrant third sector when we have a national care service.

I would like to make a couple of other points. One relates to self-directed support. For six years, we have been tracking self-directed support through freedom of information requests on the number of people who are on various options, by local authority. The situation has remained virtually unchanged since SDS was first introduced. About 10 per cent of people are on option 1, about 80 per cent are on option 3, and options 2 and 4 have about 5 per cent each. Option 1 is very good for those who receive it, but not everybody wants the responsibility and the control that go with option 1.

We are setting up a care system in which there is inequality, because option 1 is undoubtedly better. We should be looking at option 2 and bringing in and working with the third sector. I would have liked more debate about how what is envisaged could be realised. I can see why a national care service is seen as a good thing, but I am yet to be convinced that it is the answer in social care, given the infrastructure and all the small care providers that we have in place at the moment.

Henry Simmons (Alzheimer Scotland): Good morning. I am wearing two hats today, but I will try not to let them overlap too much.

I will begin by making a point from a fair work perspective. We held a detailed inquiry over a two-year period and produced a series of recommendations in 2019. The core message from that is that fair work is not being delivered consistently across the social care workforce. The main issues that we found related to how services were being commissioned and how the balance of risk was being passed from those who assessed commissioning needs to organisations and thereafter to the workforce. Many people in the workforce have very changeable work patterns and hours, which range from some people doing 70 hours per week to people being on fewer hours and not necessarily having enough to live on. I can come back to that later, but we feel that our recommendations, which Derek Feeley included substantially in his review, should be delivered on.

Regarding the scale of the issue of people living with dementia and the challenge that it presents, we welcome the proposed national care service. We understand the complexities that Professor Watson highlighted, which need to be worked through. We believe that the three national dementia strategies have been excellent from the point of view of their content, the vision and the approach in the key areas. There are probably seven fundamental areas of transformation involved, ranging from diagnosis to post-diagnostic support, integrated care and advanced care, with substantial work within our general and specialist hospitals wrapped around that, and an underlying aim of making Scotland a dementia-friendly community.

That cannot be questioned as a national strategy—in fact, it has received significant international attention—but the difficulty begins when we try to implement the same vision in a consistent way locally. We see small components of that vision being delivered—for example, there might be an area that delivers excellent post-diagnostic support services, but where delivery falters when it comes to more integrated provision towards the advanced stages. There is not a methodology or a mechanism for those who conceive the national strategies to have any depth of accountability for them. We have strategies that the Government develops, that the Government and the Convention of Scottish Local Authorities own and that have ministerial drive and policy support, but implementation falls to the 32 local authority areas, and there is no accountability structure within that.

When Derek Feeley's report highlighted that gap and determined that we had to have a ministerial level of accountability, we very much welcomed that, but we do not want to have to wait. The committee has an important role in ensuring that the national care service does not become the longest grass that we have ever found ourselves in, given that we are talking about a five-year period for developing it.

As Professor Bell mentioned, the issues, challenges and scale of the problem that we face in respect of people with dementia need a significant level of attention and focus. That should not all happen at the end of the process. We are doing some joint work with the Scottish Government to tackle prevention and brain health. About 30 per cent of dementia cases are thought to be preventable. That can mainly be addressed through lifestyle changes and intervention for 40 and 50-year-olds. We have a strategy for that, but it needs to have universal application across Scotland. It also needs to be further tested.

09:30

On diagnosis and post-diagnosis, the earlier we can work with individuals and support them—we should do so as soon after diagnosis as possible—the more we can help them to build resilience and retain a really high quality of life. The evidence is that that takes off the pressure that comes from inappropriate and unnecessary admissions to residential care—some people might get two or three more years, which is a lot. Given that such intervention costs about £1,500 per person per year, it is clear that it is a minimal intervention that can bring great rewards. However, we have never been able to manage that consistently.

There is a commitment for every person to be seen post-diagnosis by a link worker for a minimum of one year, but we have reached only 40 or 50 per cent of that target. That shows that, despite strong evidence, strong models and strong ways of reshaping our system, we have never really achieved an approach across Scotland that gives everyone the consistency and level of support that they are entitled to. Subsequently, we do not get the transformational change in the system because delivery is too scattered, and we do not achieve the full potential of the national strategies. Similarly, no one can be held to account for delivery, because there is a real breakdown between the national strategies and local delivery.

The Convener: Members want to come in on a lot of that. However, first I will bring in Judith Proctor, before going back to Derek Feeley to round things off.

Judith Proctor (Health and Social Care Scotland): Good morning. It is an important debate, and chief officers are keen to be involved in the discussions about the development of a national care service.

The convener asked what we think the most pressing issues are. They have been touched on already; they are around preparing the workforce for the future and the resources that will be required to achieve equity of access and equity of outcomes for people. The issue of creating really good jobs for people and making care be seen as a career that someone would aspire to and that offers opportunities is also important. We have some immediate challenges as regards the workforce that provides care and support for people. We could be doing more on terms and conditions to make sure that those jobs are good jobs.

Derek Feeley talked about the ambition that is set out in the national care service proposals for access to be equal and easy for people—I support that. At the moment, however, we are not all set up in the same way and not all local systems have the same resources to deliver the services. Resources are not necessarily allocated in the same way and, over the years, we have seen differences in the allocation of social care funding for adults in particular. Therefore, key to the development of the national care service has to be fair and equal allocation of resources, whatever structures emerge, so that we can create fairness of access across Scotland, while recognising that there will be some variation because of the different geographies.

I also agree with Professor Watson's point that there are many things that will create a springboard in people's lives other than formal services. In creating a national care service, we have to think about the community support that we would want to be provided. Things that really support people outside formal services are thriving and vibrant communities and those committee opportunities that are usually delivered locally by local community groups and the third sector. As we develop the NCS, it is important that we engage with third sector organisations and consider the tension between a nationally delivered service with national standards and the need for localism that reflects local areas.

I disagree with the point about it being difficult and there not being the bandwidth to manage social care and health in an integrated system. We have worked hard over the years in integration joint boards and health and social care partnerships to create and develop our services in as integrated a way as we have been able to under the current arrangements and to manage that as an integrated system. We need the levers to go further in that direction rather than retreat on that core principle. We have made gains, and it is important that we do not lose those in the work that we take forward.

Derek Feeley: I want to come back to the convener's point about priorities. In our report, we identified three sets of priorities. Understandably, much of the focus has been on the creation of a national care service, but that is only one part of the report. There are two other sets of things that we thought were critically important. First, there needs to be a shift in our thinking away from seeing social care support as an unsustainable burden on society towards seeing it as a good investment, and a shift away from crisis towards prevention and anticipation, which we have touched on already. We also need to move away from seeing social care as being about managing need and towards seeing it as being about ensuring that people's human rights are met. Without that fundamental shift in our thinking, there is a risk that we will end up with a national system that is about burden, crisis and managing need. That is a priority.

Secondly, as several colleagues have touched on, we thought that it was important to strengthen the foundations of our social care support system. We need to recognise the work that unpaid carers do and we must enable them to do it better, which involves recognition that they, too, have human rights. There needs to be investment in our staff, who are fundamental to the work that we need to do, and we need a way to close the implementation gap. There is a gap between the intent of the legislation on self-directed support and the integration of health and social care—groundbreaking pieces of legislation—and people's lived reality. The second priority that we identified is a need to strengthen our foundations.

The third priority is to redesign the system, which is where the national care service comes in. However, there is also a need to reform commissioning and procurement, and to elevate the voice of lived experience at all levels of the system. That is one of the ways in which we can address Nick Watson's questions. He is probably right that there is a tension between standardisation and personalisation. However, we need both of those: we need to enhance both standardisation and personalisation if we are to have the kind of social care support system that we want in Scotland. We are going to have to manage that tension in the best way we can.

Self-directed support is a great example of that. Self-directed support is about recognising the needs of every individual. The report from Self Directed Support Scotland and the Health and Social Care Alliance, which came out in the course of our review, showed that we were about 50 per cent of the way towards where we needed to be with the implementation of social care support. That is one of the reasons why our report recommended that one of the priorities for a national care service should be improved implementation of self-directed support. That is more likely to be done at large scale at the national level through a national care service than it is by asking 32 local authorities to do it.

The Convener: All those contributions have been very useful and will allow us to focus on and dig into some of the areas that you have highlighted.

Sue Webber (Lothian) (Con): Thank you, Derek, for your hard work in producing the report, which has been the subject of much discussion in Parliament already. We have seen the plans for a national care service. The idea has expanded quite rapidly since you carried out the review. Given what we have heard today, do you think that the larger remit could lead to the required social care reforms in the adult sector taking longer, and can we afford to wait that long?

Derek Feeley: It has taken us many years to create the system of social care support that we have just now, and to change it will take some time. There are also some things in the report that we could be doing right now. We should begin the process of changing the narrative, which is why the social care covenant group was set up—to start to change people's perceptions. In the report, we make recommendations on further investment in the independent living fund—we can do that now. We could also begin the process of reducing the chasm that currently exists between purchaser and provider in the commissioning procurement process—we could do that now.

There is no doubt that it will take some time for a national care service to be established, but that does not necessarily mean that we should not do any work to improve social care in the interim. I hope that we will get on and do some of the things that can be done without the legislation during the course of the—absolutely necessary—passage of any legislative vehicle.

The Convener: We will move on to talk about fair work.

Carol Mochan (South Scotland) (Lab): As Sue Webber mentioned, there has been a lot of discussion about the Feeley report, a key aspect of which is how we support the staff. How important is it that we get it right for the staff and make social care a fair work profession? I am particularly interested in some of the aspects that the trade unions are interested in around pay, terms and conditions, and social care being seen as a profession with proper structure in the way that staff are trained and employed. I want some feedback on what we should be looking at in that area.

The Convener: Henry Simmons seems the obvious person to start on that question.

Carol Mochan: Yes, that would be excellent, as Henry Simmons mentioned that issue at the start of the meeting.

Henry Simmons: I refer the committee to the inquiry report that we produced in 2019 on behalf of the Fair Work Convention. The inquiry was chaired by me and Lilian Macer from Unison. It was the first piece of work that the convention engaged in, having developed the fair work framework. We looked at it over two years because so many issues about social care were being highlighted in the development phase of the framework.

There were three components to that work. First, we set up a social care working group, which included experts from every area—the Government, local government and providers. We used that group as an analysis point, to take evidence and views and to think about and reflect on the sector mainly through the eyes and ears of workers. We also commissioned Strathclyde University's Scottish centre for employment research to do two pieces of research. One looked at volunteer organisations that were committed to supporting fair work within their organisations and the second was about issues related to personal assistants. We found that work in social care is fulfilling for those who are doing it, but it is not fair.

09:45

There are some particular areas that the committee would want to know about. There are more than 1,000 organisations delivering social care in Scotland, and those organisations take varying approaches to the voice that workers and employees can have. Some take great approaches and have trade union recognition, but some have none. It is very variable. A workforce of 200,000 workers has no effective national voice and no national approach to negotiation or to the protection of fundamental rights and opportunities.

That has to be cross-matched with the commissioning processes that have become the norm since the purchaser-provider split of the 1990s. Organisations have to engage in various forms of tendering and commissioning, and they used to have stable grants. They knew how many staff they would require and how long they would be able to employ people for, but it moved to being more of an hourly-rate system in which staff are not certain about their number of hours or their support.

