OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 24 October 2023

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 24 October 2023

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE

30th Meeting 2023, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

*Paul Sweeney (Glasgow) (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:

James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Tom Ferris (Scottish Government)
Eddie Follan (Convention of Scottish Local Authorities)
Eddie Fraser (Society of Local Authority Chief Executives and Senior Managers)
Tim McDonnell (Scottish Government)
Jenni Minto (Minister for Public Health and Women's Health)
Professor Soumen Sengupta (Health and Social Care Scotland Chief Officers)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 24 October 2023

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning, and welcome to the 30th meeting of the Health, Social Care and Sport Committee in 2023. I have received apologies from Emma Harper. James Dornan joins us as her substitute.

Our first agenda item is to make a decision on taking business in private. Do members agree to take items 5 to 8 in private?

Members *indicated agreement.*

Subordinate Legislation

National Health Service (General Dental Services) (Miscellaneous Amendment) (Scotland) Regulations 2023 (SSI 2023/247)

09:15

The Convener: The second item on our agenda is an evidence session with the Minister for Public Health and Women's Health on the National Health Service (General Dental Services) (Miscellaneous Amendment) (Scotland) Regulations 2023. I welcome from the Scottish Government Jenny Minto, who is the minister; Tom Ferris, who is the chief dental officer; Ailsa Garland, who is the principal legal officer; and Tim McDonnell, who is the director of primary care.

I invite the minister to make a brief opening statement.

The Minister for Public Health and Women's Health (Jenni Minto): Good morning, and thank you for the opportunity to speak about the dental regulations, which are to be dealt with under the negative procedure. As the convener has noted, I am supported today by my senior policy officials Tom Ferris and Tim McDonnell, and legal official Ailsa Garland.

If I may, I will talk briefly about the purpose of the regulations, as well as the changes that we will be making under them. As the committee will be aware, the Scottish Government has been working on NHS dental payment reform for some time now. In my letter of 18 October to the committee, I outlined the key components and benefits of the new payment system, which will be implemented in just over a week. I will be happy to take any questions on that during the meeting.

In relation to the regulations, a number of key changes are required to various existing regulations to support payment reform. As part of those changes, we are introducing a single capitation arrangement for all patients, regardless of age, and all treatment items will, where it is clinically appropriate, be available for both adult and child patients.

We are also making changes to support unregistered patients. The system that is known as "occasional treatment", under which unregistered patients can receive only a reduced set of care and treatments, will be removed through the amendments that will be made by the regulations. That means that both registered and unregistered patients will be able to access the same comprehensive range of treatments, by removal of what might be construed as a two-tiered system of care.

The changes are also focused on bringing clinical practice up to date. The new single capitation arrangement will rest on "managing" the oral health of the patient, by replacing the requirement to

"secure and maintain the oral health of the patient".

The more achievable aim of managing oral health recognises that self-care is an important determinant of successful oral health outcomes.

I confirm that the equality impact assessment for the regulations reports no significant issues, and that the business regulatory impact assessment reports no adverse consequences.

In summary, the regulations are part of the significant work that we have undertaken to prepare for implementation of payment reform on 1 November 2023. The changes will support the introduction of the most significant reform to NHS dentistry in a number of years, and it is our intention that the reform will help to sustain and improve patient access to NHS dental services for the long term.

I am happy to take questions from the committee.

The Convener: Thank you for your statement, minister.

How do you intend to evaluate and monitor the impact of the payment reform?

Jenni Minto: We have been very clear about that since we started discussions a number of months ago with the British Dental Association and, more widely, with dentists in Scotland. That work will start once the system is bedded in. We have already started with some very well-attended webinars to ensure that dentists understand what the changes are and how they will implement them in their practice.

We will constantly keep review of the system in mind. Tom Ferris meets dentists and directors of dentistry regularly through national health service boards and the BDA. We have been very clear with the BDA that we want to work with it to ensure that this is the right start for the reforms that we are looking at.

The Convener: You mentioned the BDA a couple of times in your answer. Its criticism was that you

"did not consider new models of care or alternative delivery models as part of payment reform".

Can you comment on why the Scottish Government did not do that?

Jenni Minto: Yes, I can. I am aware of that issue from my conversations with the BDA.

In Scotland, we have a blended method. It combines a capitation payment for the number of people who are seen by a practice—one of the changes that will be made by the regulations is that adults and children will now be treated for the same fee, which, I think, is positive—and a payment for the services that a dentist provides. I think that that method will work very well, given the variety of dental organisations and businesses that we have.

