OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 25 October 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 25 October 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

29th Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

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

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Professor Sir Harry Burns (University of Strathclyde)
Dr Irena Connon
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Professor Jon Glasby (University of Birmingham)
Professor Catherine Hennessy (University of Stirling)
Nick Kempe (Common Weal)
Professor Catherine Needham (University of Birmingham)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 25 October 2022

[The Convener opened the meeting at 09:05]

National Care Service (Scotland) Bill: Stage 1

The Convener (Gillian Martin): I welcome everyone to the 29th meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from Emma Harper. Our colleague James Dornan, who is joining us online, is substituting for her.

Agenda item 1 is a presentation from Dr Irena Connon, who undertook commissioned research on international models of social care for the committee's consideration ahead of our scrutiny of the National Care Service (Scotland) Bill. I invite Dr Connon to give a presentation of no more than 20 minutes, after which we will ask her questions.

Dr Irena Connon: Thank you. I am going to talk to the committee about my rapid review that compared international models of social care. The aims of the presentation are to provide an overview of the rapid literature review that I conducted and, in particular, to outline its key findings, the main features of the different models, key similarities and differences between each of the models, and some important considerations in thinking about the transferability of models. I also want to have a look at evidence-informed recommendations for decision makers.

The purpose of the literature review of international models of social care was to provide a descriptive and comparative overview of the literature available and the types of evidence. The review was structured around six particular research questions: how social care is structured, delivered, funded and governed; the benefits and limitations of each model; the impacts on population health outcomes and healthcare delivery, which are also important; the enablers of and barriers to the effective implementation and delivery of each model, especially around integration reforms, in other countries; the enablers of and barriers to the long-term sustainability—especially the financial sustainability—of each model; and the points that we need to consider in thinking about the transferability of the models, particularly to Scotland. Our questions were answered for each of the countries or groups of countries, which were Australia, New Zealand, Japan, the United States and Alaska, Switzerland, Canada, the Nordic countries, the European Union countries—Germany, the Netherlands and France were particularly focused on—and all four of the United Kingdom countries.

The review combined systematic, narrative and Delphi method techniques to review the existing literature, which was both academic literature and the grey literature. The data collection process looked at the available interdisciplinary materials, so it covered a broad range of materials, and the findings were verified via the project advisory group. The final sample consisted of 166 articles and documents, which were coded for, and subjected to, detailed scrutiny.

On the findings, which are the key things, we looked at how social care is funded, structured and governed in the different countries. As members can see from the slides, there is a sample of some countries. The key details are available in the summary sheet that was given to members. We can see the key similarities in delivery in the mix of public and private providers in Australia and Canada, but we can also see the differences in funding. We can see that, compared with Switzerland, Japan and the EU placed high levels of expectation on informal care, and we can see some similarities between the German system and the Japanese system, both of which are funded through compulsory social insurance schemes, but we can also see also how they diverge in their delivery.

The Nordic and New Zealand systems are quite similar to the system in the UK in some ways, but they are very different in other ways—particularly with regard to the extent of integration in the New Zealand system and the amount of provision by for-profit providers that we have in comparison to the Nordic countries, although that level of provision has been increasing in recent decades.

I draw members' attention to the slide that shows the key differences in funding and key aspects of governance and delivery. A number of countries fund care through central taxation or, in the case of EU countries, through centrally organised compulsory insurance schemes. The Alaskan model is very different and is funded through Alaska's own version of Medicare. In France, the social insurance scheme is funded via taxation, both centrally and regionally. Japan's insurance scheme is funded regionally. Canada is a particularly interesting example because the arrangement is made on a provincial basis, with powers transferred to the provinces via federal and central legislation.

There are key differences in the locus of control. In Australia, care is under federal control, but the division of federal and state responsibility is not particularly clear, which has caused problems. In Switzerland, although care is funded centrally, municipalities have control over governance. In the Nordic countries, control is largely central, although districts have the power to make arrangements. That control is supported by strong national legislation concerning eligibility and the quality of care, which places limits on those powers. That is similar to the situation in New Zealand, where regional authorities have control but within national legislative limits.

There is a broad range of eligibility, from very strict conditions to broader coverage. That is connected to the final column of the slide, which deals with expectations about informal care being used to plug gaps. In Australia, eligibility is determined by needs, on a means-tested basis, and the expectation of informal care is low. In Japan, the criteria are very strict: the coverage for those who do qualify is broad, but it is meant to plug gaps in informal care provision.

In EU countries, the provision of care is based on eligibility, but the criteria have become far stricter in recent years, particularly in the Netherlands. In those countries, there is still a high level of expectation of informal care. In Germany, in the past, there was legislation that ensured that family members contributed to the cost of care for their relatives. People without children paid higher premiums, which was very controversial and contentious. In Alaska and the US, care is means tested but the level of service provision is very low, so families end up plugging the gaps regardless of the kind of cultural expectations to do so that are felt in countries such as Japan.

The final column on this slide deals with the integration of social care and healthcare, which is important as it affects provision. In Australia, the two are separate. In the US and Alaska, social care is not covered by Medicare unless it is part of residential healthcare services or rehabilitation services. In that system, much of what would be part of age or social care here, in Scotland, such as general assistance in the home, is not provided. In Canada, social care is part of extended healthcare and provision is broader than in the US or Alaska, although the majority of care for older people is still provided in residential settings; home care coverage is substantially poorer. In Switzerland, social care and healthcare are linked in terms of service provision, but they are not integrated as they are in New Zealand and in Northern Ireland. In the other UK countries, there has been a move towards greater integration.

We also looked at the strengths and weaknesses of the different models. In the Australian system, the opening of care provision to private providers has led to much concern about increasing inequality, and the lack of integration impacts the delivery of care for those with complex needs. However, as I said, there is a reduced need for informal care. In the US, the key problem—it overarches all the other issues—is the inequality in access to age care and the exacerbation of social, economic and racial inequalities in healthcare. Alaska is different from the other states in that the models that have been provided for indigenous people are aimed at ageing in place, with a lot less emphasis on the use of residential care.

There is the potential to reduce inequalities in outcomes because these models are built on a diversity of world views with different conceptualisations of health and wellbeing. They have moved beyond simply recognising cultural diversity towards building a system that is based on it. However, the system is also primarily health focused, so the amount of social care provision remains limited.

09:15

In Canada, the majority of social care is provided in residential institutions, and there are big differences in provincial arrangements, which can create inequalities in access between provinces. However, some of the strict regulations in Canada on the licensing of care homes helps private, for-profit providers to meet care delivery standards.

In Japan, the system is very much based on a paternalistic medical model. The high levels of informal care are particularly concerning as a gender equality issue, with women being the ones who carry out the majority of care. However, access to care is standardised and coverage is good if you qualify.

In the EU countries, the system provides for a basic level of care only, with the rest expected to be covered by informal provision. Another downside is that single-sourced insurance schemes can be vulnerable to macroeconomic fluctuations. However, contribution-based systems have been said to be associated with a reduced need for political bargaining, whereas, in Canada, some of the short political cycles have been said to limit the effectiveness of reforms.

The system in Switzerland ranks very well internationally, but the fragmentation of governance and delivery between the federal, municipal and local authorities in terms of delivering governance has been associated with an increased risk of suboptimal quality of care.

The Nordic countries, which are often considered examples of best practice by international standards, provide universal coverage, supported by national-level legislation that ensures equality in the level of care that is provided and in the quality of services. A lot of the literature discusses how marketisation has challenged the principle of universalism, because there is an introduction of payment for add-on or top-up services.

In the New Zealand model, integration helps to meet the care needs of those with particularly complex needs. There is an emphasis on overall wellbeing, and it is well integrated. A lot of it is focused on addressing existing health and social inequalities.

In Scotland, increasing integration has the potential to create a more holistic approach to care provision. However, the cons of what has been happening with integration include the issue that health can emerge as the dominant partner. Public expectation for social care provision is high, and eligibility in Scotland is relatively high, whereas in Northern Ireland, where there has been an integrated system for decades, there have been quite a few issues due to the multiple layers of decision making and unclear lines of accountability. Also, care user choices can be limited.

England has a slightly greater reliance than Scotland has on for-profit care providers, but the key challenge for integration in England is the lack of a statutory basis for it. Satisfaction with social care in England has also been decreasing in recent years. In Wales, the biggest concerns are over accessibility, care quality and co-ordination. However, it has been found that pooled budgets help to facilitate data sharing and commissioning.

The third research question was about the impact of each system on population health outcomes. The answers to that question need to be considered when thinking about the pros and cons of each model.

We can draw the conclusion that poor integration between health and social care can negatively impact those with complex needs, as it does in Australia. That is especially clear when we compare it to the situation in Japan, for example, where the system is positive because, although eligibility is limited, it covers a large range of services for those with the most complex disabilities and needs.

Limited coverage in the US is very much linked to widening social, economic and racial health inequalities. In Alaska, there is a bit more provision for care services for indigenous people, which is associated with greater preventative health outcomes as well as better treatment for chronic disease and lower hospital admission rates.

In Canada, differences in provincial arrangements result in national-level inequalities in access to care and in health outcomes.

In all countries, the marketisation of social care has been linked to growing inequalities in health outcomes. However, the impacts can be somewhat mitigated by national-level legislation on the quality of care and the amount that providers can charge, as is the case in the Nordic countries and, to an extent, in Switzerland.

Integrated care provision is associated with better overall quality-of-life outcomes, which affect health outcomes, and it is helpful for reducing pre-existing inequalities. In the UK, so far, there has been little evidence that attempts to increase integration have affected health outcomes, but the longer-term effects and impacts are not really known. It will take several decades before we start to see the impact of those attempts.

Let us have a little think before I detail the findings from the other questions. Underpinning questions about integrated care are questions about how health-related care relates to social care. I encourage you to consider how social care needs reflect healthcare needs and quality-of-life and broader wellbeing needs. Where is the demand now, and where will it be in the future? With that in mind, think about which models you might favour in an ideal world.

That may be limited by questions of funding and the ability to deliver, but we need to think about what should come under the rubric of social care. Should it be about extended healthcare needs, with wider wellbeing being part of something else, such as community, or should broader wellbeing come under social care? That is the fundamental question at the base of those models.

I will move on to the findings on the barriers to and enablers of the success of different models of integrated care. We looked at what the different countries said about successes and barriers. The New Zealand approach had a clear vision of one system and one budget helping to achieve positive outcomes.

In EU countries, in Alaska and the United States, and particularly in Canada, the amalgamation of the district health authorities into a single provincial health authority helped to improve outcomes. Another important lesson that we can take from this is that frameworks and standards can help to facilitate successful integration. In the Nordic countries, a key lesson is that marketisation can challenge equality of access but, if funded care services remain comprehensive enough that very few demands for top-up services are made, it will not impair the universality of provision.

I will now turn to challenges to the financial sustainability of the models. It is worth thinking about how likely it is that each model can be sustained. All are affected and challenged by an ageing population, which places rising demands on care. Although the Nordic model is the gold standard, it is coming under pressure on its ability to provide universal care in the future, owing to the ageing population.