Prior to the pandemic, we had what our report describes as a non-committal framework approach to commissioning. That is a fundamental flaw in the system. It asks an organisation to commit to becoming part of a framework agreement within a local authority area. The process for that is informed by fair work principles, so the detail is reasonably okay, but the problem is that the organisation that is making the commitment has no idea how much work it will be asked to do. It has no sense of that, so it takes a risk in committing to having the staff to deliver the work.

The local authority or IJB that commissions the approach would want to have several providers, in order to meet the variable level of need within social care. The organisation commits, signs up and is on the framework agreement. Then it waits for work to come in. That work might come in a trickle or in a heavy flow. The organisation does not have the capacity to keep a workforce sitting and waiting to react to that need, so it brings people in on low-volume hours—about 11 per cent of care workers are on zero-hours contracts. That allows the organisation to react to need as it comes through.

The local area benefits by having organisations that can react to need, and the organisation benefits because it can secure a level of work, but the workers do not benefit. If they are on a four-hour contract, or a zero-hours contract, they do not know whether they will be asked to work. Workers who are on 35-hour contracts might end up working 70 hours a week if their employers have to react quickly and fill a gap when the tap gets turned on.

The commissioning process has shifted risk on to the organisations and then on to the workers, who bear the burden of that risk. That is fundamentally unfair. That does not happen in other parts of the health and social care system. There are other areas in which we cannot predict need although we can estimate it, such as accident and emergency units and primary care environments. Why is the social care workforce the only one to which we do not give security?

We recommended that there should be a national body to set the terms and conditions and to create a minimum set of standards. I would say that no one should be employed for anything less than 17.5 hours per week, although the amount should be determined by personal choice. We should have more detailed data to understand the prediction of need, so that the workforce is securely employed to deliver what is required. We should remove the risk of the worker being the person who has to manage the gap between unpredictable volumes and delivery.

In 2019, before the pandemic, we argued that there should be an immediate end to non-committal framework agreements and that there should always be, in any framework or agreement, a commitment of employment requirements so that organisations can say that they will have, for example, 10 staff available to deliver the service. There might be a gap and there might be downtime. The philosophy that has crept into social care in respect of there being no downtime or travel time and no minute in which public money is not being used to deliver the service is part of what has corrupted it. That approach is simply not realistic.

Social care workers do not have the chance to manage their diaries. They are given timetables, and they do not have the opportunity to make decisions about spending a bit more time on an individual who might need that. They have a task-based, slotted approach because we are trying to ensure that every single penny is being spent to get the best value and everything is tightly driven. However, all that we are doing is losing value and destroying the workforce.

It would not be an exaggeration to say that the workforce is among the most important and significant yet the most undervalued and poorly served in respect of standardised, high-quality terms and conditions.

The Convener: Judith Proctor would like to come in on the fair work issue.

Judith Proctor: Henry Simmons touched on the principle that Derek Feeley mentioned earlier: every system is perfectly designed to deliver the outcomes that it delivers. Some of the challenges that we currently see are the result of the system that is in place. In Edinburgh, which is my area, much of what we do has been outsourced, and the commissioning practice has been competitive rather than a co-production one.

A lot of work is happening in different places to address that. How do we create good co-production in a commissioning framework? Derek Feeley's report talks about having ethical commissioning as a principle and about putting that in place. We need to start by really understanding what the framework is for Scotland—what we are going to use as an ethical commissioning framework, what its principles are, how we are going to apply it nationwide, how it will be scrutinised and how we will know that, when we put good ethical commissioning principles in place, the impact on the workforce will be the improvement that we want to see.

I echo some of the comments that have been made. It is hugely important to listen to the workforce, which is hugely motivated. People want to do an excellent job in caring for and supporting people and helping them to have a good life. However, people are leaving the workforce because the job is difficult, and it is sometimes made more difficult by the terms and conditions and the challenges. We have to listen to what those in the workforce say about what works for them and what makes for a good job and career.

There might be a variety of different contracts for different people. We want a more diverse and diversified workforce. We know that the workforce has largely been female, and that has certainly not helped to secure fair terms and conditions or in preventing the job being relatively low paid. We need to go a long way to make the job attractive—and seen to be attractive—and to attract a diverse workforce. Flexibility is the key to that.

We should be working with universities and colleges to support students to think about taking up part-time work alongside their studies in care. That work gives people a tremendous foundation and experience that helps them in their lives. If we are going to attract diversity, we need to offer flexible roles and flexible times for people to work.

If we treat the workforce well and create diversity and flexibility, the people who are supported will get support that is far more flexible than what we are able to give them now. By focusing on terms and conditions, we will improve not just the experiences of the individuals who provide care but the experiences of the people who require care, and that is really important.

That links to the question of localities, locality working and localism. The more we recruit services locally, the more we will create the continuity that we are looking for in our communities and better jobs for people, particularly in some of our more deprived areas. It is important that we think about recruiting locally for local services.

Professor Watson: On fair work, having cautioned against a national care service, I think that one of its advantages would be the possibilities that it would give staff for career progression and advancement. One of the problems with social care is that a lot of care workers have very contained working lives in which they work only with particular groups and there is very little opportunity for employment progression. In a national care service, people could become area managers, senior managers or supervisors, and there would be the possibility for training. We should recognise that. Given that the majority of care workers are women and that a large number of them are from further disadvantaged communities, a national care service would have the potential to tackle some equalities issues.

The Convener: Fiona Collie wants to come in on an earlier point.

Fiona Collie: I want to come in on Sue Webber's question about the national care service's larger remit and whether that could lead to things taking longer. I admit to having some anxiety about that, because we simply cannot afford to wait. The development of a national care service is very important, but we also need to invest now.

The pandemic has been, and continues to be, highly damaging for carers. It has stretched carers to the limit and beyond, and it has exacerbated existing impacts and inequalities. Eight in 10 carers are providing more care. Critically, three quarters of carers have said that the care needs of the person whom they care for have increased, so more care might be required. The system will have to look at that.

We have discussed with COSLA and the Government the need to identify investment but also to get—for want of a better way of putting it—quick wins. We have been able to get money into the system as quickly as possible to support staff, carers and the people who receive services, but we need money in the system now. Over the past few weeks, there has been a lot of talk about ambulances and A and E departments, but there has been less talk about the challenges of social care and of providing support and meeting the demands now—never mind future demands.

As we come, I hope, further out of the pandemic, we will need to respond to people who now have more care needs and to carers who are, in many cases, beyond exhausted and needing additional support.

The Convener: We will return to the issue of coming out of the Covid-19 pandemic in other questions. Gillian Mackay has some questions on fair work.

Gillian Mackay (Central Scotland) (Green): At the beginning of the pandemic, there was a lot of focus on the incredible work that is done by care workers, but it feels as though some of that focus has waned as attention has moved to the pressure that is being placed on the health service. Are we doing enough to continue to value and highlight the contribution of care workers during the pandemic?

The Convener: I think that that question is best directed to Fiona Collie, because it leads on nicely from what she has just said.

10:00

Fiona Collie: The answer is probably no, and I think that many carers and care workers would say something similar. They feel that, as the demands increase—they are not decreasing for any carers—their contribution is being overlooked. They need to see some clear provisions on the table to support them now and as we come out of the pandemic. As furlough ends and offices reopen, carers are having to make choices around how much more infectious the delta variant is, whether they can go back to work and what that will mean for the wellbeing of the individual for whom they care. Vaccination has made a big difference, but there is still a gap. We need to find a way to fill it, and to support carers through the current situation.

Judith Proctor: That is an important point—there are real pressures on care workers right now. People who joined the care workforce during the pandemic, perhaps because they were furloughed or because they were inspired to care as a result of the support that was put in place, are now returning to their pre-pandemic jobs or moving to different sectors. As society has opened up again, the demand in other sectors has been huge as well, and other parts of the economy are offering higher wages than carers are currently getting.

As colleagues have said, carers are tired. It has been a very difficult period for them, and people are making choices to go into other roles. We have to do more, both nationally to promote roles in care and support people into the sector, and locally—[*Inaudible.*]—because we cannot go into winter with a depleted workforce. We really need to focus on what we can do now, as well as creating an aspiration for the future of the care workforce in Scotland.

Henry Simmons: I support everything that has been said. A key challenge in the social care sector has always been that carers look across at their health sector colleagues and their terms and conditions, security of employment and value. However, that often comes from the discourse at national level. People talk all the time about the NHS. Throughout the pandemic, we relied heavily on the social care workforce, but those workers could not even access the special supermarket slots during the first stages. There is a real need to say, “Right—we must start to equalise these terms and conditions, and we must make a real commitment to the social care workforce.”

As I said earlier, carers are in crisis and there are not enough of them. We still restrict them to minimum levels of hours and employment and then use them in a flexible way. We do not need to do that—in fact, we do not have enough workers to support that. We need to move really quickly and agree that having a standard set of terms and conditions that everyone gets is a top priority.

There is another issue that the committee should be aware of. Organisations that can offer better terms and conditions, such as bigger organisations and local authorities, will suck in staff who are looking for security. Some larger organisations may be able to offer a 35-hour week contract, for example. However, the smaller organisations provide vital support, and they have stood up during the pandemic and done things that one would not imagine. Some of them became food banks or delivered medication, and some helped people to get money or just maintained contact with them.

There has been a phenomenal response from not just the social care sector, but the third sector and broader civil society. However, the funding for a lot of those organisations is now under threat, and it might be that very few of them survive fully intact, which will mean that some of their workers might be in a redundancy position.

The infrastructure of our voluntary sector is intertwined with that of our social care sector, which is intertwined with the NHS infrastructure, yet the NHS is the part that gets the main attention and focus. We need to look across our community structures in such a way as to highlight each area with the same focus, priority and respect. If we do that, we might get somewhere in dealing with the whole-system changes that are required.

Professor Watson: We have found in our work on Covid and social care that, at the beginning, there was a big reliance on family members, as a lot of families did not want people coming in because they wanted to keep Covid out. However, a lot of people are concerned that, having taken on that caring role, they have not been given that support back as we have started to open up. Care has been reduced and people cannot get assessments. There are a lot of issues about getting new assessments for conditions that have got worse and support needs that have increased during Covid.

We need to consider that social care was already creaking and that Covid has created a big mess. I think that it was Judith Proctor who commented on the bandwidth. I did not mean that health and social care should not be integrated; what I meant was that, at the beginning of Covid, all the focus was on health. Nobody talked about social care, or if they did, they talked about social care in care homes; nobody talked about domiciliary social care. There was a lot of argument about whether we could get personal protective equipment into care homes, but nobody asked how we could get PPE to those people who were receiving care in their homes. Third sector organisations had to run around and source their own PPE because it was not being provided.

I think that domiciliary social care disappeared off the map at the beginning of Covid. That was because people do not have the capacity to look at all those different things. There is a danger that, the more integrated we get, the more some of those things will disappear. At the beginning of the pandemic, social care became just about care of the elderly in care homes and not about those people who were living at home and receiving social care there.

Professor Bell: I agree. The esteem in which social care is held is so much lower than that in which the NHS is held. Anything that the national care service can do to increase that level of esteem will be very beneficial.