In fact, yesterday Tom Ferris met some of the academics whom I referenced in my letter of 18 October, who are very supportive of a combined method of paying for our NHS dentistry and think that that is the right way. We have been very clear that we are building on a foundation that we already have in Scotland that works very well and on which practices are already built. I think that the reformed blended system is the right way for us to move forward. In that meeting, Tom Ferris discussed the possibility of making changes in Scotland. The advice that we got from academics from North America, Europe and Australia was that, if we look at how dentists' services work across the world, we see that a simple lift and shift would not necessarily provide a better service. Their strong view was that we should modernise a system that is already working, which is what the Scottish Government has endeavoured to do, through the changes that we are making with the regulations and payment reform.

The Convener: Thank you.

Sandesh Gulhane (Glasgow) (Con): I declare my interest as an NHS-registered general practitioner.

Minister, thank you for coming. Has any analysis been done on how much extra the average patient who is eligible to pay, and who is not eligible for any free prescriptions, will have to pay?

Jenni Minto: The problem is that there is not an "average patient". Everyone in Scotland comes as an individual to see their NHS dentist.

The letters that I have been getting—I am sure that you are the same as me, in this regard—are about access to service. That is what people are really pushing for: they want to ensure that we improve access to NHS dentistry. As I said earlier, what we aim to achieve through the changes in regulations and fee structures is sustainability of services.

Tess White (North East Scotland) (Con): Thank you for coming today, minister.

Was any consideration given to other reforms? The current focus is on a disease-centred model. Did you look at preventative, instead of disease-centred, approaches?

Jenni Minto: I think that what we are looking at is a prevention-centred dental care service. The childsmile programme that we have rolled out to improve the oral health of young children is not disease-centred; it is very much centred on prevention.

We have also been very clear—again—about sustainability of services and ability to access dental services, which I think are really important.

The change that we are making with regard to unregistered patients is also important, because it moves us into the preventative space. When we bring all the regulations together, they show that we want to ensure that there is sustainable access to NHS dental services for the people of Scotland.

Tess White: In relation to reform, the number of university places for graduates has flatlined, and graduates who qualify tend not to want to go into the NHS because of the funding model. Will the new model attract graduates to the profession?

Jenni Minto: As we know, we lost one cohort of dental students during the pandemic, which is about 160 students, or 5 per cent of the workforce. I am pleased to be able to let the committee know—I might also have referenced this in my letter—that 183 dental students are going through training this year, which is incredibly positive.

With regard to the point about dental students not wanting to move into NHS dentistry, I know that the COVID-19 Recovery Committee took such evidence. However, evidence that the Scottish Government and officials have had does not, in fact, show that. Many students want to go into the NHS because it gives them such a fantastic training base. My local practice on Islay supports trainees to come and experience working in a rural practice, which gives them a wide range of training opportunities.

Tess White: That is attractive for training, but will the reforms help to stop the bloodletting from dentistry?

Jenni Minto: The intention of the reforms is to ensure that we continue to make NHS dentistry attractive to dentists.

Tess White: I have a final question. What difference will the single capitation arrangement make to patient access and treatment options, and how will you assess the impact of that change?

Jenni Minto: As I said in response to the convener's question earlier, we will work very closely with dentists to ensure that we get a note of and recognition of how the changes improve accessibility and sustainability of the service. That will be on-going work, once the system is bedded in.

Paul Sweeney (Glasgow) (Lab): I thank the panel, in particular the minister, for coming today.

The changes that are coming in on 1 November have caused some confusion and concern among patients, which has been communicated to us. What support is the Scottish Government providing to dentists to respond to an influx of concerned inquiries, and what public messaging and information are being provided to assure people that the change is nothing to be overly concerned about?

Jenni Minto: We have been aware of that in planning for the change, which will happen next week. As I said earlier, my officials have held a number of webinars with dentists to explain the new regulations and way of working. I understand that they have been extremely well appreciated and well attended. I think that there were about 1,000 people at the first webinar meeting, which was oversubscribed. As a result, another one is being held tomorrow evening to ensure that dentists are across the subject. We are also doing webinars on specific subjects, including periodontistry, to ensure that the reform is widely known about across the profession. Feedback has been incredibly positive.

I thank my officials for the work that they have put into that engagement, because I appreciate how important it is that the professionals absolutely understand the changes that we are making.