Another challenge in Australia, Canada and the UK countries is the changing pattern of care needs, such as the move towards care at home, which you need to be able to fund and provide the workforce for. At the same time, in the US, where there is low state spending, the system is coming under pressure from increasing inequalities in health, with people requiring care at younger ages and often for more complex needs. So, in this case, reduced spending alone is unlikely to solve the problems.

All contribution-based systems that are funded through central taxation are affected by economic fluctuations, so they are not completely stable. The integrated system in New Zealand is dependent on increased spending on community care to sustain it and to avoid some of the problems that we have recently seen in Scotland, where health spending has emerged as more dominant.

Lastly, we looked at factors that we need to consider when we think about transferring a social care model to a different context. If something works, can we uplift it and implement it somewhere else? From the limited number of studies that explored transferring models to different contexts, we found that, in practice, that can be difficult.

The ability of a transfer to succeed financially is dependent on the wider economy, so timing is important, and there is a need to consider how the fundamental principles that underpin a country's model of care compare with those of a recipient country. The Nordic model is underpinned by a principle of universality that is widely accepted publicly; so, if we implemented the US system, which is founded on principles of freedom and responsibility, in the Nordic countries, it likely that the level of resistance would be high. The same would be true if we implemented the Nordic model in the US. Likewise, in Japan, there is still a strong cultural value of providing informal care. Therefore, it is likely that implementing the Japanese model in the Nordic countries or in Australia, where there is wider emphasis on supporting a dual-earner model, would result in a lot of resistance.

We therefore need to think about the core concepts and values that underpin a model and determine where they fit with the social and cultural values and expectations of the recipient country. We also found other factors to consider, such as the rate of population ageing in both countries. For example, the Japanese system is coming under pressure from an ageing population; however, we need to keep in mind the fact that the rise is much more rapid in other countries than it is in Scotland, so perhaps the model might be more likely to be sustained here.

Other factors include population geography and governance structures. Canada has a huge geographic area, with differences in population dynamics in each province. Although we might say that regional governance can add layers of complication, in an area as large and diverse as Canada, there is a strong case against a one-size-fits-all model.

We also need to think about population diversity. We can have a universal system, which works in some contexts; a system that recognises increasing diversity, such as in New Zealand, which is helpful for addressing existing inequalities; or a system like the Alaskan model for indigenous people, which is based on diversity in how we understand health and wellbeing.

What can we learn from the review? All systems face pressure due to population ageing. There is no single perfect model. Integration can help to deliver more holistic approaches to care, but strategies need to be put in place to ensure that social care does not end up in a subordinate position to that of primary healthcare. Increased for-profit provision can enhance inequalities, but that can be somewhat mitigated by higher-level national legislation and ensuring that the level of care services remains high enough that demands for extra services are low.

We also learn, particularly from many of the case studies in Canada, that delivering savings should not be adopted as an immediate objective of integration. Stricter demands for eligibility risk increasing reliance on informal care and widening inequalities in health and quality of life, not only for the care recipients but for the people who provide care.

From the findings, we came up with 10 recommendations for decision makers, which are available at the end of the report that the committee has. I will read a couple of those out to you:

> "Care services should be provided on a consistent basis across all geographic areas"

to avoid geographic inequalities in provision and outcomes.

> "A clear 'one system, one budget' approach"

can

> "reduce complexity",

and

> "Eligibility for access to social care services should remain high to prevent rising inequalities, unmet needs and increased dependency on informal care providers."

A lesson from Northern Ireland is that

> "A standardised definition of what 'personalisation' of care means"

would be helpful for the care user as well as for the people who are responsible for delivering care.

> "Mechanisms that address cultural differences between locally accountable social care services and centralised health services"

can

> "help improve integration",

but

> "Financial savings should not be viewed an immediate objective of integration"

and

> "Budgets intended to support integrated care should not be used to offset overspends in acute care."

When we think about the challenge of an ageing population, we must acknowledge that

> "Forward planning and significant investment are required to meet future care needs."

The ageing population poses a challenge to the sustainability of all the models that we examined.

09:30

The Convener: Thank you, Dr Connon. I will let you catch your breath for a moment.

You ended by making a point about the ageing population, which is a worldwide concern. Another concern that I imagine affects most countries, and which we are facing in Scotland, is how to attract people into the care sector. An objective of the bill is to make working in the care sector an attractive career, with parity of esteem with our health sector; indeed, that issue came up when you talked about New Zealand. Do you think that, because of what has been done there, New Zealand has less of a problem in attracting people into the care profession? Are there other models that you can point to where there have been good outcomes after reforms have been made?

Dr Connon: One example would be the Nordic model, particularly as it is used in Sweden; its standards for the accreditation of professionals and service delivery have attracted people into the profession. New Zealand, too, has such standards.

The wider literature focused on Japan, which has low wages for those involved in social care. There is an emotional labour aspect to that. Social care is often undervalued, because it is assumed that caring is something that people can do naturally, without particular training. That idea, which has prevailed for decades and still influences the lack of funding for social care, is increasingly being challenged in New Zealand, in Australia to some extent and in the Nordic countries, particularly in Sweden.

The Convener: Before I bring in my colleague, I want to ask a follow-up question. There is accreditation, but you also mentioned remuneration for people working in care. Has that also been addressed in the Nordic countries?

Dr Connon: Yes.

The Convener: Sandesh Gulhane has some questions on that theme.

Sandesh Gulhane (Glasgow) (Con): Thank you for the presentation on the work that you have done. I have one question, which is about your methodology. You excluded papers that were published in languages other than English, but that presents a problem. Japanese is the dominant language in Japan, French is the dominant language in France and German is the dominant language in Germany—we could keep going like that. How many papers—and how many for each language—were excluded on that basis? If you excluded so many papers, how can you say that your research on those particular countries is robust?

Dr Connon: First, the numbers are detailed in the report, but we did not end up excluding many papers that were not in English. We are talking about academic articles. Some journal articles are published in French, German or Japanese, but the majority of high-level, high-ranking international journals are in English. People who work in Japan and conduct high-level and high-quality research for publication in the highest-quality journals are publishing that work in English. It is the same in France.

In Canada, because of the requirement for some journals to be bilingual, a paper will often be published in English and French, so we were able to access it that way, too. The research that the researchers have conducted in France and Japan is contained in high-ranking international journals and has been verified and peer reviewed by international experts before being published.

Sandesh Gulhane: How many were excluded? I could not see that number.

Dr Connon: The report gives the exact number that were excluded—I cannot remember off the top of my head. It was not very many.

Paul O'Kane (West Scotland) (Lab): I want to ask about social work. I imagine that it is challenging to make a comparison, because the scope of the bill goes beyond the practical delivery of social care. Northern Ireland is perhaps a good example to look at, because social work there is delivered slightly differently via more of a health board model. Have you found any international examples of elements of social work, as a profession, being put into a national social care structure?

Dr Connon: Yes, we can see that in New Zealand, Japan, Australia—to a certain extent—and the Nordic countries.

Paul O’Kane: Do those arrangements involve criminal justice, children and young people’s services or learning disability services, for example, as well as just older people’s services?

Dr Connon: Absolutely. In New Zealand and Japan, that is particularly the case around disability services. Children’s services come into the arrangements, too, as do criminal justice addiction services and other rehabilitation services.

The Convener: I have a couple of questions on that point. You mentioned the countries where there is an expectation of and a reliance on family care. Do those countries give any kind of financial support to those carers, as we do with the carers allowance? Are those families expected to just get on with it, or is there a variation of the kind of support that is provided here?

Dr Connon: There is a variation. In the Japanese model, in particular, there is very much a reliance on informal care—that is the expectation—and social care is used to plug the gaps in that informal provision. That is the other way round from the way that things are here.

In the Netherlands, allowances are available for people providing informal care to help cover some of the costs. Again, though, that help is extremely limited. It is also means tested and is very much defined as a last resort. There are long-standing cultural expectations around informal care—that is what is behind the approach. Funding is available to support that informal care rather than to, as it were, develop it.

The Convener: I do not want to presume, but I would say that, in this country, that cultural expectation tends to fall on women. Is that the case in those other countries?

Dr Connon: Very much so, yes. It is very much related to the earner models. In the Nordic countries, Canada and Australia, particular emphasis is placed on the dual-earner model more broadly. However, the Netherlands, even now, is still dominated by the breadwinner model in terms of how the cultural norms are embedded in the system. In short, it is very much the case that, in all countries where informal care is provided, the responsibility falls on women.

The Convener: And that has a knock-on effect on other measures of a wellbeing society, such as the gender pay gap.

Dr Connon: Yes. It is linked to the gender pay gap, a lack of opportunities for women to progress, increasing levels of stress among those who provide informal care and poorer quality-of-life outcomes. That is especially the case in Japan. Because people are living longer, people of working age are having to provide care for two generations—their parents and their grandparents.

The Convener: I call James Dornan, who is joining us online.

James Dornan (Glasgow Cathcart) (SNP): Thank you very much for the very helpful presentation, Dr Connon. I want to ask about eligibility. You seem to suggest that there is a balancing act here: either we make the eligibility criteria higher and give a better service or we lower them and have a lower than optimum service that extends to more people. What are your thoughts on that? Where do you see the balance being struck?

Dr Connon: There is a balance to be struck. There are a lot of lessons to be learned from the Netherlands and Japan, where they set particular standards for qualifying eligibility. Because demand was a lot higher than anticipated, they had to increase the criteria for access to care. That was very much the case in the Netherlands, where increasing the criteria led to long waiting lists as well as gaps in care provision. Similarly, in Japan, demand was higher than expected and they upped the criteria.

It is a balancing act. The difficulty with funding only a basic level of care through the system and some people then paying for additional top-up services is that such an approach has been associated with rising inequalities in wellbeing in relation to access to care and to increased health inequalities more broadly.

My recommendation is that the eligibility criteria be fairly broad, rather than too strict, so that many people can qualify and lots of services can be provided. That would reduce the reliance on informal care and ensure that there are as few inequalities in accessing care as possible.

James Dornan: That was a good answer, but I still think that such a balance will be quite difficult to achieve in practice.

Dr Connon: Absolutely.

James Dornan: I have one more question. Under the heading “Findings 3”, you say, pretty clearly:

> “Increasing integration has had a relatively limited effect on reducing existing health inequalities to date.”

Is that because there are different systems across the UK, with different amounts of funding—or lack of funding—going into them, or is it because the new system has not been running long enough, as is the case in Scotland?

Dr Connon: It is a combination. As far as Scotland is concerned, the system has not been running for long enough; it will take about 15 years to a couple of decades to see the generational impact of its effectiveness.

In addition, if we compare satisfaction with some of the outcomes in Scotland and England, we find that the lack of funding for social care is a problem. There have been teething problems so far, with health emerging as the more dominant partner, and that needs to be addressed before the system can reduce many of the inequalities. There are underlying health inequalities in Scotland, but an integrated system has the potential to reduce them—if we get it right.

James Dornan: Can I ask just one more—small—question, convener?