The elephant in the room that nobody seems to want to speak about is the overall level of resources that is devoted to social care. It would be interesting to see how the national care service is going to be budgeted for once it has been established. At the moment, resource comes through the budget for communities and local government. That budget increased by 4 per cent in money terms between 2019 and 2021, whereas the health budget increased by 18 per cent. Decisions have to be made about the strategic direction of how resources are allocated between health and social care within that overall budget.

Derek Feeley made the point in his report that one of the benefits of a national care service would be that it will enable improvement in the data that is available for making the decisions that need to be made. Our work on care home deaths during the pandemic was not helped by the levels of quality and availability of data from across the social care sector. As Professor Watson said, the position is even worse for domiciliary care.

The Convener: Paul O’Kane has a question on pay. Paul, if you can direct it to somebody in particular, that will be great.

Paul O’Kane (West Scotland) (Lab): Professor Bell spoke about the elephant in the room, which is finance. Pay is part of that, and trade unions such as the GMB are advocating for £15 an hour for care workers. I am trying to get a sense of whether procuring better and more sustainable rates of pay is the first step, and the other aspects that we have discussed—training, qualifications and social care being a longer-term career—will follow from that. Derek, do you want to comment on that?

Derek Feeley: Sure. Thank you for the question. In the conversations that we have had, whether with third sector organisations or people who receive social care support, it was definitely noticeable how many of them said to us, “If you are going to invest in one thing, invest in the workforce.” The work that Henry Simmons, Lilian Macer and their colleagues did in their review of fair work is an outstanding foundation for making that investment.

In our conversations with the trade unions and the discussions that they enabled us to have with their members, we found that many people have perspectives on what a fairer rate for the job would be. You are right about that. At the moment, we focus on the real living wage. In my view, that is a starting point but not necessarily the end point. We need to get beyond that if social care is to seen as a valued career and the highly skilled work that it is.

In the report, we recommend a national programme of job evaluation such as the one that there was for the NHS. That would give us a sense of what fair pay in the sector really is. The fact that we do not know that is one reason why we could not put a firm price tag on the required investment. Roughly speaking, however, for every £1 that we go above the real living wage, we would need to invest about £100 million.

The Convener: Henry Simmons wants to comment on that. We will then move on to questions from Emma Harper.

Henry Simmons: There has been good progress with the living wage, but if someone has a great hourly rate but only two to 10 hours of work a week, that does not really matter. We need the full package. I ask the committee to look at the fair work framework, which calls for security, respect, fulfilment and opportunity. People need the full package in order to have good-quality work and employment, and the social care side does not have that. Apart from the right terms and conditions, people need access to training, support, supervision and time to reflect. All of that makes for good work, but social care does not have those things because the system has pushed them away.

We need to agree on what a good, fair and equitable hourly rate is, and the best place to look for that is probably our healthcare colleagues. The terms and conditions that are enjoyed in the various levels of the NHS have been well developed and negotiated, elaborated on and agreed. We do not have that in social care. I think that, if you use the NHS as a parallel, you will get close to something that would be reasonable. We need to move on from looking just at pay.

We also need an approach that looks at the whole, because we see in the sector that, as the wage level for most workers is increasing, that of next level up—front-line supervisors and managers—is not, so the pay gap is getting smaller. These environments need very skilled managers and people who can co-ordinate and work with and understand individuals. If we do not value the people at that level in the way that we do in the NHS—to use that comparator again—we are going to see a gap. We will not have enough managers to manage the complexities in the system because it will not be worth their while to do so.

We need to look beyond the hourly rate alone and look at the whole framework and system, including the structures within organisations, if we are to deliver a high-quality service.

The Convener: Emma Harper has some questions on the related theme of the recruitment and retention of staff.

10:15

Emma Harper (South Scotland) (SNP): I am interested in issues and ideas around fair work, recruitment and retention. My first job, before I started my nurse training, was in a care home, although that was a long time ago. What should we do to support recruitment and retention, aside from considering wages? A band 5 staff nurse gets about £15 an hour, and they train for three years, with knowledge and skills development, competency demonstration and assessment. Does there need to be more structure in education in order to encourage recruitment and retention and so that people's roles are perceived as skilled jobs, whether they work in home care, in a residential home or in a nursing home?

The Convener: Do you want to direct that question to anyone in particular, Emma? I see that Judith Proctor wants to comment.

Judith Proctor: I would like to comment on that, and also to pick up on the previous question. It is interesting to consider how much people who do not have experience of providing care or of being with somebody who is cared for know about the job. There are a lot of preconceptions about it. Not many people who are outwith the sector will know what it takes—the skills, training, decision making and autonomy that are required to do it. We could do a lot more to promote and explain it, and to allow people who care to share what the job is like and what it is about the job that they like. As Derek Feeley's report draws out, it makes a difference to people's lives—it makes a life-changing difference for people who would otherwise be isolated or unable to contribute to society. It is really important that we explain that.

When we talk about social care, it is important that we also think about the development of the profession of social work. I do not think that that is focused on in the debate as much as it should be. Good, well-supported social workers and well-resourced social work capacity ensure that people have good access to care and that we can meet the aspiration to make access easier and build services.

Terms and conditions are important in the creation of a career structure. We have touched on the keenness to have parity of esteem with the NHS, which has single workforce pay spines. However, I wonder whether we are thinking about what the linking of terms and conditions to such a structure might do to the current diversity of the market in care, which has a broad range of different providers. I do not have an answer, but I wonder whether, having created a single set of terms and conditions and a single role definition, we would begin to have a greater amalgamation of organisations, or whether it would lead us to a single nationalised workforce, as we have in the NHS.

Derek Feeley: There are a handful of things that we can and should do. The first is to grow public awareness of what a good career in social care could be, and the second is to recognise and celebrate the value of working in social care support. We touched on that earlier, and I think that more could be done there. The third thing concerns pay and conditions. If we really mean what we say about social care support making a valued contribution to civic society, we should pay people accordingly.

The fourth area is training and development. We have heard a lot of stories from people about how they have to do their training and development in their own time, at the margins of their work. If we believe that providing social care support is skilled work, which it undoubtedly is, we should train and develop people accordingly. The fifth thing is to give people—Nick Watson touched on this—a sense of career progression so that they can see social care as a career.

If we did those five things—raising awareness, celebrating value, improving terms and conditions, increasing training and development, and giving people a sense that they could have a career in social care—that would help with recruitment and retention.

Professor Watson: The issue of social workers that Judith Proctor touched on has also been pointed out by Iain Ferguson, who is a professor of social work. The problem with co-production and the use of bottom-up approaches is that social workers can feel deprofessionalised. With self-directed support, health and social care integration and so on, we have a lot of language about the co-production of services, but it has all been about co-producing and co-working with those who receive care. That is important, but the professionals also need to be involved in the redesign of services. At the moment, the people in the middle say that they feel like things are being done to them.

One of the issues with the implementation of SDS has been that it does not seem to be pushed by the street-level bureaucrats, if you like. Maybe we need to involve them more in the design and delivery of new care services. How will social workers feel about being brought into a national care service when they have always been part of social work? How that will come through will have to be looked at.

The Convener: We move on to questions on the funding of social care, which Paul O'Kane will lead on.

Paul O'Kane: We have moved from the recommendations in Mr Feeley's review to what the Government has consulted on. The Feeley review gave a figure of £0.66 billion as an adequate investment for its proposals. However, we now have an expanded remit, and there has been commentary from Audit Scotland on the growing requirement for care, particularly with an ageing population. How realistic is the £0.66 billion figure, and what further work needs to be done to understand it?

The Convener: If you are not directing that question to any particular panel member, I will go to Derek Feeley first, and other panellists can then come in.

Paul O'Kane: Given that I named Mr Feeley, I had better let him respond first.

Derek Feeley: The numbers are as realistic as we could get them in the time that we had available. However, we spent most of our time talking to people rather than doing financial analysis. As we pointed out in the report, though, we did the best work that we could to give some indicative numbers. Again, those are probably floor rather than ceiling numbers and they exclude investment in fair work, because we could not quantify that before we knew what the hourly rate would be, for example.

I think that we have done a reasonable job, in an approximate kind of way, at looking at how we can get to unmet need, what the cost of removing charging would be and what would be involved in the uprating of free personal and nursing care, which we think is necessary. Our sense is that the numbers are a reasonable approximation and give us a reasonable place from which to start, but there is undoubtedly more work to do.

Henry Simmons: Earlier, Professor Bell gave an indication of the number of people who are expected to progress to advanced dementia. Those figures are huge and frightening. The work that Derek Feeley did in relation to the recommendations on free personal and nursing care is a great start.

The committee probably needs to consider the fact that the needs of many of the individuals who will develop advanced dementia are healthcare needs. Just now, our system puts those needs into a social care environment. The issue of who pays for care in the future will be absolutely fundamental. We would argue that it is fundamentally unfair for someone who is in an advanced state of dementia and cannot walk or talk and needs assistance to go to the toilet to pay for that part of their care, at least, because those needs are healthcare needs.

The recent developments such as the national insurance contribution increases and the idea of cards miss the point about the need for a fair and equal social care system and how we articulate that need. There is no doubt that many people who have complex and advanced dementia cannot be described as requiring social care. They have healthcare needs in a social care environment.

We estimate that creating that equal platform will cost perhaps £40 million more than what is currently being spent. We need to look beyond the immediate situation and think through the changing nature of what our care system is working with and the needs that people have. People move from healthcare to social care and then back into healthcare as their needs progress. However, that part of our system does not adapt to change.

Professor Bell: The estimate of the cost of the national care service is around £0.66 billion and, as Derek Feeley said, there really is not anything in that around significantly improving the terms and conditions of care workers. Currently, we spend around £4 billion on adult social care, so what is proposed is an increase of more than 10 per cent.

I have to admit that I was one of the people who was involved in forecasting the increase in costs associated with the introduction of free personal care in 1999—another one of those people is currently the Scottish Government's chief economist. I have to say that we got it pretty badly wrong, because we significantly underestimated the costs at that time.

Having said that, I do not think that the Scottish Government at the time or successive Scottish Governments would regret the decision having been taken, especially given any comparison with the situation in relation to social care in England. However, as has been highlighted by the increase in national insurance and its intended hypothecation to the Scottish Government, which is an interesting take on devolution, clearly, the question of who pays if we are going to significantly increase the resources that are allocated to social work is important.

As Henry Simmons has said, we must expect those resources to significantly increase over the next decade or two, so we have to have a conversation in Scotland about who makes a fair contribution, and we have to define what a fair contribution really means. However, given the way that local government budgets have moved in the past decade or so, it is not obvious how, if that situation were to continue, additional resources would be found to meet the kinds of demands that we have all been talking about, not only on volume but on the things that need to be put in place to improve quality.

10:30

Fiona Collie: I will be brief, although it is a difficult question to answer. When we looked at a right to respite and started to produce figures on it, we saw that it could equate to £500 million, depending on what sort of right was introduced. The investment will depend on the scale of change that you intend to make. If you want to make a real difference to the lives of unpaid carers, for example, the cost to replace what they provide is around £43 million a day, which amounts to £10.9 billion overall. It really depends on the scale of change that the national care service intends to deliver.

When we are working out the investment that is required, we need to start balancing that with what the cost of not investing would be. Being an unpaid carer means losing employment, so we should ask what that means for the Scottish tax system. If disabled people cannot work because they cannot get social care to support them to do so, what is the cost to the Scottish tax system and the economy? We need more balance. It is about considering not just cost, but what the investment will deliver for the Scottish economy.