09:30

On public messaging, you are absolutely right. In fact, I walked past a dental surgery in Glasgow the other day and thought, "Oh my goodness, they've got their poster out early", but it was a different poster. We are doing a variety of public engagement and messaging, including posters in dental practices, libraries and so on, as well as a multimedia campaign, so the information will be on the radio and other media outlets. I hope that we have everything covered, but we will evaluate that as we go.

Paul Sweeney: There is an issue around preventative care, which is mentioned in the policy notes. It is concerning that the drumbeat for a routine check-up will slip from six-monthly to yearly. What modelling have you undertaken to assess the impact on overall oral health in the population?

Jenni Minto: Thank you for that question. The frequency of check-ups has been commented on in the media. The yearly review is in-depth and follows the National Institute for Health and Care Excellence guidelines.

However, it is really important for everyone to understand that it is for the dentist to make the decision based on the patient. In response to Dr Gulhane, I referenced the fact that there is not an "average patient". It is important to recognise that if your dentist feels that you need to be seen more regularly, he or she can choose that.

I was disappointed to be told by my dentist that I had to come back in six months, because I thought that I was looking after my teeth's health pretty well and was hoping for a check-up in nine months. However, the approach is really focused on the patient. That is what the regulations give us the opportunity to do.

I am sure, Mr Sweeney, that if you were to reflect on that and were being seen by another area of the health service and were told that you did not need to come back in six months but in nine months, you would see that as good news. We need to remember that the frequency of check-ups is based on the patient and the clinical expertise of the dentist.

Paul Sweeney: I also want to raise a concern that the British Dental Association raised, which was about whether that approach is sufficient to narrow inequalities. My recent experience of trying to get an appointment for a check-up in my practice, which is probably in one of the poorer districts of Glasgow, is that it was very difficult, because the permanent dentist has left the practice, which is now using locums.

With regard to patients' oral health, the change of wording in the regulations from "securing and maintaining" to "managing" arguably places more responsibility on the patient for their oral health. We know how difficult it is to rebook appointments when they are cancelled, and the appointment could slip. That could be even more complex for people who have poor mental health or chaotic lifestyles. Has the Scottish Government anticipated that risk? If so, what plans and measures are in place to mitigate it?

Jenni Minto: Thank you for that question. As you will have seen in the BDA's response to the committee's letter on the regulations, it said that that approach is actually something that it had been looking for. It feels that managing patients' oral health is doing things at the right level because we all have a degree of responsibility for looking after our health.

I take on board the point about access; I underline, yet again, that we are seeking to improve access through the payment reforms that we will put in place next week.

Sandesh Gulhane: In your previous answer to me, you spoke of improved access to dental services. Given that the BDA warned that the SNP was overseeing the end of NHS dentistry in Scotland, are you confident—and will you guarantee—that the reforms will lead to improved access for patients?

Jenni Minto: I have been in this role, and have been an elected person, long enough to know that it is very difficult to guarantee anything in this life. What we have done is based on discussions with dental practitioners in Scotland and takes cognisance of academic research, to which I referred earlier. We believe that it is the right change at this time to ensure that access to NHS dentistry in Scotland is maintained.

Sandesh Gulhane: Therefore, access will be maintained, not improved.

Jenni Minto: No. The intention is to also improve access. We have been very clear that we intend that the regulations will improve the sustainability of, and access to, NHS dentistry in Scotland.

Sandesh Gulhane: To be clear, will the changes improve access for patients?

Jenni Minto: That is my hope.

Sandesh Gulhane: Okay.

One of the big issues that dentists talk to me about, when it comes to access for patients who want to register, is lifetime registrations of patients. They say that they feel that when a patient has not engaged with a practice for between three and five years, they should be able to take that patient off their list to allow space for other people to come on board, because their lists are full; however, they say that it is far too difficult to do that. Will you consider making what seem like perfectly reasonable reforms and changes when it comes to lifetime registration?

Jenni Minto: As I said, we have made it very clear that we will have continual discussions with the BDA about the payment reform that we have introduced.

Sandesh Gulhane: I am sorry, but the question was not about payment reform; it was about lifetime registration of patients.

Jenni Minto: I mentioned payment reform specifically because that is what we are talking about now. We have continual meetings with the BDA and dentists, and everything is always on the table when we are in discussion with them.

Sandesh Gulhane: You are the one who brought up improved access, minister; you mentioned it in response to one of the first questions that I asked you. That move would improve access, according to dentists who come to see me.