The Convener: Yes.

James Dornan: It is about informal care expectations. How did you figure out the low, high and mixed levels of expectation? When you say that the expectation is low in the UK countries, I take that to mean that there is not an expectation that your family will look after you, but we all know of cases of families looking after people.

09:45

Dr Connon: Yes, we all know of cases—and I am sure that they will include many people here. Many people will be providing care for older people. However, the system is set up in such a way that anyone who needs care should be able to access it. It is based primarily on need, not on who you know or who you have supporting you, whereas in Japan or in the Netherlands, they will ask "Who provides care? Who do you know? Who are your family?" and that will be included in your care needs assessment. The expectation is that, although informal care might be provided, people who need the care will be able to access the services.

James Dornan: Thanks very much for that.

The Convener: I call Sandesh Gulhane, who has a quick question, and I see that Tess White, who is online, wants to come in, too.

Sandesh Gulhane: Towards the end of your concluding remarks, you said that there was a strong argument against having a one-size-fits-all model in Canada, due to geographical variation. I feel that Scotland, too, has significant geographical variation. How does your comment about Canada fit with recommendation 1, which is on care services being provided on a consistent basis, and recommendation 3, which is on taking

"A clear 'one system, one budget' approach"?

Dr Connon: Canada is spread over such a large geographical land mass and there are various differences with regard to transport and accessibility between the provinces, the territories and the north. It contains a big mix, with very remote rural areas at large distances from high-density urban areas, and there is also a large indigenous population with a lot of health inequalities. That is the argument against having a one-size-fits-all model. The evidence in Canada, where the different provinces have had various projects to integrate health and social care more, is that amalgamating at the local level within the provinces has worked. In other words, centralisation has worked within but not across the different provinces, because the needs are very diverse.

We have been talking about geographical diversity in Canada; Scotland, too, has high geographical diversity but in a smaller space. It, too, has a particular mix of the remote areas of the Highlands and Islands and high-density urban areas, so we would need to consider whether a one-size-fits-all model would work here.

In New Zealand, it is all about having a clear "one system, one budget" model. It is very much about funding and delivery being controlled and tied together more centrally, while at the same time tailoring approaches to particular places—something that Wales has been looking at, too—to ensure that people have equal access to care, particularly in the remote areas where there can be difficulties in finding the workforce to provide it. Instead of having different budgets or different ways of governing—in Switzerland, for example, there are three levels of governance in different provinces, which creates problems—it is about tying together the governance mechanisms and centralising things while still allowing enough flexibility to be able to provide for geographical differences and population diversity within a region.

Tess White (North East Scotland) (Con): Dr Connon, you have done an excellent piece of work on what is a very complex issue. I have a question about funding models. I think that you said that, in Japan, healthcare was differentiated from social care. In the Japanese model, or in other models, are salary deductions made from a certain age for healthcare and, separately, for social care? Does that happen just in Japan or are there any other countries—say, Singapore—where it happens?

Dr Connon: In Japan, deductions for the social insurance scheme are separate from deductions for the health insurance scheme, and the same applies in the Netherlands and in Germany. Those schemes are funded through contributions from a certain age. In Japan, one level of contributions is made when a person reaches a certain age, but there is also a lower level of contributions that starts at an earlier age. It was proposed at one point to lower the age again, but there was resistance to that. In the same countries, contributions to the social insurance schemes are compulsory, but they are separate from contributions to the health insurance schemes.

Tess White: Are Japan, Germany and the Netherlands the main models in that regard?

Dr Connon: Japan and the Netherlands are the two big models. Germany is a model to an extent, but if you are looking for clarity on how the schemes are funded and what the barriers are, I suggest that you look at the Netherlands and Japan.

Tess White: In those models, what are the percentage differentials for contributions to the schemes? Are salary deductions for social care 50 per cent of the deductions for healthcare, or is it difficult to say? Are the deductions on a par?

Dr Connon: It is difficult to say. To begin with, they were very unequal. In Japan, salary deductions for social care are now slightly lower than the deductions for health, but they have been standardised.

The Convener: Two members have put in late bids for questions, but I can only allow two more, as we are running out of time. I call Carol Mochan and then Stephanie Callaghan, and then we will need to wrap things up.

Carol Mochan (South Scotland) (Lab): Thanks so much for your time, Dr Connon. I am interested in two things. They are big things, but perhaps you can comment on them quickly.

The first thing is about reporting on the quality of care that individuals and families get and the second is about the staff who provide that care. Perhaps I can link those two things together by highlighting my interest in local accountability. With healthcare, we often say that the closer the decisions are made to the person, the better the outcomes will be. I wonder whether there is any sense of that in any of the models that you have discussed.

Dr Connon: Do you mean that the closer to—

Carol Mochan: I am interested in the local accountability that exists in the models, given the ways in which the services have been set up and are managed.

Dr Connon: In Northern Ireland, they have had the idea of personalisation in care, but a lot of people do not really know what it means. Older people who rely on care have been more reluctant to engage with things that are new, and that applies to terminology, too.

In the Nordic countries and the Netherlands, standards of care have increased and there are frameworks for accountability for carers. The same is true of Canada. That approach has been associated with more positive outcomes, although there is a particular challenge, which has been reported heavily in the Australian literature, of high levels of staff turnover, particularly due to low wages. That has had an impact on the quality of life of the people who receive the care.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): We are very focused on wellbeing, but it seems from the data that all the countries have struggled to measure success in that regard. Does anywhere stand out as having done good work on that? Is there any work that we should be looking at and incorporating into what we are doing?

Dr Connon: Are you asking about wellbeing in particular?

Stephanie Callaghan: Yes.

Dr Connon: The New Zealand model is focused on wellbeing, and it has departed from the approach of having healthcare on one hand and social care on the other. There are also the Alaskan models; they are all about improving care for indigenous people, but they are founded on indigenous world views and their ideas about health and wellbeing. Therefore, they are more focused on wellbeing, without the separation that we have between physical and mental health. It is very much the opposite in Japan, where a very medical model of healthcare dominates the social care eligibility criteria.

The Convener: I thank Dr Connon for the power of work that she has put into the report and for spending so much time with us this morning to answer our questions. It was a very useful start to our scrutiny process.

We will take a 10-minute break to allow for a change of witnesses.

09:55

Meeting suspended.

10:07

On resuming—

The Convener: The second item on the agenda is our first evidence session on the National Care Service (Scotland) Bill. I will run through our witnesses, starting with those who are in the room.

We have Professor Sir Harry Burns, who is professor of practice and special adviser at the University of Strathclyde; and Nick Kempe, who is the convener of the Common Weal's care reform group. Online, we have Professor Jon Glasby, who is professor of health and social care at the University of Birmingham; Professor Catherine Hennessy, who is professor of ageing at the University of Stirling; and Professor Catherine Needham, who is professor of public policy and public management at the University of Birmingham and is involved in the Economic and Social Research Council's centre for care. Welcome, everyone.

I will go round all the witnesses to get their initial thoughts on the bill. First, I mention to colleagues that we will not have time for every witness to answer every question. Therefore, I ask that they do not follow my lead and that they direct their questions to individuals, otherwise we will quickly run out of time and we will not get through all our themes.

I will ask the key high-level question. Does this framework bill adequately meet the objectives of delivering potentially better health outcomes for people who receive care, and does it meet the needs of those who require assistance with the care of a family member?

I will go to Professor Hennessy first.

Professor Catherine Hennessy (University of Stirling): In its conception, I would say yes, it does. I very much underline what Dr Connon said, in her review of the evidence, about systems that provide an overarching integrative structure, lines of accountability and mechanisms for financial integration, quality assurance, performance review and service delivery.

What I think would strengthen the bill—although I am not about changing the language in it—would be to include somewhere an explicit statement of a life-course approach to health. I read the policy memorandum to the bill; it goes step by step through the various parts of the system that are going to be tied together and joined up, but we need a stronger sense of the fact that risks to health are accrued, and protections for health conferred, while on the life course. From in utero through to late old age, all those risks and protections are joined up. Such a statement would provide an underpinning rationale for what the bill proposes.

To answer your question, I note that the elements that Dr Connon emphasised—in essence, an overarching integrative structure accompanied by the ability to be flexible, and to tailor services and provision, at a local level—are definitely there in the bill.

Professor Catherine Needham (University of Birmingham): My understanding of the bill is that an improvement in health outcomes is not necessarily the measure of success by which we would know that it has worked. Health outcomes are, of course, part of what the bill is trying to achieve—the realisation of human rights, supporting people to thrive and ensuring that communities prosper—but that aspect is located within the much bigger wellbeing piece. The key question, therefore, is what the theory of change is here. Why would centralising accountability and creating new care boards achieve those goals around thriving and wellbeing?

Our four-nations comparative research, which looked across the four nations of the United Kingdom over the past 20 years, found that we have had a series of disappointing pieces of legislation that have not achieved their goals despite being strong, well supported and well grounded. They include the Social Care (Self-directed Support) (Scotland) Act 2013, the Social Services and Well-being (Wales) Act 2014 and the Care Act 2014 in England. We need to think about how we learn from what has not worked so well in the past with regard to the implementation of good legislation.

Around that, there are a few things to think about. We need to pay more attention to the policy mix and the interaction between different parts of the policy. For example, self-directed support may not sit well with integration, as the learning from Scotland has shown. We also need to think about what kind of message centralisation sends. There is a risk that it sends a message of low trust to the rest of the system, in the spirit of, "Well, I might as well do this myself because I cannot trust other parts of the system to get it right." That is problematic.

It is not about getting all the care packages in place but the culture change that is needed—who we need in the system and what kind of structures will build that culture change.

The Convener: I should clarify that I mean health and wellbeing. I missed out the word "wellbeing", but that is what was in my head. I am talking not only about health outcomes but the general wellbeing outcomes. I will bring in Professor Jon Glasby.

10:15

Professor Jon Glasby (University of Birmingham): I am looking in from a different health and social care system. Our experience over time and our experience of the evidence is that, when there is a major national change or a major structural change, there is a risk that the structural change becomes an end in itself in the short term, rather than just a means to an end. It can detract attention from improving front-line services. It can increase the sense that there is a lack of role clarity, and it can harm morale locally. In our experience, if you manage it well, it can take 18 months to two years after the change to get back to roughly where you were before. Therefore, in planning for the long term, we need to recognise that some things might get worse rather than better in the short term, as the changes come through.

As Catherine Needham said, we need to be clear about the outcomes that we are trying to achieve and clear about the fact that that way of designing and reforming is the best way to deliver those kinds of outcomes. We also need to be clear about the fact that the period during which things get worse before—we hope—they get better is worth it for the outcomes that you are striving to achieve.

The second thing that we often see around health and social care integration is that it is very easy for a more medical and acute-led model to dominate social care and wellbeing priorities. The way that you run specialist health services is potentially very different from the kind of care and support that people might need in their homes and in the community to lead their chosen lifestyles. Trying to do both at the same time with equal focus on health and social care has proved to be difficult. It is not impossible, but medical and acute needs often dominate in a crisis.