I have a brief comment on social workers. What I hear most often from carers—this is very much anecdotal—is that their social worker has changed or is off work so they cannot get hold of them, or they cannot get a social worker at all. It is an extremely important role in supporting the assessment of individuals, so it is vital that there is investment in that regard to try to overcome some of the current problems.

The Convener: We have a couple of supplementary questions from members. Evelyn Tweed can go first, followed by Sue Webber.

Evelyn Tweed (Stirling) (SNP): I thank everyone for their contributions so far. I am interested in funding, and in particular in what Fiona Collie just said about the scale of change and what we are actually trying to achieve with a new national care service. In addition, I am interested in issues on data and so on, which were raised earlier.

In the redesign of the national care service, and if we are to excel in preventative care, with all the new measures that we want to bring in to make it a great service for people, can we ensure that costs can be contained in the long term, or is it your view that costs will always increase?

The Convener: Would you like to direct that question to anyone in particular?

Evelyn Tweed: Perhaps Fiona Collie can go first.

Fiona Collie: It is potentially a question for an economist. It is very difficult to contain the cost and continue to do what we want to do, because we have a rising ageing population, and there is an increase in the number of individuals with more advanced dementia.

There is also the point about data, and the point about investment versus cost. We need to see the question as a whole. If we invest effectively and that helps the local economy to invest in the third sector, for example, there is a multiplier effect. We need to start looking more widely at the economic benefits rather than simply at the cost of social care, and we need to balance those things out. In my opinion, it is quite difficult to contain the costs, but I am not an economist.

The Convener: [*Inaudible*.]—economist. We will go to David Bell next.

Professor Bell: I will say a couple of things about the data. First, when we assessed the costs of free personal care, we tried to get a handle on what is called unmet need, which is the amount of need in the community that is not registered with local authorities, health boards and so on. There must be unmet need out there, given the increase in the thresholds that need to be reached before people get access to services. That is a critical point.

The second point goes back to something that Henry Simmons said. A lot of late-term costs associated with Alzheimer’s could be prevented by making lifestyle changes. We are the only part of Europe—we are in a very significant minority in the world as a whole—not to have a longitudinal study that follows older people as they age. I am a member of the scientific board for the European study, which throws up huge amounts of helpful research on how older people deal with the challenges that they face.

Derek Feeley: I will make three quick points. First, I do not think that anyone is asking for a handout for social care; we are asking for investment in social care. Studies show that that would be a good investment to make. Work done by the Scottish Women’s Budget Group shows that investment in social care would get us about twice as much economic value as the same investment in construction would get us. A study of Northern Ireland’s independent living fund showed that £11 of social value was generated for every £1 that was spent on that fund. That goes back to my point about trying to approach such issues with a different story about what social care is in our minds. We should see social care not as an unsustainable burden but as an investment in a good society.

Secondly, cost containment will, of course, be difficult, but it will be easier if we have good data. The lack of really good national data on social care is an impediment to good stewardship of our resources.

Thirdly, there is something about accountability in our recommendations. When I was the director general for health and social care and the chief executive of NHS Scotland, I came to the Parliament’s health committee and, as accountable officer, I was properly held to account for how I was spending our health budget. No one has been similarly held to account for how our social care budget has been spent, and it is time that someone is, although I am glad that it will not be me.

The Convener: I know that Nick Watson wants to come in. Perhaps he can come in after Sue Webber asks a short supplementary question.

Sue Webber: I am sorry, but it might not be that short.

The Convener: It will have to be.

Sue Webber: Okay. My question is about the challenges with commissioning and procurement.

The Convener: We will come on to questions about procurement, but we are not quite there yet.

Sue Webber: I apologise, convener.

The Convener: I will bring in Nick Watson.

Professor Watson: We are talking about care as though it is one sector. We must remember that people work in care in three different sectors. I think that about 39 per cent work in the private sector, about 27 per cent work in the voluntary sector and about 34 per cent work in the public sector.

Care workers work in different sectors, and I do not quite understand how the national care service will bring them all together. Are we going to nationalise those in the private sector, incorporate those in the voluntary sector or whatever? I am not entirely sure how any of this will go through or how it will feed into the national care service. We just need to remember that care workers work in a variety of sectors, with different stretches and pressures on them.

As for the finances, we must also remember the number of people who work in the care sector in Scotland and their importance to the economy. Nearly 300,000 people are employed as care workers across Scotland, and they make a massive contribution to the economy. We can see that as something positive if we look at things in that way.

The Convener: That leads us nicely to questions from Stephanie Callaghan on the scope of the national care service, which I know we have touched on a fair bit already.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): With the national care service, we are talking about a significant increase in scope, and I want to ask Derek Feeley and Judith Proctor about the proposed community health and social care boards. How can we ensure that they have the breadth, capacity and ability to collaborate to join up health and social care services in a way that allows us to design care around individual needs?

Derek Feeley: I will go first and then Judith Proctor can provide more detail.

We see integration joint boards as playing a really important role, because they will not be the only way in which a national care service gets intelligence about local needs and priorities. They will be the implementation arm of national strategy and direction as determined by the national care strategy. Those bodies will therefore have a crucial role in planning integrated services locally and engaging with local communities to determine local needs, as well as rethinking the social care solutions of the future by bringing in innovative new practice and different ways of meeting people’s needs. In short, they will play a crucial role as the delivery arm of the national care service—or, at least, that is how we have imagined it in our report.

The Convener: I will bring in Judith Proctor at this point.

Judith Proctor: I hope that you can hear me—my system has thrown me out, so I am having to phone in. I am pleased to be able to rejoin the meeting.

It is important that we think through the scope and the function of the new community health and social care boards. We also need to give due scrutiny to the proposals that will emerge from the consultation on the national care service to ensure that what comes after is workable and has been stress tested. Will the proposals that emerge through the bill process actually deliver the sorts of changes for people that we want to see on the ground?

I very much welcome Derek Feeley’s point about this being about local delivery in our communities, because one of the real benefits of integration is the real focus on localities. We know that we have a real diversity of communities across Scotland and, for me, an important principle is that any organisation should be of the community that it serves.

10:45

As a chief officer who has worked in an integrated system, I think that if we are going to make the changes that we need to make, we need to learn from the Audit Scotland reports that showed what has held us back, why we have not achieved, even though we have been integrated for a relatively short time—around six years—and what has stopped us from going faster. We need to ensure that the new community health and social care boards have all the levers that they need in order to be the delivery arm of the organisations, and I question whether that can be delivered through what looks in part in the current consultation to be an organisation that will commission elements from one of the partners. Consideration has to be given to those boards having the operational levers to pull to deliver as well as the resources, and that question being addressed through a fair and equitable allocation to the boards that recognises that we do not have a level playing field just now.

The Convener: I have extended the time for the panel, and I hope that everyone can stay with us for the next 15 minutes, because we still have key issues to consider. We said that we wanted to focus on unpaid carers, so we will move on to talk about them.

Stephanie Callaghan: How do we ensure parity for unpaid carers who carry out different jobs? How do we go about getting that parity? With demographics changing over the next few years, a lot of us will be looking at taking on a caring role. Derek Feeley spoke about shifts towards human rights in social care support. How can we shift the ethos and culture in society to really value the care that carers provide?

Derek Feeley: I would take advice on that from Fiona Collie, so I will not say too much about it; I will give her the stage.

In our conversations with carers and carers groups, they asked us for a number of things, the first of which was for their contribution to be recognised. The Parliament can have a really important role in recognising and celebrating the contribution that carers make. We should never take that for granted. I think that that would help.

The second thing was a bit of standardisation. There is a lot of variation in the extent to which carers assessments are done and agreements are honoured. If we promise to do things with and for carers, we should deliver. That would help.

The third thing—I mentioned this earlier—was that it should be recognised that carers also have human rights, and they should be helped to do the vital work that they do by helping them into employment that they want and to take a break when they want to do so. It is about easing their path.

Those things would help, but Fiona Collie is immersed in that issue from day to day. We got most of our ideas in our report about carers from listening to her and her members.

Fiona Collie: The point about the recognition of the role of carers and the contribution that they make is extremely important. However, carers quite often talk about how frustrated the hidden army and unsung heroes are. What they need is support to enable them to undertake their caring role safely, so that it does not damage their health and wellbeing; to carry on working or to go into education, if they want to do that; and just to have an ordinary life, in which they can go for a swim or meet their friends and have a break from caring.

During the pandemic, about 75 per cent of carers did not have any sort of break. I would like to be able to say that that is unusual, but it is not. Even in normal times, carers struggle to get a break from caring. They struggle to get support or even recognition for their own health and wellbeing. We often hear from carers who neglect their own health and wellbeing. They cannot get support even to go to their own health appointments and to look after themselves. The issue is multifaceted.

On the point about the adult carer support plans and carers assessments, we started with a challenge in the Carers (Scotland) Act 2016. We developed the positive approach of every carer being able to get an assessment if they needed one. We did not limit that to people who provide “regular and substantial” care. That was very much about prevention, recognising when people need support from the very beginning, and planning. When it comes to some conditions, we know what the trajectory looks like for the person who is receiving support, and there are opportunities for getting that support in rather than waiting until a crisis. However, when that is overlaid with eligibility criteria, it breaks.

Although I hate to use the term “resource”, carers are a huge resource for social care in Scotland. We would not think of saying to a care worker, “Oh well, you can’t have any holidays—you can’t have any break from this,” or, “Well, you can’t be off if you’re sick.” I would like to think that we would provide occupational health services if someone had an injury. We would provide the equipment that they needed, at the earliest point. However, we are not yet at that point.

What a national care service needs to deliver, first and foremost, is choice: letting people choose what care they want to provide. There might be some level of care that they want to provide and other things that they cannot do. A support plan is needed behind that, to determine what a carer needs in order to have the life that they want and to support the person that they love—they are often caring for a person that they love. It needs to balance that with ensuring that the carer’s physical and mental health and wellbeing are not damaged. If they have health and wellbeing needs, they need to be met quickly. Too many carers are, quite simply, breaking down. That will have a long-term impact, because those carers will at some point cease to be able to care, because they have been damaged by providing care.

There are huge opportunities for the national care service to change and shift how we view carers, and to get the support behind them to say that we value care workers, that we value unpaid care providers equally, and that we will provide the support that they need.

The Convener: We are rapidly running out of time and I know that some witnesses still want to come in. If I do not have time to come to them, they might want to follow up by email anything that is pressing, because we still have to talk about procurement and the aftermath of Covid-19. I will bring in Gillian Mackay very quickly on the issue of unpaid carers.

Gillian Mackay: My question should probably be directed at Fiona Collie. A lot of unpaid carers have been unable to take breaks, and the pandemic has also had a significant impact on their mental health. I was caring for my grandpa. The pandemic, and the risk that my outside activities posed for his health if I brought Covid into the house, cast a shadow. What should we do in the immediate term to make sure that unpaid carers' mental health and risk of burn-out is decreased to the greatest possible extent, and are there other things that we should be doing to make sure that, as we recover from the pandemic, unpaid carers do not continue to suffer unnecessarily?

Fiona Collie: Your point about mental health support is very important. From the beginning, we have heard the distress and fear of carers as they have been asking themselves questions like, "If I do X"—go to the shop, for example—"will that put the person I'm caring for at risk?" To be honest, that very real fear continues, but there is now burn-out on top of it.