What are the plans when it comes to domiciliary visits to improve access for patients who are unable to go to a practice?

Jenni Minto: If you do not mind, I will pass that question to Tom Ferris.

Tom Ferris (Scottish Government): We have a programme of extended-duty dentists whose main focus is on going into care homes. We hope to extend that programme, which was in abeyance during the pandemic.

We are having more ongoing discussions with that group of dentists to ensure that the 1 November reforms help them to fulfil that purpose. We are absolutely focused on ensuring that residents of care homes, as well as other citizens, have access to NHS dentistry.

Sandesh Gulhane: Are you saying that that programme is on-going, but is not among the reforms that have been brought in to improve access to domiciliary visits?

Tom Ferris: No. Most care-home residents are seen either by the public dental service, which is the board-managed dental service, or by enhanced-skill general dental practitioners. I would prefer enhanced-skill GDPs to take responsibility for that work, because that would free up the PDS to work with other vulnerable groups in the community.

Our focus is on making sure that GDPs feel that working in an enhanced-skill environment in a care home is worth their while; our work on that is on-going. It is part of the reforms, and we are trying to ensure that it works. We are having a conversation with them specifically to say, "This is what is on offer. Does it seem as if it is working for you?" We have had one meeting already, and there is another one in the diary.

Sandesh Gulhane: Thank you.

Evelyn Tweed (Stirling) (SNP): We have already talked about the shift in language and people taking responsibility for their own oral healthcare. How will the Government support those on low incomes or no income to do so?

Jenni Minto: The Government supports people on low incomes in a number of ways. I think that between 20 and 25 per cent of adults in Scotland do not have to pay for their NHS treatment. The fact that we have free examinations is important as well.

Earlier, I highlighted other initiatives, such as childsmile for getting younger children into the habit of cleaning their teeth, which have been incredibly helpful. Statistics that came out today show that 82 per cent of primary 7 schoolchildren have no obvious tooth decay. That high level backs up the investment that we have put into the preventative side of oral healthcare for children.

Evelyn Tweed: We know that there is an issue with stalling registrations for very young children—aged between zero and two—which are 25 per cent lower since the pandemic. There seems to be a lag in areas of higher deprivation. How can the reforms be carried out in a way that minimises health inequalities? How are we going to get on top of that?

Jenni Minto: That is a really important question to ask. Broadly speaking, we intend to maintain access to NHS dentistry across Scotland through the reforms. I will hand over to Tom Ferris.

Tom Ferris: On registration for zero to two-year-olds, that is the lowest cohort, and it always has been. It takes particular initiatives to ensure that we improve that, and we did that primarily through the childsmile programme. That was in abeyance over the pandemic, and it has only just got back up to strength, so I see those figures beginning to improve over the next few months and years. However, we should not be complacent.

If you are a parent with a young child, it is very difficult to think that there is another thing that you have to do in going to get your child registered, so the childsmile teams in nurseries and practices work in co-ordination to make that as seamless and easy as possible.

Although that figure has always traditionally been lower, Evelyn Tweed is right that it is lower than it has been before, but childsmile should make the difference again.

Gillian Mackay (Central Scotland) (Green): The BDA is

"concerned that certain aspects of the new Determination 1 may result in unintended consequences, which may result in an increase to oral health inequalities. For example, a single examination fee which does not take account of disease experience, may favour patients with minimal past dental disease and/or current dental disease".

Do you share those concerns? How will any unintended consequences be monitored?

Jenni Minto: As I have said on a number of occasions, we believe that this is the right reform, building on the foundations of the way that dentistry is funded and provided in Scotland.

It is also incredibly important that we continue the dialogue with our dentists to ensure that we are getting the right changes made, whether they relate to governance, workforce or access, which are all important.

I know that Tim McDonnell wants to make some comments about access.

Tim McDonnell (Scottish Government): This also responds to a previous question. Because we have an independent contractor model in Scotland, the confidence of the contractors working in the sector is a critical factor in relation to both the sustainment and improvement of access. Because we have engaged with the profession throughout the development of the regulations and, critically, the payment system, and because we will keep engaging with it—whether through town-hall meetings through my team, or through the webinars that the minister has referenced—that will help to build confidence in the profession that the payment measures can sustain access. They will allow independent contractors to make good business decisions that can promote and sustain the oral health of the population and its access to critical NHS dentistry.