Thirdly, there is quite a famous article on the five laws of integration, one of which is that your integration is my fragmentation. Whenever we change our boundaries, we inevitably create new boundaries elsewhere, so there is always something that you gain and something that you potentially have to work harder at to maintain. As I understand it, just to give an example, there are still some unanswered questions that are being worked through with regard to children's and adult's safeguarding and the relationship more generally with children's services as well as the relationship with justice services. A set of organisational changes that, on paper, should make some relationships easier, could make other relationships harder, so there are pros and cons to weigh up in the design process.

The Convener: I will come to our colleagues in the room. Professor Sir Harry Burns is first.

Professor Sir Harry Burns (University of Strathclyde): I would like to emphasise some of the points that have just been made. Earlier, there was discussion of wellbeing and so on. Since I gave up being a surgeon many years ago, I have focused on how we create wellbeing in our society. Operating on people in the east end of Glasgow made me very aware that what they needed was not more surgery but more wellbeing.

What worries me about the bill—it is what worries me about any bill that affects the health service and so on—is that it will be a very top-down process, with targets and indicators and all of that kind of thing to go along with it. There is no question that the way to get effective change is to ask front-line staff what is needed and to give them the capacity to make things happen. On that question of people's wellbeing, I have looked at lots and lots of projects all over the world—not necessarily on social care but on improving wellbeing—and the critical factor is to not tell people what they need to do but to ask them what matters to them and then to help them to achieve that. In that way, people feel empowered and they begin to make changes in other aspects of their lives. Therefore, a critical part of the process is engagement with the individual who is in social care.

I feel strongly about the social care of young people. Children have been taken into care because they have had very bad experiences, and we know that those bad experiences will have profound effects on them throughout their lives and that many of them will end up in jail or in hospital, for example.

Recently, a colleague in Wales published a paper that included his calculation of the cost of adverse childhood experiences in 28 countries. He did not include Scotland in that, but by using his method we can see that adverse childhood experiences in Scotland cost the Scottish economy £5.4 billion a year, as children who experience chaotic upbringings end up in care and often in jail. They do not do well at school—indeed, they often do not attend school—they do not get jobs, and they never pay taxes. If we add all that together, we see that that is a huge burden on the Scottish economy.

We need to think about care not as a system that we impose on the population. I accept that we will need to have some of kind of regulatory framework for care, but we have to empower front-line staff to support the people whom they care for and ask them what they need, what matters to them and how they can be helped to make a change to their lives. On that theory of change, Scotland has already done that through the early years collaborative and the patient safety programme, for example. What do we want to change, by how much, by when, and by what method?

Another point that is very important to me is that the data has to be collected. The general data protection regulations get in the way of all sorts of important data being collected. I embarked on a project in which I asked community nurses which families they were caring for and were worried about. We then asked the local accident and emergency department whether it recognised any of the names. The answer was yes. We also asked local community policemen, who recognised all of them. We asked the national health service how often it treated those people, and it said, “Oh, no—we can’t tell you that.” That gets in the way of identifying people who need care and support.

We should build into the approach a system of data collection that shows how well people are responding to the care that they get. That is really important and central to creating enhanced wellbeing across Scotland. However, things have to be done in a way that allows front-line staff to shape what is delivered rather than that being imposed from the top down.

I should stop there.

Nick Kempe (Common Weal): You asked a very general question. We set out a vision for a national care service in “Caring For All: A National Care Service for Scotland”—I hope that that has been sent to all MSPs. That partly came out of the Covid crisis. If you ask me whether the bill will solve all the deficiencies in the care system that were created by the—

The Convener: That is not what I asked.

Nick Kempe: I know.

The Convener: I appreciate that. I am not saying that the bill is a magic bullet, but does it potentially provide the framework—

Nick Kempe: I would say that it would not provide the framework for dealing with a similar crisis. On where we need to start and to pick up on what Sir Harry Burns said, there is no definition of care. There was no definition of it in the Feeley review. Care is integral to our lives. It is a reciprocal, relationship-based thing that underpins the whole of society. It runs from the smallest of things, such as the way in which we acknowledge or say hello each day, all the way to how children are brought up. Care is fundamental for us developing into adults. It is very important—it is what holds society together.

The other thing that happens with care is that it goes wrong. That can be on anything from tiny things—we all have our off days—through to situations in which parents who are under various pressures, which are influenced by social matters, cannot cope with their children, so those children are harmed and they suffer. It can range to a position where people just stop caring for each other at all and everyone starts to be out for themselves.

Care is therefore absolutely fundamental to what we do, which has great implications for the proposed national care service and the bill. Because care is integral to everyday life, it is not something that we can necessarily decide on from the top. I support what Sir Harry Burns has said about it needing to be focused and considered from the bottom up rather than from the top down. That is one of our comments on the bill.

A positive aspect of the bill, which we have not mentioned but which we are absolutely behind, is that it envisages there being central Government funding. When the 1945 Labour Government set up the welfare state, it was a failing that care was always left on one side and was discretionary in comparison with the health service, the needs of which were to come before resource. We need absolutely the same approach to be taken on care as is taken on health. The bill does provide the potential for that, but at the moment it lacks a mechanism for creating data on unmet need. In order that we can decide what finance is needed for a care service, a mechanism for measuring such need should be added.

The Convener: I will pass over to my colleague Tess White.

Tess White: My question is for Professor Kempe. It is about quality versus consistency, in the context of care. During the consultation, Aberdeen City Council said that although the bill might improve consistency in care services, it would not necessarily improve the quality of care. What are your thoughts on that?

Nick Kempe: I am sorry—I am not a professor. I think that I am the only person on the panel who is not.

The vital point is that quality of care depends on relationships between the staff—the social workers who are organising care and the care staff, who themselves need time to develop relationships with the people for whom they care.

The problem with the current system is resource. We have a lot of time-based and task-based commissioning in which, for example, home helps have to be in people’s houses at certain times and are really rushed. Staff in care homes also do not have time to care for people. All that leads to huge frustration; it does not lead to good relationships, which we say is the single thing that would make the greatest difference to the quality of care.

That comes back to my earlier point, which is that for that to happen we need to devolve decision making to the front line, where staff need to be able to negotiate relationships. As I have said, care can go wrong and relationships can be difficult. I am a social worker—when a social worker is working with a disturbed child, that relationship will be difficult. The child will not necessarily like them to begin with, so the social worker has to hang in there.

It is also difficult to work with a person with dementia who keeps repeating the same thing a hundred times. To have the patience to deal with that, to get through to the person and to form a relationship with them is extremely challenging, so we need to resource staff to do that.

Such challenges mean that we also need a comprehensive training programme for staff. It is shocking to me that, at the moment, a person can walk into a care job and be sent to work in the house of a client with challenging behaviour when they have had no training and no preparation, and have no understanding of the health problems that could be causing the client to act as they do.

The Convener: Thank you, Tess. Sandesh Gulhane wants to come in.

Sandesh Gulhane: My question is for Sir Harry Burns. You have spoken about data. One of the things that I am frustrated by is the lack of data. We need to find out what we have now, identify the change that we are going to make and what change we would then see in the data, and then robustly collect that data. I know that you said that you had stopped on that, but I would like to hear a bit more about it.

10:30

Professor Sir Harry Burns: I have spoken to people in all sorts of sectors. The social housing sector has data on windows that get broken, doors that get kicked in and so on. When I speak to education folk and ask them whether children from those homes attend school or whatever, they say that they cannot tell us that. The health service has data on how many young people from that home attend accident and emergency departments with drugs overdoses, alcohol issues or whatever.

If all the data that we hold in various silos was brought together, we could form a picture of families that are desperately in need of support—especially the children in those families, who are the problem of the future. We could do that, but it is very difficult. When I asked a group of educational psychologists whether they had data about which kids get excluded from school, they said that they collect the data. When I asked where it was, they said that they do not know and that they are not allowed to put it on a computer. It is probably in a cardboard box under someone’s desk—that kind of thing. That is dreadful.

If we could bring the data together, we could identify individuals who need support and, in particular, their children, and we could make a huge difference to outcomes. I spoke to a colleague in Wales who has done financial calculations; I suggested that we go back five years and look at the data as it was five years ago and then look at those families now. If things have changed, we should ask them what has changed and what made the situation better. Then, we should scale that up.

A couple of years ago, I was president of the British Medical Association. I hasten to add that that is not a political position; I was not allowed to be involved in BMA politics. However, the BMA allowed me to ask questions of doctors, so I asked primary care doctors across the UK what projects they had seen that transformed the wellbeing of families with whom they deal. I have collected a list of 30 or 40 projects; if we were to start testing some of them and follow the data, we would transform wellbeing and reduce demand on the care system.

My worry is that, if we do not do that we will create a care system, just as we have with the NHS, that talks about purchasers, providers and so on, and about targets and indicators. At the moment, the NHS is, because of targets, being run off its feet trying to catch up with the problems that are associated with Covid, waiting times and all that kind of stuff. Boards are petrified about failing on the targets. If we were able to change the way that front-line staff were able to deal with patients, we would get better outcomes. It is partly about empowering front-line staff by providing data that lets them see that what they are doing is making a positive difference in their communities, then scaling that up. We would transform our society.

James Dornan: I agree with everything that you have said. Data is the important issue here. We need to collate it so that we know what it is that we are facing and how we can improve on it. One of the things that we will be fighting against is what we saw with the named person legislation, which is that people are very unwilling for others to get the data that is required. How do we overcome that?

Professor Sir Harry Burns: I am not saying that we need the data just for the sake of having the data. We need it in order to help people—to identify the individuals who are in need of support. If we can implement the change in that very supportive fashion, people will see that their society is improving. There will be fewer social problems in their communities and young people will do better at school, and will leave school with qualifications, then get jobs and so on. All those things will make society better. We are looking at data not in order to blame folk, but to support them and give them better lives.

I vividly remember one man whose story made me decide to leave surgery and go into public health. He was in hospital for the third or fourth time with acute pancreatitis, which was caused by alcohol. I said to him, “If you keep on drinking, you’re gonna die.” His response was, “I know—I’m not stupid—but life is really rubbish and the only pleasure I’ve got is the booze, so I’m gonna keep on drinking.” I realised that it was morally unacceptable for me to let that man suffer like that; that should be the case for all of us. We need to identify and support such individuals.

James Dornan: I appreciate that, and I agree completely. However, that is what the named person legislation was meant to be about, but opposition to it was so great that we could not move forward. You are right—without that information, we cannot help people like the man you described.

Professor Sir Harry Burns: No matter where you are on the political spectrum, given that £5 billion a year could be saved, what’s not to like?

James Dornan: Thank you.

The Convener: I will bring in Professor Hennessy before we move on to talk about definitions of care.

Professor Hennessy: This relates to Sir Harry’s point about data. I want to give an example of the importance of collecting the right data in relation to the kind of outcomes that we want to achieve.