It is good that the national wellbeing hub covers unpaid carers, but we need more to happen, and there are a number of short-term things that can be done. I understand the pressures around remobilising the NHS and some of the issues affecting mental health services, but there needs to be a plan for supporting the mental health of carers and getting investment to carers centres to increase their capacity to provide emotional support and, for example, to spot purchase counselling. Indeed, some carers centres have counsellors that work with them.

We need to try to get a plan together and—I hesitate to use this term, but I will—get some money out the door to the centres, which have been providing support all the way through this period, to increase their capacity in that respect. We also need a longer-term plan for support from the NHS, but that is the balance that we need to strike now.

As I have said, we also need some quick wins with regard to support for carers. I do not want to minimise the investment that has been made, but the question is what we do now to help carers. Is this about having more flexibility in self-directed support or individual budgets to meet need when care support is not available or is going to be delayed? Is it about increased funding to carers centres to provide emotional support, or is it about putting more money into providing breaks and allowing individuals to have a family holiday? That could be linked to what VisitScotland has been doing. That said, it is all very well giving vouchers to people on low incomes, but they need other funding to help with transport and so on.

This is all about speaking to carers and asking them what they need, then getting the money out the door as quickly as possible.

The Convener: We move to Sue Webber for some questions on procurement and commissioning.

Sue Webber: I want to try to bring everything together into one question and contextualise what I am asking about with something that was in the press over the weekend and which I think highlights the need to promote preventative support, collaboration and the integration of new and more innovative solutions such as the West Lothian Food Train, which I have visited.

I suppose that my question is for Derek Feeley and Judith Proctor, given that Mr Feeley's comment that there are things that we should be doing now and Ms Proctor's role in representing all IJBs. At the weekend, we heard about a 90-year-old woman who starved to death. It is the first time that that has happened for decades. Age Scotland called it "desperately sad", saying that it highlighted the scale of pensioner malnutrition around Scotland, and it also mentioned "harrowing stories" from pensioners who talk about empty cupboards and problems with grocery deliveries, particularly people who are not online. While we are waiting for what we are discussing to happen, what can we do with the legislation that we have to repurpose these services and stop such things happening now? What can we do with, say, commissioning and procurement?

Judith Proctor: The story that you have highlighted is shocking, but I am afraid that I have not seen it.

Nevertheless, you make a very important point. We touched on some of the issues earlier in the conversation such as taking a local approach and how we can work in true partnership with the third and independent sectors and those community-based groups that are present in and creating the kind of thriving and vibrant communities in which people can participate and where they are visible and seen. That is a hugely important part of our considerations about how we resource a national care service and the sort of community that we want.

Most of us in the health and social care partnerships—in fact, all of us in the conversations that we have been having—are working with our third sector organisations and interfaces on the lessons learned from Covid. Food poverty is very much a feature of that, and how we support people who are housebound and people in their communities is important. There are some brilliant examples. You have mentioned the Food Train, a long-standing organisation, which has been working for a number of years in different parts of Scotland. There are other food-focused charitable or third sector organisations in different partnership areas. The role of day services and day centres is also important in that.

11:00

I also highlight the role of social work and the importance of encouraging people to come forward if they have any concerns about somebody, and of our being able to support them and signpost them to vital services.

That is impacted by resources. We have to consider our ability to fund and support such organisations if we are going to create networks and safety nets for people, particularly older people.

Derek Feeley: I agree that the sort of tragic events that Ms Webber describes should never happen.

There are two sets of ways in which a radical reform of commissioning and procurement could help. The first involves what we commission and procure. At the moment, that is too often transactional, focusing on time and task. The result of the commissioning and procurement process is a lot of 15-minute visits, which is often not what people need. We need to turn our attention to what we are commissioning and procuring. How can we make that more relational and less transactional, and more preventative and less crisis oriented? That would help.

There is also the matter of how we commission and procure. Our report makes some recommendations about that. We would like there to be a more collaborative approach and to take the market out of commissioning and procurement, at least to some extent. If the market needs to play a role, it ought to be much more actively managed. We recommend a role for the Care Inspectorate in market oversight in so far as the market exists. We would like that to be replaced with greater collaboration, and we would like to hear the user voice much earlier in the commissioning and procurement process.

The second main focus when it comes to how we should change commissioning and procurement involves ethics. There is a call in our report for ethical commissioning, so that commissioning and procurement can be used as a vehicle for fair work, as we have already discussed, while placing a new set of requirements on care providers around transparency, with a commitment to high quality and participation in quality improvement activities. In our view, those would all be essential prerequisites to awarding public money to any care provider.

The Convener: Sandesh Gulhane has a question on procurement.

Sandesh Gulhane (Glasgow) (Con): This is directed to Derek Feeley. In your summary, recommendation 17 says:

> “Integration Joint Boards should manage GPs’ contractual arrangements, whether independent contractors or directly employed”.

Under that model—in the ideal vision that you have set out—would you want the general practitioner workforce to be directly employed or independent contractors ?

Derek Feeley: We are not envisaging that the employment status of GPs would change. Largely speaking, GPs would continue to be independent contractors.

Sandesh Gulhane: How would the IJB manage the contracts with independent contractors and those who are directly employed? What are the differences in that management?

Derek Feeley: The focus should be on local enhancements to the national contract. As I am sure you are aware, there are variations to the national contract in different bits of the country. We think that it would make sense for consideration to be given to enabling integration joint boards to manage those alongside the other contracts in health and social care that they will—[*Inaudible*.]

Sandesh Gulhane: Would there be a difference between those who are directly employed and those who are—

The Convener: Sandesh, Judith Proctor wants to come in. It is best if people are brought in through me; otherwise, it is quite difficult to manage. I will bring in Judith Proctor before coming back to you.

Judith Proctor: I will put the question in context. In practice, IJBs or health and social care partnerships are effectively managing much of the engagement and relationship with GPs in relation to the contract through our primary care teams. The work on primary care improvement plans is locally driven in health and social care partnerships. Under the contract, 2C practices in which GPs are employed—that accounts for a small number of general practices that usually have a specific set of circumstances—are managed by the health and social care partnerships, which all have, through their IJBs, clinical directors and lead GPs for that. Therefore, that management is already happening. Derek Feeley's report on the NCS talks about oversight of the overall contract moving from those boards to the new community health and social care boards.

I hope that that is helpful.

The Convener: I will let Sandesh Gulhane back in, but this has to be his last question, because we have to move on to our final theme, which is Covid-19.

Sandesh Gulhane: My question is for Derek Feeley. In relation to IJBs, will there be a difference between those who are directly employed under the 2C contracts and independent contractors, or will things be done in much the same way?

Derek Feeley: We do not envisage there being a significant change in the current arrangements. As Judith Proctor described, it is much more about ensuring that, in the spirit of integration, integration joint boards have the facility and capacity to oversee GP contracts. Judith Proctor is much better able than I am to describe the detail on that and how it might work. We do not envisage there being a massive shift in the current arrangements; it is much more about tidying up.

Judith Proctor: I agree. I do not think that the arrangements that are set out in Derek Feeley's report or in the NCS consultation will make a big practical difference on the ground because, in large part, we are all overseeing the contractual relationship now.

The Convener: David Torrance has a question about Covid-19 and social care.

David Torrance (Kirkcaldy) (SNP): Good morning. Over the past 18 months, the pandemic has led to pressures and difficulties for the social care sector. What lessons can be learned from the social care sector's experiences during the pandemic?

Judith Proctor: It is hugely important that we reflect and learn the lessons from the pandemic—we are still learning lessons now. As a group of chief officers, we undertook work on the lessons that have been learned through Covid-19, and Scottish Government colleagues contributed to that. We have also done that work in our individual partnership. A range of other work has been done on support for and oversight of care homes and on access to PPE.

From the work that we undertook on care homes, we know that the need for clarity in our communications with the sector is important. Care homes need to have points of contact so that we can support them, and there needs to be clarity on how we support them to access and implement guidance.

I think that the way in which we communicated with our teams and the organisations that we work within was also important. We needed to ensure that we were being clear about what we were doing and the challenges that the restrictions were bringing us and that we were amplifying the national messages in terms of how we were operating under the restrictions and what we were asking people to do. Obviously, it was important that we were able to demonstrate practical support for the care sector through things such as access to PPE and the sustainability payments. We needed to ensure, as far as we were able, that we did not see a significant gap in our ability to resource the sector. That will remain important as we go through the pandemic, because we have seen impacts on the capacity of care homes, with people leaving the sector and the increasing costs of recruitment. The lesson about ensuring access to appropriate resources to maintain the current level of service delivery is vital.

The point that not every stage of the pandemic has been the same is important. We need to reflect on the different waves and the different parts of the pandemic. It is equally important that we do not think that the pandemic is over and that we have learned all the lessons from it, because we are now at a unique and differently difficult point in the pandemic, and we must reflect on what we can learn at this point about the impact of issues such as the tail of Covid as it goes on. It is important that we reflect on points over time and do not just think that it is over and we have learned what we have to learn, because we have more learning to do.

Professor Watson: At two points during the pandemic, we interviewed 38 disabled people in Scotland and 30 in England, and we also interviewed 20 organisations that are involved in social care in Scotland and the same number in England. One of the key lessons that we learned concerned the fact that, at the start, when nobody knew what was going on—it was a crazy and difficult time—people who were in receipt of domiciliary care seemed to disappear off the map. People told us that they felt lost and left out.

If it was not for the third sector stepping in, many people would have been in real trouble. The third sector played a key role in maintaining contact, services and support for disabled people. People working in local authority social care who were working with people with a learning disability, for example, were moved to care of the elderly, because that was prioritised over community services, which meant that lots of services for disabled people—drama groups, art groups, cookery groups and so on—were closed overnight. Those might not seem important to most people but, for a lot of people with learning difficulties, those groups provide their only social contact. They provide them with a community, and they were just closed overnight, and those people were left without those communities.

The third sector stepped in and set up karaoke groups and so on. Glasgow Disability Alliance was running around the city doing things such as dishing out iPads and teaching people how to use them. That worked in some areas, but there are huge differences in digital access. About 80 per cent of Glasgow Centre for Inclusive Living's clients are digitally excluded but, among a similar group in Edinburgh, the figure is only about 20 per cent. Different things are going on.

One of the things that happened during the pandemic was that the needs of disabled people were forgotten about, because everyone was talking about other issues, and communities disappeared.

One of the other things that happened was that informal carers were left to provide a lot of support. That relates to points that were made earlier. It was perhaps understandable that people's short breaks were stopped, but nobody thought about how they could provide people with some other sort of short break, such as an afternoon off that they could use to go for a walk or something. In September, I spoke to a mother of a 27-year-old man in Scotland. She had had absolutely no contact with the local authority since March. She was looking after this young man on her own. Nobody had attempted to offer a short break, and she was close to breaking point. People were left alone. It was all right if people were able to make a noise about it but a lot of people were not, because they were so busy and swamped with other things.

11:15

We have to push the notion that domiciliary social care is very important and it needs to be put at the top of the agenda. We must also remember that the role of the third sector is essential in that. Many third sector organisations have managed with very precarious working situations. Some of them are currently providing services without contracts—they are working on a month-to-month basis. The precariousness of employment in the third sector is quite frightening—the way we are treating workers in that sector is unacceptable.