Gillian Mackay: Dentistry is one of those areas in which patients find it more difficult than others to raise concerns and give feedback on treatment and on-going reforms. Is there a plan in place to ensure that people can have their voices heard and that ways of giving feedback—good or otherwise—are advertised so that people can input into the system?

Jenni Minto: That is a really good question. The first thing that came into my head on NHS dentistry, and NHS boards more widely, was that people can feed in their views on the Care Opinion website. To be honest, high street dentistry—if I may describe it as that—is very much constructed of individual businesses, as Tim McDonnell has just said. However, I encourage people to use Care Opinion if they want to give feedback on NHS dentistry.

09:45

David Torrance (Kirkcaldy) (SNP): Good morning, minister and other panel members. How will the reforms assist in retaining people in NHS dentistry and recruiting new people into it?

Jenni Minto: That is a very wide question. As I have said previously, the changes in the fee structure and the regulations will maintain and ensure the sustainability of the service across Scotland.

On encouraging people into dentistry, one of the areas that we want to look at is the workforce. There have been two pretty big impacts on the dentistry workforce. One is from Brexit and the difficulty that it created in getting dentists from outwith the United Kingdom to come to the UK. I have written to all my counterparts and their chief dental officers in the four nations, and we are organising a meeting to talk about how we can improve the throughput if dentists wish to come to practise in the UK—and specifically Scotland, from our perspective.

We also want to look at improving the workforce within dentistry. For example, there are some very highly skilled dental technicians, and we would like to explore giving them a bigger locus in seeing patients. We are talking about the possibility of doing that. That is not a magic bullet that will solve our issues, so we are working together on a lot of things. That is why the connections and discussions that we have with dentists, as Tim McDonnell and Tom Ferris have highlighted, are so important, whether they are through the BDA more widely or through the NHS directors of dentistry.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): Minister, we know that dental services have been struggling to recover to pre-pandemic levels and that there has been a significant backlog of patients awaiting treatment. How will the reforms enhance the recovery and sustainability of NHS dentistry in the short term and the long term?

Jenni Minto: The nub of the reforms is about ensuring that we sustain NHS dentistry in the long term. Like you, I have received lots of emails about the access that people have to dentistry. We have the reforms, but we also need to remember that the Scottish Government has put other grants in place. For example, the Scottish dental access initiative offers £100,000 for a new practice in an area. We have been in discussions with health boards to ensure that we target those grants in the right areas. We also have some remote—although I do not like using that term—grant payments, which are really important.

The conversations that Tom Ferris and I have with the health boards are also important, because the boards have a responsibility to look at how dental services are being provided in their jurisdictions. I was pleased to hear that Scottish Borders, Dumfries and Galloway and Highland are now working together to encourage more dentists to come to areas that have had recruitment issues. As I said to David Torrance, we also need to keep an eye on the breadth of skills in dental surgeries to ensure that they are supported.

Stephanie Callaghan: Are there any concerns that the increased costs will discourage those who pay for part of their NHS dental treatment from seeing their dentist? Could that have an impact on sustainability and early treatment?

Jenni Minto: We should remember that everybody under 26 gets free dentistry and, as I have said, between 20 and 25 per cent of adults do not pay for their NHS dentistry. What we had to do was look at the best way of ensuring that we sustained the number of dentists and dental

practices in Scotland, and it was felt that a slight increase in the fees was the right move. The fees are still capped at £384.

As I think I mentioned earlier, the concern that I have been hearing with regard to dentistry is about access. That is the issue that we believe the changes and amendments in the regulations will help us to address.

Stephanie Callaghan: I have another very short question, but I should first say that I entirely appreciate and understand the logic behind this. With the current cost of living crisis et cetera, will you be closely monitoring the situation, just in case it throws up any issues?

Jenni Minto: Most definitely. The cost of living issue floods through every decision that we make just now, so it is absolutely something that we will be keeping an eye on.

Stephanie Callaghan: Thank you very much.

The Convener: I thank the minister and her officials for attending today.

National Health Service (General Dental Services) (Miscellaneous Amendment) (Scotland) Regulations 2023 (SSI 247)

09:51

The Convener: Agenda item 3 is consideration of two negative instruments, the first of which is the instrument on which we have just taken ministerial evidence. The purpose of the instrument is to make specific changes to existing regulations to support payment reform and to make the miscellaneous changes that the Government had intended to make at the next opportunity of amending the existing regulations.

Sandesh Gulhane: I again declare an interest as a practising NHS GP.