Back in the 1970s and 1980s in the United States, there was huge Government investment in alternative models of long-term care provision for older people. There were 30 federally funded and state-funded long-term-care demonstration experiments, the core 13 of which I reviewed. I looked at their aims and outcomes and, in particular, at what kind of data was collected on outcomes. All those experiments, some of which were national and therefore covered a huge number of states, and which, as I said, represented a huge investment of federal spending, had the primary aim of keeping frail older people out of residential care—nursing homes—and in the community with support services, typically under case management teams.

The evidence from across all those projects showed that such models of care provision cost as much as, or slightly more than, institutional nursing home care, but real benefits were shown in terms of increases in wellbeing and in health-related quality of life for the participants, and in family caregiver satisfaction. However, only some of those couple of dozen projects even measured the things through which they made the greatest impact.

Dr Connon’s point 9—about initially not being so fixated on financial savings—is real: benefits from the projects were also realised in other domains. We need to understand what outcomes we are going for and what data is relevant to them, and we must make sure that data collection is not governed by the law of the easily measurable.

The Convener: Thank you. We move on to definitions of care, the questions on which will be led by David Torrance. If other colleagues want to come in, they should let me know.

David Torrance (Kirkcaldy) (SNP): Good morning. A number of written submissions have raised issues on how care should be defined—for example, on where healthcare ends and social care begins. How would the panel members define social care and support?

Professor Sir Harry Burns: Ask people what they need and help them achieve that—whether that be in health, social care or whatever.

An example of a significant project took place in the south of England—in a community in Falmouth, in which all the men had lost their jobs when the naval dockyard closed. The place turned into a literal war zone, with fire bombing and gang fighting and so on. Two health visitors turned it around. After a very nasty incident, they put letters through 50 doors, inviting local residents to come to a meeting. Five people turned up. The health visitors asked what would make a difference. “The place looks a tip. Let’s tidy up the gardens and paint the houses.” They did that. Five years later, the place was completely transformed. For example, employment went up by something like 70 per cent, and health improved dramatically.

Health and social care are so interrelated that they cannot be defined separately. It is about what we can do for people that gives them a sense of self-esteem, self-worth and self-control. That is what is important.

The Convener: If any online panel members want to come in, they just have to type R in the chat box. There we go: Professor Needham wants to come in, I think. Maybe we should let people know that I see “Professor Catherine” on screen, but there are two Professor Catherines. If I mix up the two of you, I apologise—the surname is just not coming up.

Professor Needham: Thank you. It is important to remember the point in the Feeley report about social care being the means to an end, not an end in itself. There is a definition that the social movement Social Care Future uses, which I really like:

> “We all want to live in a place we call home with the people ... we love, in communities where we look out for one another, doing the things that matter”

to us. That is absolutely what it is about.

I agree with Sir Harry that the only way to know is to ask people and let them co-produce and design the supports that they want. Only some of that will be about health. A lot will be about people's housing, education, employment and their broader relationships. For me, it is about that much more expansive definition.

Professor Glasby: I was going to say exactly the same as Catherine Needham, using the Social Care Future definition. For me, the aim of a social care system is to ensure that frail and disabled people have the same choice and control over their lives as non-disabled people.

I run the UK centre for implementing evidence in adult social care—IMPACT. Our belief is that good care is not only about services but about having a life. That plays out in the ethos of care and support, but it also links to the question about data and about setting and monitoring outcomes.

10:45

A number of years ago, I was involved in evaluating a mental health collaborative programme in England in which mental health services came together, set a series of improvement targets and challenged and supported each other to try to deliver them. Shortly afterwards, I was rung up by someone from another nation—it was not Scotland—who said that they were thinking of doing something similar and asked whether we had any advice. The improvement target that they were thinking of setting was to increase the percentage of people who had a signed copy of their care plan from 20 per cent to 35 per cent and the person asked me whether that was a good target to set.

I remember saying a couple things. First of all, everybody should have a signed copy of their care plan since we introduced those reforms in the 1990s. Leaving that aside, if I had a choice between having a signed copy of my care plan and not having one, I would probably want one.

I get the point that having a signed copy of your care plan is indicative of a broader cultural change and set of relationships within services, but I also said that most of the people with mental health problems with whom I have spent time say that they want three things: to live somewhere of their choosing, to have a job that they enjoy and to have more friends than they currently have. I suggested that that nation run a nationwide collaborative programme and set as the three aspirations people living somewhere that they like, people liking their jobs and the number of friends that people say they have. There was dead silence at the end of the phone for what felt like an age before the person said, "Do you know what? I am not sure that nation X is quite ready for that yet."

There is something really important about not only the definition that we adopt but the outcomes that we try to support people to achieve. Those have to be self-directed if people are going to have the same choice and control over their lives as non-disabled people. The difficulty with some of the service structures that we create around that is that some of our other public services are not set up to try to deliver such aspirations for people's lives, so it becomes difficult to join services up culturally because of a lack of fit in desired outcomes.

Nick Kempe: I have said a little bit about the definition of care. There is a huge overlap with health, but different knowledge and practices are required for health and care. Health is more science based—it varies, but it is more science based—whereas understanding care and making it work is about relationships, so completely different practices are needed. In the middle, there are people such as general practitioners who end up doing a lot of what social workers should be doing if they were allowed to. They do the relationship-based work with people.

I am not trying to say that there are two totally different systems, but we need to recognise what people bring. Health professionals and care staff are expected to do different tasks and, therefore, require different training. It is important to see a distinction between care and health, whatever the overlap is.

Professor Sir Harry Burns: I do not disagree with what Nick Kempe said. However, although there is a science to health and wellbeing, simply telling someone who smokes that it is bad for them is no good if they do not feel in control of their life and do not feel that they want to be healthy. Does anyone really believe that putting calorie counts on menus in restaurants will make any change happen? If someone feels a sense of self-esteem and control, they will want to go out running in the morning and do all the things that we are suggesting anyway.

As a medical student and a practising clinician for 15 years, I never once heard the term salutogenesis. It was always pathogenesis—the causes of disease. Salus was the Roman goddess of wellbeing and safety. It was the Scandinavians that taught me about salutogenesis, and that is what we are talking about—it is about creating wellbeing, and when you create wellbeing, you reduce risk of ill health. It is important to know that there is a crossover here.

David Torrance: In the presentation that we heard earlier, one of the recommendations was that

> "A standardised definition of what 'personalisation' of care means should be developed."

How important is that? I will go to Professor Glasby first.

Professor Glasby: There is a risk that we develop some concepts and they become quite complicated. For me, personalisation and self-directed support are fundamentally simple. They are about people having choice and control over their care and support so that they have more choice and control over their lives. Personalisation and self-directed support are about trying to have decisions that matter to people made as close as possible to the person whom the decisions affect. Ideally, the decision will be made by the person themselves or, if it cannot be them for some reason, by a person who really knows and cares about them. In that sense, the approach is little more than sensible delegation, as the architect of the personalisation agenda in England, Simon Duffy, once described it.

We have quite a lot of complicated concepts but, for me, it is about independent living, choice and control. It is fair to say that, in some parts of England, where I live, we have sometimes paid lip service to those concepts but really allowed the old system to carry on in the way that it has always carried on, rather than more genuinely rebalancing the power imbalances and genuinely promoting choice and control.

As with integration, the means sometimes become an end in themselves. Therefore, if I have 400 direct payments in my council and you have 300 direct payments in yours, I would automatically be seen as doing much better than you, irrespective of whether either of us was actually doing anything to increase choice and control for disabled people in our local areas, and irrespective of the fact that, alongside direct payments, there are 101 other things that we could and should be doing to increase choice and control.

I worry that we are making the issue more complicated than it needs to be. Really, those terms are just words for people having choice and control over their lives, and their subsequent ability to lead their chosen lifestyles.

The Convener: We will move on to talk about a key theme that came up when we heard from Dr Connon, which is the future demand for social care and the demographics. Gillian Mackay will lead on that.

Gillian Mackay (Central Scotland) (Green): Good morning to the panel. What factors need to be considered in addressing demographic changes? We have not only an ageing population but a large population living to very old age. As we heard from Dr Connon, there is the potential for people to be unpaid carers for multiple generations or for people to be carers into old age. We also have a declining birth rate. I will go to Professor Hennessy on that.

Professor Hennessy: All the trends that you have just mentioned are projected to be exacerbated in the next couple of decades. Those issues definitely should be right at the forefront of our thinking about the implications of the bill and the impact of the restructuring.

I go back to my comments about the framework of health across the life course that is implicit in the bill. What comes out at the far end of the life course in later life and older age is a product of everything that has happened before and the support that we provide, or the lack of support, for individuals at all stages of life. In the bill, I see an acknowledgement that integrating systems of care for individuals across the various stages of life and the different needs that they have, not just for healthcare, is very much part of the thinking. That will affect the kinds of outcomes that you are talking about and how we are able to deal with the trends, and not just with the financial impact of some of the demographic changes and trends.

Gillian Mackay: What actions should the Government take to address the urgent challenges presented by the workforce demographics, with the workforce comprising predominantly older women who have caring responsibilities of their own?

In the interest of time, I will combine my questions and ask anyone who contributes an answer to that question to also cover what they believe needs to be done to ensure that those who do caring as a career are given parity with NHS colleagues.

Professor Glasby: Some major structural issues affect this. Recently, I did a session for the archbishops' commission on reimagining care and, before I went live with the commission, I did an online exercise in which I looked at what jobs were available in the area of Birmingham where I live. I found that you could be a home carer for minimum wage or be a dog walker for £15 an hour. We make social choices about the things that we value, and until those change, it is difficult to see how care could become a different kind of career opportunity for people.

However, in practice we can do a lot of things in the meantime. That could include making direct payments so that people can hire their own personal assistants, which could potentially open up different routes into thinking about the nature and make-up of the social care workforce. Values-based recruitment allows us to recruit people with the right attitudes and values and not necessarily those with prior experience, which might broaden the pool of people we can recruit from.

Next year, at IMPACT, which is the centre that I lead, we hope to do some work on how we can recruit more men, in which we will think about the nature of care work and masculinity. As a rule of thumb, about 80 per cent of the care workforce is female and 20 per cent is male at the moment. Our attitude to the nature of care means that we automatically confine recruitment to half of the population straight away, so there is something fundamental about the nature of care and masculinity.

The advantage of a national care system could be that we could do something about pay and conditions so that there is greater parity with the NHS. I have never understood why we have separate systems and rates of pay in health and social care, given that people often move across those boundaries during their career. Actually, the work of a home carer who works in the community, in a lot of people's homes, autonomously and unsupervised, is often much more complex than the work of a healthcare assistant who works in a hospital where there is a lot of support and supervision, and there are systems and processes in place and colleagues around.

I would take this opportunity to have a national debate about those issues and create a unified framework that has parity built into its design.

Professor Sir Harry Burns: I agree very much with those comments. Having seen a close relative receive home care, I can say that the level of responsibility that the carers had was very significant. They were on their own and they did not have other folk to help them out if a difficult issue arose.

I come back to the point about giving front-line staff responsibility and supporting that with appropriate rates of pay. Home carers seem to me to be well worth NHS rates of pay, for sure.