The Convener: I will bring in Henry Simmons. This will have to be our last contribution before we take a break.

Henry Simmons: At the start of the pandemic, it was clear that people were going to run out of money and have difficulty getting food and medications. There was an excellent level of collaboration to try to meet their needs. It was also important that some of the established services such as the day services and home care services that we have mentioned took part in a good bit of partnership working that enabled us to reshape services. For example, Care Inspectorate registrations were modified and funding for day care was allowed to be used for digital visits and digital technology support. We can take some good lessons from that about collaboration and reacting to crises.

Most of all, we learned that the infrastructure around individuals that is outwith the main stream of the NHS simply fell apart. Our experience was that people jumped forward almost two to three years in terms of the progress of their dementia. People who had early-stage needs rapidly progressed to the mid and later stages of dementia. We now have a population of people who are not yet diagnosed but need diagnosed and people who have received a diagnosis and whose needs have progressed. There is a significant number—higher than we predicted—of people who have progressed to the point at which they require advanced care support.

In the midst of all that, we have seen significant excess deaths, the reasons for which we need to understand. A lot of that has been about the importance of the non-pharmacological interventions around individuals and families. If anything, that is the best example to demonstrate the fact that, if you instantly take away that social support and social infrastructure—all the things that maintain people's quality of life—there will be a quite frightening decline.

At some point we will find ourselves facing another pandemic of some kind, and we need to prepare for that and ensure that we do not just bring everything to a dead stop and then try to pick up the pieces. We have to think of ways of tapering out provision if necessary. That will require the sector being resourced in such a way that it can cope with that in the collaborative way that we did as well as in a more structured way.

The Convener: I thank everyone for attending this morning. I have kept you here a lot longer than we originally intended, but I think that it has been hugely worth while, as it has given people the opportunity to air quite a lot of thoughts that will inform our work programme.

We will now take a five-minute break.

11:18

Meeting suspended.

11:23

On resuming—

Health and Social Care Finance Stakeholder Session

The Convener: Our third agenda item is a round-table session with stakeholders on health and social care finance. The discussion is intended to inform the committee’s future work programme discussions and its approach to pre-budget scrutiny.

I apologise for keeping our panellists waiting; they have been very patient.

I welcome Leigh Johnston, who is a senior manager at Audit Scotland; Professor David Bell, who is a professor of economics at the University of Stirling and who remains with us from the previous panel; Siva Anandaciva, who is chief analyst at the King's Fund; and David Walsh, who is public health programme manager at the Glasgow Centre for Population Health. I thank all of them for joining us to help us with our work programme, and for waiting.

I would like all of you to tell us whether there is greater scope in the landscape to prioritise preventative spend. We are dealing with the aftermath of a pandemic and setting up a national care service but, time and again, we hear that we do not prioritise preventative spend enough. As we heard from the previous panel, preventative spend actually saves money for the future and has better outcomes. However, because of the pandemic, we are in a bit of a crisis moment, and it is difficult to square the circle when you have to deal with immediate concerns.

I will go round all the witnesses to hear their views, starting with Leigh Johnston.

Leigh Johnston (Audit Scotland): As we have previously reported, integration was intended to help shift resources away from the acute hospital system towards more preventative and community-based services, but achieving that has not been easy. There has been a lack of agreement on whether it is achievable in practice or whether rising demand for hospital care means that more resource is needed across the system. With the huge backlog from the pandemic, the situation requires disinvestment and reinvestment, but that, as I have said, has been very difficult to achieve up to now. That said, the pandemic offers a chance to do things differently, and we need to seize the opportunity to think about different and more sustainable ways of delivering things.

Professor Bell: I echo what Leigh Johnston has just said. Part of the difficulty of moving resources towards preventative spend, which the Christie commission advocated several years ago, lies in demonstrating the usefulness of such spend and convincing managers that there are genuine resource savings to be made in allocating more to it. That is a difficult task; it is not easy to make a convincing demonstration in that respect to those who feel that acute services are under pressure and require immediate support.

In the previous evidence session, Henry Simmons talked about how lifestyle changes might reduce the negative effects of Alzheimer's progression, and that result seems to have been accepted. I am reiterating the same point, but it is difficult to persuade managers that programmes that might not see a successful outcome for years are worth doing. Many countries have tried such an approach, some with more success than we have had, but it is a huge challenge.

Siva Anandaciva (The King's Fund): First, I should point out that I work for a think tank that is based in England, so an awful lot of what I will say—actually, almost everything—will have an English context.

I want to make five quick observations.

First, the logical—or business—case for greater investment in a preventative approach in public health services has been made.

Secondly, as the other panellists have pointed out, that does not seem to have translated into greater investment. It is a fact that things are held to different standards. A proposal to build a new hospital, for example, will, in most cases, not see a benefit for five to seven years, but I am certain that that business case will get through a lot easier than the case for a transformative increase in preventative spending.

Thirdly, for the first time in England—I think that we are largely following your lead in Scotland—some of the structures are changing to support greater preventative spend. We are forming integrated care systems in which the basis of work is collaboration, not competition for greater elective activity. The contractual frameworks will change, so we will get off the hamster wheel of annual spending and have a three to five-year budget, which will provide us with some headroom to invest in services that pay dividends further down the line. Perhaps more important, our expectation of what it means to be a leader in our healthcare system is subtly changing, from someone who runs a good ship—a good hospital or organisation—to someone who is a system leader and thinks about the health of their population.

11:30

Having made those optimistic points, I will finish on two slightly more pessimistic points.

Currently, in almost every conversation that I am in, the elective care backlog—the waiting list for planned hospital care—takes up almost all the oxygen in the room. That is for historical reasons and because that is where most of the data and performance targets are measured. There is simply not enough funding available to run two systems in parallel: a system that is focused on tackling that backlog and one that is focused on transformative improvements and preventative spend.

Finally, at present, it is uncertain what the system's strategic priority will be for the next five years. As one chief executive put it to me, "I work out what my priorities are by thinking about what I would get sacked for, and I can tell you now that, over the next five years, it is more likely that I will get sacked for not tackling the elective backlog than for any other issue."

There is a mix of some hope and a little bit of pessimism.

David Walsh (Glasgow Centre for Population Health): Good morning. I should preface my answer by saying that I do research in the area of health inequalities, which is less about health services and more about the broader determinants of health. If we are talking about prevention, we need to understand it in a really wide sense, by thinking about the big social and economic drivers of poor health and health inequalities that exist.

It is really important to look at the context. We talk about Covid and the crisis in the health service, but it is important to understand that we were already in a crisis before Covid. The impact of the UK Government's austerity measures, in taking out £47 billion across the UK from social security payments, has had a devastating impact on health outcomes everywhere, and in widening inequalities. There has been talk of a stalling of improvement in life expectancy, which is one marker of population health, but we know that that actually masks increasing death rates among the most deprived populations across the UK.

With regard to prevention, it is really important to understand that context. Even before Covid hit, we already had the widest health inequalities in western Europe, but they have become a lot wider on account of the past 10 years. Covid has come and it will go, and we will see the impact through a couple of years of markers such as life expectancy and mortality rates, but, when we look back to pre-Covid rates, we see that—as I said—we were in a crisis already.

The Convener: Thank you.

David Walsh picked up on some of the other issues that colleagues will come in on, but also highlighted what I was driving at, which is the interdependence of different portfolio areas with regard to Government having an impact on health outcomes. You picked up on the idea of economic inequality having a direct impact; we could say the same for educational inequality.

I will come back to you with another question before I go to colleagues. Last week, one of our witnesses commented that every Government minister is a health minister and that we should view health outcomes through the lens of absolutely everything else that we do. What are your thoughts on that? What could be the impact on health outcomes of a universal basic income, for example?

David Walsh: More generally, on the question whether everything matters and whether all the different Government departments somehow relate to health, that is a fundamental understanding of public health. There are thousands of models of health determinants out there, which contain many factors. They include health services, but that is only one of many factors, and it is not the most important. The most important factors are the social and economic factors that you allude to.

The evidence around the relationships between income, employment and education and health, and the conditions in which people are brought up, is overwhelming. Those relationships go back not just decades, but centuries, so it is important to understand that all those factors ultimately impact on health. On one level, that is public health evidence, but it is also common sense—we know all that.

David Bell referred to health behaviours, which do not emerge in a vacuum—they are about how people respond to the environment that they are in. Social and economic factors are imperative, and income is imperative. It is important to consider a minimum income in relation to health, and work is going on in various areas to try to understand the ways in which we can protect the poor. That is fundamentally what this is about.

To go back to the point about austerity, the impact of the cut in social security has been absolutely calamitous in taking away the safety net for the poorest and most vulnerable people in society. In the context of our rather limited powers in that area, we have to try to do what we can to protect the income, and therefore the health, of the poorest and the most vulnerable using the powers that we have. Obviously, they are very limited for social security.

The Convener: We will come on to have more in-depth discussions about some of the themes that you have all mentioned. Evelyn Tweed will ask about the strategic context for health and social care finance.

Evelyn Tweed: I am interested in some of the early comments that the panel made. How do we give managers the headroom to deal with future and preventative care and to provide an exceptional service, rather than having to deal only with the present conditions and backlog?

The Convener: Let us take this in reverse order: we will come back to David Walsh first, and I will then go through everyone. For future questions, people who want to come in should put an R in the chat box, as not everyone will be able to respond to every question.

David Walsh: Doing this in reverse order is probably not the best for me. My research is not really about health service spend. I made that point when I was invited to come along, but the committee was keen for me to talk about other things. There are probably others on the panel who could respond better to that question.

My work is more to do with the broader social determinants. Clearly, they are the factors that predict poor health in the first place, as opposed to people encountering the health service when they are already in the situation of having poor health.

If it is okay, I will skip that question and leave others to respond.

Siva Anandaciva: I would say three things in response. First, the headroom is for clinicians as well as managerial staff—I think that that was in the question. I honestly cannot tell you the number of clinicians who say, “That’s the first thing that goes.” In this country, we have SPAs, or special programmed activities, which are basically my headroom, where I can think about changing my service. Those are the first thing that goes, because I am back on the backlog.

The answer that I am picking up from some of the things that were said earlier is that, if we do not have the right supply of staff—we certainly do not in England—that headroom is incredibly hard to create. Until we increase the size of the workforce, we will always be in a hole.

Secondly, there is an issue with the technical information and the skills and capabilities that we have. For instance, is there the integrated data to show us where we should be having the greatest impact? In parts of the country such as Greater Manchester, that is the case: there are inverted pyramids over particular groups of the population that are relatively small but account for a large amount of cost. If we were going to invest in more preventative spend, that is who we should be supporting the most. Other parts of the country lag far behind. Part of that technical data bit involves giving people the capability to improve services. We have lost some of the ethos of lean operational thinking.

The third thing, which is probably the hardest one for me to get my head around, but also the most important, is culture and organisational development. What particularly sticks in my head is a conversation with a group of consultant ophthalmologists. I was trying to do the sell for having more preventative investment, with greater integrated thinking. They said that, intellectually, they got it but, for their entire career, they had been trained to focus on throughputs and getting people in and out of hospital and their service as quickly as possible. They wanted to do things such as tackling avoidable blindness and unmet need, but no one had yet told them that that was what their new job description was—they wanted clarity about what behaviour should be rewarded—or how on earth they would do things and what steps 1, 2 and 3 were.