Nick Kempe: On the demographics, age is the main determinant of care—the biggest group of those who need care are older people—but it is not the only one. There are other determinants such as social factors and, as has been pointed out, what is happening to carers.

11:00

What the international evidence does not really pick up is that in Scotland there are 860,000 people providing informal care and 25 hours of informal care being provided for every one hour of paid care, and what happens to those informal carers affects the overall need for care in the care system. With the current economic and social crisis, over-60s such as me are involved in providing care. Now that people have to work until they are 70, we have suddenly got rid of a lot of people who were providing informal care. There is a huge amount of informal care being provided—the issue is much more complicated than demographics alone.

With regard to the workforce, I totally agree on pay: the national care service should be an opportunity to introduce national pay and conditions. I think that the Government has said that it wants to do that; it is just not in the bill. There are two other crucial points. One point concerns the provision of training, which is a "may" in the bill, not a "must". We cannot have a workforce that is not properly trained, so training has to be a must.

The last point, which no one has picked up yet, is that, as I have said, caring is a demanding job. You are often working in very difficult circumstances, so, as Harry Burns picked up, workers need time for support, and that means peer support. A lot of home helps currently work out of the back of the car; they are ordered to go to places by someone on a remote app, and they never get the chance to talk to colleagues, let alone their supervisor. There is no supervision or support. People need to be able to talk to somebody and get support to deal with the stresses. There is currently so little support that a lot of effort is being spent on recruiting to the workforce people who then go straight out again. When they come upon the reality, they think, "Why would you do it if you are just left to get on with it?"

Professor Needham: The demographic projections are such that we are not going to solve the problem simply by training people and paying them well to deliver care packages. That has to come with a sophisticated approach to prevention and thinking about how we keep people in communities without overloading informal carers, who are currently very overloaded. If people are struggling with loneliness and isolation, we need to find ways to help them get back to the church or the community centre, where there are a lot of people who can provide bits of informal support and give them what they need in a way that is potentially much more enriching for them than having someone come in, pop a ready meal in the microwave and leave them to eat it by themselves. We need to link the legislation to thinking much more about how we address prevention.

The Convener: We move to colleagues who want to ask questions on the projections for future social care costs, starting with Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): The Scottish Government has committed to increasing investment in social care by 25 per cent to the end of the current session of Parliament. Can we really consider and project future costs effectively? I put that question to Sir Harry Burns first.

Professor Sir Harry Burns: I am the wrong person to ask about that. I would want you to do that, because it is the right thing to do, but there will be all sorts of other demands that need to be balanced. I keep on coming back to the £5 billion that is sitting out there, which we could be doing something with and making savings that would go a long way towards paying for social care.

Looking after people who need care is an important element in terms of justice, and I would want the Scottish Parliament to lead the way on that kind of thing, but someone has to do the sums.

Evelyn Tweed: Could I go to Mr Kempe now, please?

Nick Kempe: It is difficult to project costs, because of all the factors that I have mentioned. We have a level of inflation that we did not expect, so projecting costs is practically impossible, but we need to try to do it. That is why the bill needs to build in a mechanism by which you can track what is going on with care needs—what needs are being met and what is happening—and the resources available for that. As I said, I very much welcome central Government funding, but there needs to be a way to have a dialogue with the people delivering the care service, and there are bound to be compromises about that—that is absolutely inevitable.

At the moment, we are very focused on targeting resources at individuals. That is one of the issues with a rights-based approach. However, if we are going to have the preventative-type infrastructure of clubs, which Professor Needham mentioned, we also need a collective approach to care. Basically, we need to find a way to empower local communities to say what sort of services would make a difference in their areas. There is talk about that, and the bill has aspirations for co-design and co-production, but there is not actually a mechanism to make it happen. Instead, all the discussion is going on at the national level. I would like to see discussions at a local level that feed up.

The Convener: I will bring in Professor Glasby before I come back to you, Evelyn.

Professor Glasby: If it is helpful, we can send the committee some long-term projections that we did in England. We took the scenarios that were used for the review of health service financing by Derek Wanless when NHS resources increased so dramatically in the 2000s. We applied three similar scenarios to future adult social care spending. That methodology might be helpful. Those are projections rather than predictions, so they help you to plan and to think about different scenarios, rather than to predict what will actually happen.

Two or three of the unanswered questions that remain in many attempts to do such work include whether, where we make hypothetical savings in a system, we can disinvest from that service to free up money to invest elsewhere. Often, preventative projects will justify their contribution by the number of hospital admissions that they prevent. That might be true, but we never get around to closing the bed that that person would have been admitted to. We carry on paying for the bed, and we fill it with somebody else. Then we also pay for the preventative project that stopped other people being admitted to that bed. Therefore, in one sense we pay for it twice: we never quite get to the stage of disinvesting based on the investment in prevention.

With regard to care-related projects, it is so difficult to access publicly funded social care and there is so much unmet and undermet need that any attempt to make services better, more outward looking, more inclusive, more approachable or easier to understand tends to bring more people forward. In public policy terms, I would say that that is a good thing, because that need is there—it is just hidden—and we might then meet it better in the way that several witnesses have spoken about today. The person responsible for that budget might think that it will go down because they have integrated care, but then they suddenly find that it has gone up because they have brought forward more unmet need that they did not even know about, so it can be very difficult to manage the individual budget in the short term.

Finally, most of the methodologies tend to focus on service costs when they project forward. They do not think about costs for people who draw on care and support, for unpaid carers or for communities. Different blends of service and different designs of our system have different implications for what we spend on our public services but also with regard to the contributions that people make directly or in kind—if they are users, rather than carers—or with regard to communities. Therefore, if we look at it in the round, the cost of some public services might go up but the negative financial consequences for users, carers and communities might go down.

The judgment that we would make about the effectiveness of that spending might look different if we looked at things holistically, rather than simply looking at the public money that we spend on public services, which is only one part of the equation.

Evelyn Tweed: It would be really useful if you could provide the information that you mentioned.

Where should the Scottish Government focus its investment in social care? I put that to Professor Needham.

Professor Needham: We have not talked much about housing, which is a key part of the puzzle here. If we are to meet people's need for care and support in ways that support prevention, we must ensure that people live in appropriate housing, which is housing where they can be supported to deal with loneliness and isolation, which we know is so bad for people's health and wellbeing. It is a question of not always spending the social care pound in what looks like social care, but thinking about other forms of support that are needed. Affordable housing is also an issue for working-age people with disabilities.

We must ensure that the provision is appropriate. We know that small facilities tend to get better outcomes than larger facilities. If we are to invest in provision for older people, let us not build massive care homes that look like Travelodges and that feel, at best, like Travelodges, but which are not places of care, love, joy and support. Let us think about investing in places that feel like places where community support is available and that people can call home. Thinking about care and housing together would be a really useful way of thinking about investment.

The Convener: Our next theme, which we have dipped into, is whether the bill will achieve its policy aims.

I apologise—Tess White wanted to ask about financing. I am sorry for missing you out, Tess.

Tess White: Thank you, convener. I think that my question would be answered if Professor Glasby could share with us the figures that he mentioned.

The Convener: Okay. In that case, we move on to theme 5, which is about how the bill will assist us in making headway on its policy aims. The questioning on that will be led by Paul O'Kane.

Paul O'Kane: We have begun to touch on the issue of what the bill will actually achieve. I would like to reflect on some of the commentary that there has been since the bill's publication. The Centre for Care said that there must be greater clarity on how the reforms will achieve the intended goals. It asked how we will test the bill against the theory of change and how we will establish whether it has done what we want it to do. There has been commentary on whether the bill will fully deliver the recommendations of the Feeley review, and there has been commentary from trade unions on whether it will do anything to tackle the issues around pay and terms and conditions. Unison has gone as far as to say that the bill should be paused.

In that context, I am keen to get a sense of how the bill can achieve the aims that have been set out. Perhaps we could start with Nick Kempe.

Nick Kempe: As I understand it, the bill has quite a limited purpose—it is focused on the quality and consistency of services, rather than on what is not done. I think that care is wider than just services, as we have explained. That is one limitation.

As regards what the bill will actually do, I have answered a question about quality and the need for workers to have time, but it is worth reflecting on the need for consistency. There is a lot of talk about a postcode lottery. We know that, when it comes to the benefits system, everyone thinks that their neighbour is getting lots of money, but there are very strict rules about the benefits system and, most of the time, that is not the case—most people do not get very much.

In relation to consistency and centralised control in managing it, we also know that there is lots of inconsistency in the NHS. There are stories every few weeks about one health board doing one thing and not another.

The real problem, however, comes back to the data. Unless and until there is a mechanism through which we can collect information on unmet need and who is doing what—what informal carers are doing and so on—we will not be able to tell whether or not the care service will improve consistency. Resource allocation is absolutely key to that.

I will add another couple of points on that. If we get the resource right, that will allow for local diversity: although there needs to be accountability, people can design different types of services for different areas. We should not be measuring consistency in terms of what a service looks like, because there is not a one-size-fits-all approach. It is quite obvious that services in rural areas need to look very different from those in urban areas.

11:15

Paul O'Kane: I wonder whether Sir Harry wants to come in, particularly in relation to testing change. Obviously, he has experience of testing change and seeing what works.

Professor Sir Harry Burns: If we do what has traditionally been done and come up with a bill with targets, indicators, structures and all that kind of stuff, everyone will put their efforts into the targets—into ticking the boxes. However, we are talking about enhancing the wellbeing of people who are struggling. It is absolutely right to say that data is crucial to all of this.

Normally, for most of the population, I would say that things such as health service data and a range of other social determinants of wellbeing could be brought together. That would work for families. For care of the elderly, however, it is a bit harder to work out what data would be necessary, because you expect the elderly to perhaps need a bit of hospital care. That is an area where general practitioners, and how much effort they are putting into their elderly population, will be important. It might be that we have to come up with a different data set for care of the elderly.

I come back to the fact that we are talking about support for our fellow citizens and enhancing their sense of wellbeing and of being loved and cared for. That is what this is all about, really. I do not think that the NHS collects data on how much people feel loved, to be honest. We need to be thinking about a way in which we can enhance the ability of front-line staff to support individuals. Their being able to ask the question, “What matters to you?” and then say, “Let me help you achieve that” is the critical thing in all of this.

Professor Glasby: I always get slightly nervous when I hear a debate about consistency versus postcode lottery. Equity and equality are such key principles in the health service, but we tend to interpret them as meaning that we should treat everybody the same. However, if people or communities do not start off equal and at best all we do is treat everybody the same, all we do—again, at best—is perpetuate the existing inequalities, and if we do not design our services in the right way, we can end up making some of those inequalities worse. I therefore wonder whether we are talking about equality of outcome, rather than equality of input or services necessarily being the same elsewhere.

If we were clear about both the outcomes that we were trying to achieve and the joint amount of money that was available to spend to meet those outcomes, we could design approaches, services and supports in our local areas that would work best for our local communities. We could co-produce those with local people and involve front-line staff centrally in their design.

If I were a director and you gave me a series of outcomes to achieve and an amount of money to achieve them with, and then gave me the autonomy to work out how best to use that money to move towards those outcomes, that would feel like the best balance between the local and the national.

If we descended into a situation where we said, “Council A has such and such a service, so you need to have the same service,” we would start to overprescribe a top-down, apparent solution that might look big and bold but which could be a distraction from meeting local needs.

Paul O’Kane: That leads me neatly on to my next question. The sense that I am getting from those contributions is that this has to be about cultures, not structures, and that we have to avoid that top-down approach. Indeed, Reform Scotland said in response to the call for views that there has not been an

> “adequate explanation about why simply removing local government”,

for example, from social care would lead to implementation or to innovation in delivery. Do the panellists agree that we need to look at that in a more rounded fashion?

Nick Kempe: It is worth saying that we are talking about improving care services but, at the moment, it is not clear whether children’s services are included. Jon Glasby spoke about the two sides—the idea that your integration is my fragmentation. If children’s services are included, there would then be a lot more issues. Therefore, thought needs to be given to how you embed care in local communities and empower professionals to work with each other. That comes before top-down structural change.

The Convener: Is there a comparison to make between the Government’s approach in implementing the social security system, whereby it went round the country and spoke to people about their experiences of social security, and the approach that it is taking now, whereby it has a national care forum—the first of the meetings was in Perth last month—that involves people from the third sector and people who are experiencing social care systems throughout Scotland? Is there a comparison that we can draw between the success of that approach to social security and this approach? How important might that be as we implement the bill?

Nick Kempe: They are slightly different, because the social security system has very prescribed rules. It is about how much income people need and their experience of the system and what they need, but it is a very centrally driven system, whereas, when we are designing a care service, the variations between where people live and so on make a huge difference. What community you are in, where you are, and so on, all totally change things.

If we think about trying to design care services nationally, to design a system and some rules with stakeholders, which could then be given to local authorities or health and social care partnerships so that they can devolve and apply that system locally and come up with services, is one thing. However, at the moment, it feels as though it is a one-size-fits-all system, and I do not think that that will work, because care is very different from social security.

The Convener: Does anyone else want to comment on the approach—about actually going out to people with lived experience?

Professor Sir Harry Burns: The term “people with lived experience” is extremely prevalent and important when you are discussing people’s early life. If you hear from a person who is in jail, who has had lived experience of domestic violence and that kind of thing, about just how that has affected them, it absolutely changes your view about what they have come through and where they might go in the future.

Community is really important in that. I am thinking about conferences that I have been to. I went to a rural health conference in Australia, where communities were very involved in care across the whole system—care for the unemployed, care for the elderly and so on. They came up with clever, innovative solutions for their communities. I come back to the point that, where you see these clever solutions, you should collect the data and scale it up, tell other people about it and let them do it. That goes back to the point that we have been making: do not prescribe top-down solutions; create an environment in which people can develop their own solutions and share what works. The role of community in all of that is important. When the bill goes through, something should be said about supporting community development.

The Convener: Sandesh Gulhane has a question on that theme.

Sandesh Gulhane: I would like to ask Professor Glasby first. The Convention of Scottish Local Authorities has repeatedly said that improvements to social care need to be made now. I heard you say earlier that, initially, things are likely to get worse. Therefore, these changes will only disrupt these improvements. Could more immediate action be taken to address existing social care issues? Might the NCS jeopardise these changes?

Professor Glasby: I do not know enough about the situation in Scotland, but I am really worried about the amount of financial, service and workforce pressure that the social care system in England is experiencing and was experiencing prior to Covid and the cost of living crisis. Without urgent stabilisation, the injection of funding and further reform, elements of the social care system, at least in England, could fall over this winter or soon afterwards. Something urgent is needed here and now, perhaps to buy the time to have longer-term, more fundamental conversations such as those that we have been having today. I do not know whether that is also true in Scotland, but, as a private individual, that is my concern about the situation in England.

As I said, the evidence suggests that, when there is major structural change—even though the structural change is often designed to deliver different outcomes for the future—that change can become an end in itself rather than a means to an end in the short to medium term. It can lead to a decline in role clarity and morale. People might have to reapply for their own jobs or jockey for position in a new structure that requires the harmonising of terms and conditions, the joining up of information technology systems, the creation of new organisational identities and the changing of letterheads and signage—all the things that you must do when you create new machinery and new organisational infrastructures. However, in the short term, none of those things improve outcomes for patients or people who draw on care and support.

Therefore, there is a risk that any major change is a bit of a distraction from the day job—to put it in the nicest possible way. That is inevitable with any major change. I am not saying that we should never have a major change, because then nothing would ever change. It is just that we need to be ready for the extent of the disruption over the relatively long period that that disruption can last, and we must be sure that the outcomes that we are trying to achieve are really worth it for the upheaval that there will be en route.

At a more local level, I guess that other witnesses will have experienced a merger of a health organisation with a social care organisation or of two health organisations. Sometimes, you can still see some of the negative after-effects of the merger five or 10 years after the change took place. It might still have been the right thing to do at the time, but, in organisational development terms, you work with the after-effects of the change for many years after the merger.

For me, those are some of the issues to weigh up. What are the outcomes that we are trying to achieve? Is this definitely the best way of achieving them? Are we ready for the amount of upheaval that there will be en route? Then, if social care is facing similar pressures and difficulties in Scotland as it is facing in England, it is also about asking whether there is anything that we need to do in the short to medium term to support the sector in the here and now while we also work on those longer-term system changes.

11:30

The Convener: I see Sir Harry nodding along. Do you want to add anything?

Professor Sir Harry Burns: I simply want to support Professor Glasby’s comments about the amalgamation of health and social care partnerships, various changes to health board structures and so on. Those just divert people away from the job at hand, and it takes a while to get over that. The less upheaval that we can have in introducing this, and the more consultation there is with people on the ground and people who are receiving care, the better. We will then come out with a really good solution, which, at the end of the day, will not cost a fortune and may actually save costs in other sectors.

The Convener: We will move on to our final theme, which will be led by Stephanie Callaghan.

Stephanie Callaghan: I thank the panel for coming along. Sir Harry said early on that it is critical to ask people what matters to them and then to help them to achieve that, which can also save costs down the line. What further provisions could the bill include to ensure that the focus is on person-centred care rather than cost?

Professor Sir Harry Burns: I do not think that you can quite legislate for things such as that. I am thinking of a slide that I have from the patient safety programme. Nurses in a ward realised that, every day, they were writing down the aims that they wanted to achieve during the day and the doctor was coming in and writing down what they wanted to achieve for each patient, but nobody was asking the patient what they wanted to achieve. I have a photograph of a woman in an intensive care ward with a big hairy dog sitting on her bed. What she wanted to achieve was to see her pet poodle or whatever it was. That did her sense of wellbeing and so on no end of good, but it could not have been achieved by legislation or anything like that.

When I worked in intensive care units, if anyone had brought a dog in, matron would have had them hung, drawn and quartered. However, the point is that this woman felt so much better because someone had asked her what she wanted. I have hundreds of stories of people having asked for trivial things that have made them feel much better.

I do not think that we can legislate for that; I think that it just becomes a habit. We simply have folk doing it and other folk seeing the result of it, and so it spreads. I suggest that, when the bill comes out, we make it very plain that we want that kind of supporting-people approach. We would then go out and get the medical organisations and the Royal College of Nursing and so on and make it very plain to them that we really want that what-matters-to-you approach to become prevalent across the system. They would jump at it.

Stephanie Callaghan: Does anybody else feel that there is anything that we could include in the bill that would help to centre that?

Nick Kempe: Eligibility criteria were mentioned earlier. We would do better to get rid of eligibility criteria, at least for seeing social workers. We spent a lot of time on doing things around that. People should be able to go to a social worker as they would go to a GP and ask for help, and we need to help people who are asking for it. That is what person-centred care is about. Most of the solutions will normally involve not money, but working with people and their carers to work out what happens. However, if we stop people coming through the door, we are simply stacking up problems, diverting them and creating them elsewhere. We need to have an open-door service to start with, which is based in local communities so that people can just go there and get involved.

The opposite has been happening. Since I have been working in social care, all the local offices have closed down and everything has been centralised. We now have a community hub in north-east Glasgow for 44,000 people. That is not like going to the local GP surgery—it is going totally the other way. I do not know quite what the answer is with regard to the bill, but there should be some sort of principle of subsidiarity.

My other point is on resources. At present, there are eligibility criteria—someone gets through, and they get X amount of service. However, the best service that I ever commissioned was about keeping older people in their own homes in a tower block in Glasgow. The service was meant to keep them out of care—it was a 24-hour service with people on alarms who would go to see people whenever they needed help. It was absolutely fantastic.

I have two brilliant stories from that. There was a man with dementia whose behaviour was very challenging. He had actually been chucked out of a care home because the staff could not manage him. The staff in the service worked with him in a relationship-based way and discovered that he liked swimming. Taking that man, who had been violent, down to a public swimming pool might seem risky, but they got him there, and do you know what? All that he needed was to go swimming once a week and all his other problems disappeared.

I was the commissioner and I did not mind the fact that, in theory, looking at it individually—this is why I do not think that we should look at things individually—we were spending £550 a week on him, which is a huge amount of money. In fact, we talked to the provider and they reallocated that resource, once they had freed it up, to people who needed more help. I spoke to them about it and they made compromises all the time. In the tower block, people had alarms, and what happened there was very important. For example, a woman might want help with her nails or hair—all the things that are really important to people. I asked someone, “What happens when somebody else, who has dementia, goes wandering out the door and the alarm goes, and the staff have to leave you?” They said, “Well, we know that the service is there when we really need it. When we have a real emergency and we are on the floor, we know that staff will drop whatever they are doing and come and see us.”

That illustrates everything that Sir Harry said about local control and decision making. That is why the service was so good: the good use of resources was embedded in it. As a commissioner, I had nothing to do with the overall operation. I asked some questions, and it sounded brilliant.

The Convener: I have a question on ethical commissioning. I presume that the National Care Service (Scotland) Bill seeks to ensure that there are fair work principles and standards across everything. Obviously, local decision making will still happen for all the reasons that have been outlined, but there will be standards for the care that people are offered, fair work and fair pay principles, and a structure akin to that of the NHS. Is that really going to underpin all the local decision making?

Nick Kempe: I think so. Basically, the structure of ethical commissioning will be that people will apply the principles in the National Care Service (Scotland) Bill in practice. My view is that the fundamental point of ethical commissioning—this applies to services for people rather than community projects or whatever—is that it is all about the staff and what they do. It is about paying them properly, and seeing that they are trained and supported and have time to spend with one another.

We need national terms and conditions for all staff. That is what needs to underpin ethical commissioning. That would mean that there would be agreed unit costs and that we would know the cost of providing whatever service a person needs. It is absolutely fundamental that the approach should be the same across the country, whatever sector people work in.

Ethical commissioning has to take account of the differences in the costs of providing services. The obvious example is that, if a carer has to drive for five miles to get to someone rather than walk around the corner because they live in a rural area, the cost of that service should be built in, because it is far more expensive. There has to be some discussion about how that is done.