The places that I have been most impressed by—Greater Manchester and parts of Dorset, for example—are the ones that have really invested in organisational development, support and consultants working in a different way.

Professor Bell: I reiterate what Siva Anandaciva has just said about metrics. If all the metrics that clinicians and other health professionals are confronted with are effectively to do with short-term, acute issues, which can be easily highlighted by reporters in the press, it will be difficult to switch attention away from acute budgets.

On long-term budgets, we are about to have a spending review, but there has been very little consistency of budgeting. That is really because of the UK Government messing around with the timing of budgets and their time coverage.

I agree with a lot of what David Walsh said, but the Scottish Government's budget is increasingly dominated by health and sport, which now accounts for more than 40 per cent of the overall budget. There used to be roughly the same level of spend on health as there was on local government. For 2021, health and sport spend is forecast to be £17 billion and local government spend is forecast to be £12.5 billion. There has been a big change, and the opportunities to engage with the preventative activities that David Walsh talked about have been greatly limited.

I agree with the point about data. In the previous session, I made the point that, if we do not have the right data, we cannot take the right actions.

Silos and different ministers or different Government departments being responsible for spending their own money and not seeing that some of the resource that they are using would be better allocated to one of the other departments are a big issue.

The Convener: Emma Harper has questions on that theme.

Emma Harper: In the Health and Sport Committee, we took evidence on shifting the balance of care and moving finances into a social prescribing model. One of the things that I am interested in is the prevention of type 2 diabetes complications. We spend lots of money mitigating or treating complications—£800 million is a lot of money—when those complications are preventable.

What is the value of social prescribing? Should it really be invested in more in order to help to improve health and tackle inequalities? I am interested in that because of the previous committee work on social prescribing. Maybe we should start with David Walsh.

11:45

David Walsh: There is some emerging local evidence on the effectiveness of social prescribing. On that specific question, and on the bigger question that you have led into of health inequalities more generally, I think that it comes down to balance. GPs' prescription of social remedies might work in some cases, but if, as I have alluded to, there is a crisis in basic social security funding, social prescribing is not going to address that balance. It depends on individual cases. Clearly, if people have their income taken away and are then told that a walk would be good for them—I am not trying to belittle that, but it depends on how it fits with the individual's circumstances.

More generally, when it comes to the issue of health inequalities and what we do about them, an important point to note is that we know what to do about them, because the evidence is all out there. The Scottish Government commissioned an international policy review of what works in addressing inequalities, and what does not. That was undertaken by NHS Health Scotland, which is now Public Health Scotland. That is all published—it was published about four or five years ago—so we know that there are different levels at which policies are effective. Those include policies that address the fundamental socioeconomic drivers of health inequalities—the stuff that I have mentioned about redistributing income, protecting the income of the poor and addressing poverty. Others are in what are referred to as more environmental areas, such as housing, pollution and taxation of alcohol. There are also issues that are to do with addressing individuals' experiences of inequalities. However, the most important thing is to address the fundamental socioeconomic factors that drive health inequalities.

First, the evidence is there about what works, so what is needed is political will and political bravery. However, in the context of devolution, the question that has to be asked is about the powers that Scotland has to bring about such changes and to introduce such policies. To address those more fundamental socioeconomic factors, do we have efficient economic levers? I think that that is questionable. The evidence is there. It comes down to political will and political powers, I think.

Leigh Johnston: I want to follow up what David Walsh said on the role of Public Health Scotland. Obviously, it was set up just at the start of the pandemic and has been at the forefront of dealing with that, but I do not think that it has yet had the opportunity to take the whole-system approach to public health that it was set up for. It would be good to see what it can achieve once it is able to do what it was set up to do.

I also have a comment on the wider approach to the issue. Judith Proctor talked about it in the previous session. As I have said, integration authorities were set up to try to move the funding into the community—to more preventative care. However, we identified in our report on integration a number of areas in relation to how that could be achieved. Some of that has already been talked about. It involves the need for collaborative systems leadership, rather than thinking about the aims of a single organisation; thinking more about the outcomes that they are trying to achieve for their community; and effective strategic planning—linking resources to priorities and being able then to link those to the outcomes that they are achieving.

However, as has also been mentioned, there is a need to have access to good data. Again, we have reported on a number of occasions that there is still a lack of data on what is happening in communities—for example, in primary care and in social care. Being able to show the outcomes of preventative approaches is important.

Gillian Mackay: How best do we determine the level of funding that the NHS and social care need after Covid? I know that the British Medical Association has said that

> “short-term boosts won’t be enough to deliver the full recovery”

that services need, and that what is really needed is

> “a full review”

of health and social care spending in the context of a national conversation about our expectations. Would the panel support that approach?

Leigh Johnston: As David Bell said, health funding was already a huge proportion of the Scottish Government budget, and it has been increased by spending throughout the Covid pandemic. We said on a number of occasions before the pandemic that the NHS is not sustainable and costs have continued to increase throughout the pandemic.

There is continuing uncertainty about how the NHS will be funded in the future. The Scottish Government has made a number of spending commitments, both in its recovery plan and in the programme for government. There is talk of a 20 per cent increase during this session of Parliament. We need to see a refreshed medium-term financial framework for health and social care.

It is also important that we bring the public along with us in our approach to that. Things will have to be delivered differently as we consider our future recovery and NHS sustainability. We need a culture change from the public, so it is important that we engage with them and that we bring the public and staff along with us as we deliver services differently to ensure the sustainability of the NHS.

Siva Anandaciva: Leigh Johnston is right. There must be a refresh of the UK’s medium-term forecast for health and care spending. I have one caveat: I understand the criticisms of tactical, short-term boosts in funding. One finance director compared that to their financial plan moving from a cliff edge to a cliff face, because money comes at short notice and suddenly has to be spent in a value-for-money way.

Leigh mentioned uncertainty. I cannot emphasise enough how hard it is to develop a planned medium-term financial forecast with such uncertainty about demand. That is not only because we still do not know what the path of the disease will be but because we do not know when the demand for routine services will come back, what complexity that demand will present and how it will spread over time. There is a question about when is the best moment to have a medium-term plan. I would suggest that that should be at the start of the next financial year, at the earliest.

Beyond the question of timing, you must consider what you want to plan for. I would segment that. The first part is the direct costs of dealing with the pandemic, such as the test and trace system or PPE. The second bit is tackling the backlog, which is broader than planned elective care and includes things such as mental health services, child and adolescent mental health and community care.

Thirdly, we should also ask what a resilient health and care service would look like. That is not just about being resilient to a pandemic but about being resilient to other threats such as cyberattack. That is a pet concern for me. There is a shift to using digital and virtual consultations as the default mode. What redundancies are being built in? What does that cost?

The fourth and final part of the plan is any business-as-usual growth in healthcare spending. That tends to go up by 3 to 4 per cent per year, due to a combination of factors. You almost have to bake that in before you layer in those other cost pressures.

Professor Bell: I agree with Leigh Johnston and Siva Anandaciva. There is an annual 3 to 4 per cent growth in costs. During the earlier panel discussion, I alluded to the fact that part of the problem is the ageing population and the concomitant and largely chronic diseases associated with that.

We really do not know the rate at which unmet need—which was clearly there during the pandemic for non-pandemic-related healthcare—is going to be unwound. That will have an important effect on funding requirements.

The budget for health and sport for 2021-22 is £17 billion, and our receipts from income tax, which is our largest tax, are £12.25 billion. It is important that the Scottish Government addresses that funding issue and the issue of how to engage with the public and with staff on the inevitable growth in demand, which has to be set against the needs of the other areas of the Scottish Government's responsibility, such as education and local government.

The Convener: Emma Harper has a quick supplementary question before we move on.

Emma Harper: Thanks, Gillian, but I do not actually have a supplementary question—I was just correcting a spelling mistake in the chat box. [*Laughter*.]

Paul O'Kane: The discussion help us begin to think about the context of coming out of the pandemic and what will happen as we move forward. I am interested in service redesign, which has been touched on in previous answers. I am interested in what we can learn from the pandemic about doing things differently and in ways that bring savings. I am thinking about digital technology in particular. With regard to social care, the use of technology-enabled care is interesting. I want to get a sense of where the opportunities are for some of that.

Leigh Johnston: There are opportunities. As you said, with regard to digital technology, there have been some advances during the pandemic. There has been some redesign of the way in which people access urgent care, such as the A and E system.

However, we have to achieve a balance. There are opportunities there, but there are some potential huge cost increases. The question is how many of those will become recurring costs and some of the witnesses have already talked about some: the vaccination programme, test and protect and the increased infection prevention and control measures, such as PPE, cleaning and social distancing, result in hugely increased costs, which will offset any potential savings. There is also the huge backlog of patients who still need to be seen, and the investment required to progress digital technology will lead to increased costs and investment.

It is also important that we properly evaluate some of the innovations that have happened during the pandemic—obviously, they will not suit everyone—to ensure that they meet the needs of the population and are sustainable in the longer term.

Siva Anandaciva: I will make an overarching point. As Leigh Johnston has indicated, it is a largely evidence-free zone. There are a few real-time studies that are collecting real-world evidence, but, to be honest, there is nothing that I would rely on to make massive service changes.

In England, people are looking at three buckets for productivity improvements that were spurred by the pandemic. The first, as Paul O'Kane mentioned, is digital and virtual appointments for primary care and out-patient care. That work is certainly not finished, but the early evidence that I have seen suggests that there is clearly a wider societal benefit from reduced travel times and emissions and the need to take less time off work. The evidence for impacts on NHS productivity is much more equivocal, including the questions whether you can really reduce the number of dropped appointments or appointments that the patients did not attend and improve clinical productivity. There are real questions there that need to be answered.

12:00

The second area is more operational changes. In this country, we have seen a lot more sharing of, for example, a single clinical rota or equipment, particularly larger equipment such as computed tomography or magnetic resonance imaging scanners, across a wider pool of organisations. It is not much talked about, but that has led to reduced downtime for those assets and, as a result, some productivity improvements.

The third area is broader service reconfiguration—in other words, what services are delivered where. Because of the pandemic, many countries separated out planned routine services, particularly in hospitals, from what we call hot services, which deal with emergencies where things are harder to predict and you might have, say, a patient coming in with trauma through the A and E department. There are productivity benefits to be had in separating out those things, and the pandemic has made that approach possible.

Those are the three train tracks that we are trying to build more evidence around. Finally, though, infection control guidance will, for the next six months at least, be the rate-limiting factor on the amount of productivity that a health system can deliver.

The Convener: Paul, do you want to come back on any of that?

Paul O'Kane: No, that was helpful. I have some questions on sustainability, but we can move on to that later.

The Convener: We are just moving on to the issue of financial sustainability. Sue Webber will kick off those questions.

Sue Webber: I am sorry, convener, but my question is more generic. What does the panel think of COSLA's comments that the consultation

"cuts through the heart of governance in Scotland"

and will

"have serious implications for Local Government".

Perhaps Leigh Johnston from Audit Scotland can respond first.

The Convener: When you talk about the consultation, are you asking about social care?

Sue Webber: I am aware of the time, convener—I was just asking about finance in general.

The Convener: The finance of what?

Sue Webber: I was just seeking the panel's thoughts on the consultation.

The Convener: Which consultation? For the national care service?

Sue Webber: Yes.