When I worked for Scotland Excel, we developed a care cost calculator for care homes that showed how we could pay a fair cost for care home care across the country. That was based on an agreed wage policy. People could put in whatever wages they wanted to, training allowances and whatever, and it would come up with unit costs.

Applying such a system is not difficult. It could be applied to every service in the country, and it would be the foundation for resource allocation. It could be given to local communities, and the job of the commissioner would be to say, “Right, you have so much resource. How will you deploy the staff in a way that meets the needs of this area?” They could also talk with the staff about that.

The Convener: I will bring in two of our witnesses, and we will then have to wrap up. Professor Needham is waiting very patiently. I will then will bring in Professor Glasby.

Professor Needham: On the point about giving a voice to those on the front line, when we did our research on care in the four nations and we spoke to interviewees who were working in Scotland, they said that we should just implement the Social Care (Self-directed Support) (Scotland) Act 2013. Although I agree with the other witnesses that we cannot always legislate for this, we should also look at what is already on the statute books and at how the new bill can reinforce and reinvigorate that instead of starting again.

On ethical commissioning, I think that nine Scottish local authorities have implemented Unison’s ethical care charter. I have not seen any evaluation of that that has been done by anyone other than Unison, but it could be really interesting to see how well that is working for the signatories.

It is also about linking the fair work agenda and ethical commissioning to the end goal of people flourishing and having a good life. That has to be about making ethical commissioning for outcomes. To do good commissioning for outcomes, there need to be high-trust relationships, flexible services and very skilled commissioners. How we train and skill commissioners as well as other parts of the social care workforce is an issue.

Professor Glasby: I agree with everything that has been said. Equally, there are some situations in which a formal care service is needed for somebody. However, with the principles of self-direction, there are a lot of situations in which we might not need anything that looks like a formal care service at all. In such circumstances, there is a danger that some of our rules and regulations can become a barrier to innovation.

There was a situation in England in which a young person with very complex physical health needs needed to get to school and back each day. The local authority could achieve that only by getting a specially adapted minibus from a day centre. Each day, all of the person’s friends turned up at school on the school bus, and he turned up on a specially adapted bus that had the logo of the day centre over its door. That tied up a specialist vehicle twice a day from Monday to Friday, and it was really expensive.

With a personal budget, that young man’s parents paid some sixth formers to sit with him at the back of the school bus. The outcome of that could be judged easily because he got to school and back safely each day. That cost a fraction of what the minibus cost, and it was much more socially inclusive because he was with his friends and peers on the bus rather than on a specially adapted bus and segregated from everyone else. Nobody did a Criminal Records Bureau check on the sixth formers or asked them to register with a central register of care workers. The parents were allowed to design a very practical, everyday solution with the boy's personal budget.

I agree with what people have said about the benefits of a national system and the scope that that brings to look at terms and conditions and fair work. Equally, there are some situations in which giving choice and control can enable people to devise solutions that do not look like formal care work or formal care services at all. My fear is that, by integrating some of our services, we might move towards the more medical model that makes such everyday innovation harder, because it is even more counter-cultural in some parts of our health systems than it has been in some parts of our social care systems.

The Convener: Thank you. We have run over time, and we have to move on to our next agenda item.

I thank all our panellists—those who are online and those who are here in person—for their time this morning. Their evidence has certainly given us a lot of food for thought as we continue our scrutiny of the National Care Service (Scotland) Bill.

Petitions

Rural Scotland (Healthcare Needs) (PE1845)

Rural Healthcare (Recruitment and Training) (PE1890)

Caithness County Council and Caithness NHS Board (Reinstatement) (PE1915)

Women's Health Services (Caithness and Sutherland) (PE1924)

11:45

The Convener: The third item on our agenda is consideration of four public petitions that have been referred to the committee. PE1845 is a petition for an agency to advocate for the healthcare needs of those living in rural Scotland; PE1890 is a petition to find solutions to recruitment and training challenges for rural healthcare in Scotland; PE1915 is a petition to reinstate Caithness County Council and Caithness NHS Board; and PE1924 is a petition to complete an emergency, in-depth review of women's health services in Caithness and Sutherland.

The Citizen Participation and Public Petitions Committee referred the petitions to our committee after doing its own scrutiny of them, so that they can be considered as part of our work on health inequalities. Colleagues will remember that we did a substantial review of, and inquiry into, health inequalities. The common theme that runs through all the petitions is rural healthcare, which we routinely address in our scrutiny of the health service and which came up as a particular issue during our health inequalities work.

We need to have a discussion about what to do with the petitions. Some of the petitioners have already met the Cabinet Secretary for Health and Social Care, for example—I am talking about the final petition, on an in-depth review of women's health services. Members will also be aware that the Citizen Participation and Public Petitions Committee has already done some work on the petitions. In fact, we have a member here—David Torrance—who is also on that committee. He might want to tell us about some of the work that has been done.

Before I open up the discussion, there are some options to consider in relation to what we want to do.

The first option is to invite a selection of rural health boards to give evidence on the issues raised in the petitions and to follow that up with either a letter to, or a session with, the cabinet secretary. Obviously, that option will take the most time, and we need to decide whether we have time for that. We will not be able to do that this side of Christmas, because our scrutiny of the National Care Service (Scotland) Bill will take up all our time right up until Christmas.

The second option is to proceed directly to inviting the Cabinet Secretary for Health and Social Care to give evidence on the issues raised in the petitions, given that a lot of evidence has already been taken and we have already done quite a lot of our own scrutiny of rural healthcare in our equalities work. I should point out that the cabinet secretary has already spoken to the Citizen Participation and Public Petitions Committee about the issues that are raised in the petitions.

The third option is to take evidence via correspondence. We could write to rural health boards and the cabinet secretary to seek evidence on the issues.

The fourth option is to close some or all of the petitions.

It would be really helpful to hear from David Torrance about some of the scrutiny work that the Citizen Participation and Public Petitions Committee has already done. This is not revenge for him passing the petitions on to us. I genuinely want to know what level of scrutiny there was at that committee.

David Torrance: Thank you, convener. I will remember not to pass on any petitions in the future. [*Laughter*.]

Some of the work that has been done on the petitions that are in front of us has been quite intense. I would therefore recommend the option of writing to rural health boards and bringing in the cabinet secretary for a meeting. I think that that would be a justified approach to take.

PE1915 asks for the reinstatement of Caithness County Council and Caithness NHS Board. I do not think that it is practical for us to do that, and I do not think that it will ever happen anyway. Therefore, we should probably close that petition.

The Convener: I believe that only two people support that petition, whereas the other petitions have a lot more substantial support. There is also quite a bit of overlap between the themes in the other three petitions.

Gillian Mackay: I support David Torrance's position on writing to the health boards. The petitioners would probably like to see some action being taken in the period between now and Christmas. I think that having the health boards gather that information through correspondence and then having the cabinet secretary in after Christmas would make the most of the time that we have, as it would mean gathering information while we are doing other things as well as having an in-person session to make sure that we cover the issues.

The Convener: That is very helpful. Thanks, Gillian.

Sandesh Gulhane: I feel that PE1890, on finding solutions to recruitment and training challenges for rural healthcare in Scotland, is particularly important. We know, for example, that it is very difficult to recruit GPs, and we know that nursing provision across Scotland is not uniform. We have significantly worse recruitment in rural areas than we have in urban areas. I could go on with more and more examples.

PE1890 should be brought in front of the health boards. There are rural health boards that should be explaining what they are doing right now. We could follow that up with a meeting with the cabinet secretary to find out what is happening centrally. That is a really important area that we have not got a grasp on, unfortunately.

The Convener: I should mention that we routinely meet health boards, and we can factor into that work quite a lot of the issues from PE1890 and the other petitions. We said that we wanted to do some targeted work on the workforce, particularly in rural areas. That is why we are having the health boards in. We should remember that. I do not want to duplicate work and have an additional session.

You are preaching to the converted, because I am a rural MSP, and everything that has been mentioned is the situation in Aberdeenshire, but it should be remembered that we will be having health boards in anyway, so the petition can feed into the scrutiny that we will be doing in those sessions.

Sandesh Gulhane: My only concern about that is that there are health boards that do not come in front of us and there are health boards that hide—I do not want to use that word, but I will. We need to ensure that rural health boards come in front of us and that we get all health boards in front of us, so that we can have that discussion directly. In one of our previous sessions, the health boards that appeared were ones that were not under great scrutiny. It is very important that we get everyone here.

The Convener: I agree with you. It was mentioned during our work programme day that we wanted to hear from all health boards, so we are endeavouring to do that throughout the year.

Are there any other comments on the approach to the petitions? David Torrance suggested that we should close one, and Gillian Mackay suggested that we should write to all the rural health boards and have the cabinet secretary in.

Carol Mochan: I support Gillian Mackay's position on writing to the health boards. We would then have some information that we could look at, and we could speak to the cabinet secretary.

I tend to feel that we should keep all the petitions open. I do not think that any of us covers the Caithness area, although I am not 100 per cent sure about that. I would like to speak to somebody about that issue, because I do not know a lot about it. That would give me a chance to refer to somebody who covers the area.

The Convener: You could, of course, look at the outcomes of the Citizen Participation and Public Petitions Committee's consideration of the petition. As David Torrance has said, you could look at its recommendations with regard to the petition, which will be linked to in our committee papers.

Does anyone else have a comment?

Paul O'Kane: Forgive me—we have not done this before as a committee. As there is obviously an issue relating to local government and the structure of local government, is that an issue for the Local Government, Housing and Planning Committee? With the best will in the world, we are not going to be able to make a recommendation on the restructuring of local government in Scotland.

That is just a thought, and I am not sure how the ping-pong between committees works.

The Convener: The petition was referred to us, so perhaps it is best that we do not have much more ping-ponging than there has already been—

Paul O'Kane: Pardon that expression.

The Convener: We need to make a decision. I agree with David Torrance that we should close petition PE1915, for the reasons that he set out. We should keep the other three petitions open and use them as a springboard for scrutiny of rural healthcare and addressing all the issues that the petitioners have raised, and we should get the cabinet secretary in to give evidence. I favour Gillian Mackay's approach of writing to the rural health boards, but we should keep in mind what Sandesh Gulhane said—namely, that we need to hear from all rural health boards. When we ask them to come in front of the committee, it should not always be the same ones but all of them. We cannot compel people to come in front of the committee, but everyone should take the opportunity to talk about what they are doing to address those issues.

Sandesh Gulhane: I wonder whether we might need to say publicly who we have invited and who has declined our invitation.

The Convener: I think that that is all on the public record anyway, is it not? We can talk about that in private session.

Are we agreed on Gillian Mackay's approach?

Gillian Mackay: David Torrance said it first, to be fair to him.

The Convener: Are we agreed on Gillian's and David's approach?

Members *indicated agreement.*

The Convener: There you go—co-ownership.

Thank you, colleagues. That concludes the public part of our meeting. We will move into private session.

11:57

Meeting continued in private until 12:18.

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