The Convener: Okay. Does anyone—

Sue Webber: If you do not want me to ask the question, I can—

The Convener: No, that is fine. I thought that it would be more of a general point. If anyone wants to come in on that, please let me know.

Sue Webber: I asked Leigh Johnston to respond, although I do not know whether she wants to.

The Convener: Leigh, did you want to come back on that question? I know that it is not really what we were going to discuss—in fact, it is more a question for the previous panel—but if you want to respond, that is fine.

Leigh Johnston: I think that I have been unmuted anyway.

Obviously, I have to be careful with my comments at this stage, as we are drafting a response to the NCS consultation. As you know, we have said that changes are needed in the provision of social care in Scotland, but the solutions are far from simple. The new models of care that are required will cost more money, and it is not clear how they will be funded.

I will make no comment on the governance arrangements at this stage.

Professor Bell: I suppose that I am less constrained than Leigh Johnston. In the previous session, Derek Feeley made a very good case for the national care service, but I worry a little bit about what that leaves for local government. It has already lost the police and fire services, and its functions will be further depleted with the establishment of the national care service.

There is an issue with attracting people—professionals and elected members—into local government. As functions are drawn away, the attractiveness of that route seems to be declining. That needs some further investigation. We are a relatively centralised country, and further centralisation always seems like an issue that ought to be considered very carefully, on democratic grounds.

The Convener: I invite Sue Webber to come back in on the financial sustainability of NHS boards. It would be helpful if we could focus on that theme.

Sue Webber: I will bring that back in. We have spoken about centralisation, but Scotland is very diverse. In trying to identify how we might want to change how NHS boards are allocated their money, we find that one of the current issues with integration is that the money goes from the acute service to primary care and the social sector. What other models are you considering? What might be considered as best practice, looking across other areas?

The Convener: Who would you like to direct that to first?

Sue Webber: Let us ask the King's Fund. I am sorry—my lenses have gone, and I cannot see anyone's faces.

Siva Anandaciva: I am really sorry, but I lost the second half of the question. I got as far as allocation to acute services getting devolved to primary care. Could I get the second half of the question, please?

Sue Webber: What other funding models might be appropriate for a national care service?

Siva Anandaciva: Great—thanks for that.

I say this with the caveat that I have never seen one model that is demonstrably better than another. In this country, we are broadly considering three different models. One is a contractual model that binds together health and care organisations broadly for the totality of their services. If we take a patch such as Greater Manchester, the contract might basically say that all the organisations must work together to improve the health and wellbeing of the population of Manchester. There is a single, lump-sum allocation, and the people in the local system must decide how they want to divvy up that allocation to best meet that goal of improving the health and wellbeing of the population.

The second model that we are considering is more structural. It merges organisations, so that a single budget is used. That is not a contract binding different parts of the system together—they are now one organisation. In parts of Birmingham, primary care services are working as part of the acute hospital, together with community services—an integrated provider, basically.

The third model is much more disease specific or patient cohort specific. For example, there was a contract for cancer services in Staffordshire where, rather than binding everything together, people came together to plan how they would improve the health and wellbeing and, essentially, the mortality and morbidity of patients with cancer.

I have seen no evidence that one of those models is better than another. I would give two reasons for that. First, we can do whatever we want, but if we do not have the wider conditions for success, which are enough staff, long-term planning and clarity in the strategic direction of travel, the contract cannot overcome all those issues.

The second element is much less technical and is purely down to leadership. When parts of Tameside and Glossop came together, across the local council and the NHS, to tackle rough sleeping, the contract and the structure came years after leaders came together to acknowledge that their model was broken. People who were sleeping rough were ending up in hospital because services such as bed and breakfast provision were being cut. What if we were to say that there is one Manchester pound, the best way to invest it is to have those preventative services, and the contract can be sorted out afterwards? It was culture before form.

It is worth considering a menu of options, but recognising that that can get you only so far.

The Convener: The system that is used in Scotland at the moment is the NHS Scotland resource allocation committee—NRAC—formula. Would any of our panellists like to highlight some of the issues with that? This is the crux of the matter. That is the formula that is being used right now, but what else is out there that might address some of the concerns that have been expressed about the formula?

Professor Bell: The allocation to health boards is driven by the kind of formula that drives allocations to local government. The formulas are based on estimates of need, which are principally driven by population size, but also by demographic structure, levels of deprivation and so on. I have had a lot of experience with those kinds of formulae and whether they can be fine-tuned to improve their performance.

Clearly, there are areas that feel that they are hard done by; for example, there was a long period in which NHS Grampian felt that it was getting insufficient money, given the issues that it faced. Part of the problem is that a lot of this is hidden and people do not understand how the determinations are made. Bringing it into the general public discourse so that there is some understanding would be useful, but I would hesitate to say that I have a better formula that will result in a reduction in Scotland's health inequalities in the near future. It is a wider problem than that, and it goes back to our earlier discussion about social and economic circumstances that will not be resolved simply by allocations to health boards.

The Convener: I will bring Siva back in.

Siva Anandaciva: I agree with Professor Bell, and I would like to provide a shorter but better answer to the question than I did before. We use a very similar resource-allocation formula in England, which is broadly weighted capitation. You can tweak the parameters and inputs to change how much weighting is given to deprivation. I have not seen a fundamentally better way of allocating healthcare resources than weighted capitation of the usual components of deprivation and age.

If you want to fundamentally change things, there is as much to be done by changing how money is used once it has been allocated to a health board, as changing how money is centrifugally flung across the country.

The Convener: David Walsh wants to come in.

David Walsh: To follow briefly on what David Bell said, I agree about the complexity of how these things are measured. The formulas try to take deprivation into account, but it is not measured terribly well in some respects. Also, with regard to the impacts of austerity over the past 10 years, we are not capturing some of those additional levels of poverty. That interacts with some currently pertinent issues, such as the very high rate of drug deaths in areas, such as Dundee, that have measured levels of deprivation similar to other places that do not have those issues.

I am not suggesting that I know a better formula—as has been hinted, it is very complicated—but I think that there are potential tweaks around understanding aspects of deprivation that the current formula might not be picking up.

The Convener: I certainly hear that point in regard to rural poverty in my area. Sandesh Gulhane has questions about financial sustainability.

Sandesh Gulhane: I want to ask about the way that the money is used. My understanding is that a board gets its money through its funding, which is then divided into allocations. I always hear clinicians saying that they are not able to use that money, so who is the determiner of how that money is spent? Is it clinicians, or is it managers? Who do you feel it should be?

The Convener: Who would you like to direct that question to?

Sandesh Gulhane: Can we start with David, please?

12:15

The Convener: David Bell or David Walsh?

Sandesh Gulhane: I am sorry—David Walsh.

David Walsh: I think that the correct answer was David Bell, because I do not do any research on funding for NHS boards. The other David might be a better bet for that question.

Professor Bell: It is not my first-choice subject, either. Clearly, there has to be clinical input to the decisions that are made by health boards, but there also has to be an overall strategic view. Decisions have to reflect the challenges that an area faces. It is not always the case that clinicians have the strategic picture of what is happening, so views need to be brought together before decisions are made. Clearly, clinicians have to be involved, but it is not clear to me that the process should be clinician driven.

The Convener: Stephanie Callaghan has some questions on the integration of health and social care.

Stephanie Callaghan: I will direct my questions to Leigh Johnston and Siva Anandaciva, but they can correct me and suggest that someone else answers.

I am an elected councillor in South Lanarkshire. Leigh Johnston spoke about the systems management approach. IJBs and health and social care partnership directors have quite a difficult role in working with chief executives in health and with local councils. Pre-Covid, there was some success in freeing up hospital beds through preventative care, upskilling staff, preventing admissions, discharging people from hospital more quickly and shifting funding into care and treatments that are delivered in patients' homes. With the NCS's much bigger scope, how will we achieve a bigger shift from hospital to community care? How should the funding work? How do we get the right culture and ethos in place for that shift to happen?

Leigh Johnston: I recognise what you have said. As you know, South Lanarkshire was one of the case studies in our integration report, with the moving of money and freeing up of hospital beds.

I can refer only to our previous report on integration. It is important that we learn the lessons from the difficulties in health and social care integration. The collaboration and agreement that will be needed for the reforms have been difficult to achieve elsewhere. Again, I go back to the six key areas that we identified, which are still very relevant to the proposed reforms. There must be collaborative leadership, and people should be encouraged to think about outcomes for their community rather than what a single organisation is trying to achieve. There should be good longer-term financial planning, which we have talked about, so that the required disinvestment and reinvestment can be planned and that resources can be shifted from acute hospitals into the community. There should be effective strategic planning, so that priorities are linked to resources and people are clear about the outcomes that they are trying to achieve.

Another area that we identified related to agreed governance, particularly clinical governance, and accountability. We should be clear about where decisions lie and when someone is no longer responsible for something.

The issues around data are still key, too. How can we share data appropriately across the system to ensure that people do not have to repeat their stories? Of course, the other issue is the lack of data to allow us to understand what is going on in community care, social care and primary care. That makes it difficult to understand activity and to plan for what needs to change and the outcomes that you are trying to achieve.

The other issue, which we have already talked about, is the need for on-going, meaningful and sustained engagement with the community, the public and the service users. We need to take them along with us as we reshape services, because that requires culture change in the public as well as in staff.

Siva Anandaciva: I will make four very quick points.

First, as Leigh Johnston has said, you need to be absolutely crystal clear with regard to accountability. Are you as a board jointly accountable for the entire pathway? If not, the default will be that, once a patient has been deemed medically fit for discharge and has left the organisation, the clinician's accountability ends.

Secondly, there is a strong argument for building outwards from particular services or opportunities where there is better evidence that joint working works. Examples would include safe discharge into a new setting, end-of-life care and rough sleeping. I have seen too many instances of health and care organisations coming together either to boil the ocean or to focus on things that are an NHS-specific issue. I vividly remember a councillor saying, "Why am I sitting in three-hour meetings talking about a joint venture on pathology? It has nothing to do with me. If we were talking about end-of-life care, I could absolutely see why we would all need to be in the room."

Thirdly—[*Inaudible.*]—been doing any big strategic change programme. They include making sure that you spend time together. There is a group of chief executives in the south-west of England who carve out some time every Friday afternoon to come together to understand each other's—[*Inaudible.*] All we need is to trust each other. We do not need to get along with or even like each other, but we do need to trust and understand each other.

Some quite tactical tasks have been set for organisations. For example, everyone in a health and care board might be told, "Right—go away and by the next meeting make one decision that is to the detriment of your organisation but benefits the system." Moreover, what I have seen time and again is that people who train and learn together work better together, so I suggest that there are opportunities for joint training and working.

My fourth and final point is almost a reality check. Almost every piece of evidence that I have seen has made it quite clear that integrated care can deliver better value and a better-value outcome for the inputs into the health and care system, but the evidence that it saves money is very ropey. If the task that we are setting people is to improve value, that is great, but if it is about taking loads of cash out of the system, that creates the wrong dynamic and tension and just sets people up to fail.

The Convener: We have come to the end of our time. I thank both panels of witnesses for spending this time with us. Your evidence will be valuable as we think about our work programme and financial scrutiny of the upcoming budget.

At our next meeting, on 5 October, the committee will consider a legislative consent memorandum and discuss its future work programme. That concludes the public part of the meeting.

12:24

Meeting continued in private until 12:40.

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