A lot of dentists are still concerned that these changes do not address the root cause of their problems and do not feel that they will be enough to sustain services, especially in rural and deprived areas. Indeed, they do not feel that the changes will allow the Scottish Government manifesto pledge of free dentistry for the under-26s to happen. Over the next year, I would like to see evidence to assess these changes and the improvements that have been made to access as a result.

The Convener: Thank you for those comments. Obviously, they will now be part of the *Official Report*.

I propose that the committee make no recommendations in relation to the instrument. Are we agreed?

Members *indicated agreement.*

Health and Care Professions Council (Miscellaneous Amendment) Rules Order of Council 2023 (SI 2023/995)

The Convener: The purpose of this instrument is to provide the Health and Care Professions Council with the power to increase fees charged for processing and scrutinising applications for admission to its register, for renewal of registration and for readmission or restoration to the register. It also enables the practice committees and appeal panel to hold remote hearings outside of emergency periods. The policy note states that the Health and Care Professions Council's fees were previously updated from July 2021 and that offering remote hearings alongside in-person hearings will make it easier for some attendees, such as those with mobility or mental health conditions, to engage with the process.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 26 September 2023 and made no recommendations in relation to it. Moreover, no motion to annul has been lodged.

I believe that Sandesh Gulhane has a comment.

Sandesh Gulhane: I again declare an interest as a practising NHS GP.

I want to take this opportunity to tell the committee and the public that I have received a lot of emails and correspondence from members of the Health and Care Professions Council who are opposed to the increase in fees, given the global cost of living crisis and their feeling that the increase is not justified. A lot of people are unhappy about this but, in the council's defence, I understand that this is the first increase in fees in years and that the council feels that, if it does not increase them, it might well go bust. It is, I think, a very difficult decision that is being taken.

The Convener: Again, those comments will be part of the *Official Report* of the meeting.

I propose that the committee make no recommendations in relation to the negative instrument. Are we agreed?

Members *indicated agreement.*

The Convener: I suspend the meeting to allow for a changeover of panels.

09:55

Meeting suspended.

10:05

On resuming—

National Care Service (Scotland) Bill: Stage 1

The Convener: Agenda item 4 is an evidence session on the National Care Service (Scotland) Bill. We will hear from representatives of local government and integration joint boards. I welcome to the meeting Eddie Follan, who is the chief officer in health and social care at the Convention of Scottish Local Authorities; Eddie Fraser, who is the chief executive of East Ayrshire Council and is representing the Society of Local Authority Chief Executives and Senior Managers Scotland; and Professor Soumen Sengupta, who is the director of health and social care in South Lanarkshire health and social care partnership and is representing the Health and Social Care Scotland chief officers group. We move straight to questions.

Tess White: Mr Follan, does the sharing of legal responsibility between the Scottish Government, the NHS and local authorities blur the lines about who is accountable when services are not delivered adequately?

Eddie Follan (Convention of Scottish Local Authorities): To go back to where we got to with legal accountability, we are talking about shared accountability. Although we huvnae worked through what that will look like yet, we are having discussions about that, and the intention is that it should not blur the lines at all. We are also looking at an escalation framework.

At the end of the day, decisions on the delivery of social care will have to be taken jointly between the NHS and Scottish Government ministers. From my perspective, although we do not know the detail, we should be clearer about how accountability is delivered.

Tess White: The buck has to stop somewhere.

Eddie Follan: Yes. We have to work through that in relation to the legislation. I understand that the committee wants to be clear about that in considering the next iteration of the legislation.

We were in a difficult position initially. There was a bit of a stand-off between wirsels and the Government in relation to the bill. I know that the committee heard evidence on that issue. We had to get to a better place to take it forward, and the political agreement between us is that we have a system of shared accountability. However, as I said, we have not really got to the stage where we have worked through that. We are working with the Scottish Government and the NHS on what that will look like, but we set out with the intention that we will know who is responsible for delivery and what we will do if things go wrong.

Tess White: How satisfied are COSLA and the local authorities that the new agreement has addressed the issues that councils raised?

Eddie Follan: We are in a much better place. Our concern was always that there was the potential for the transfer of staff, assets and functions away from local authorities. I will not rehearse aw that, because I know that we have probably spoke to most committee members about it, but there isnae gonnae be any transfer of staff, functions or assets. We are therefore in a much better place with the Government. We are working in partnership with it and the NHS, which reflects the shared accountability. It also reflects local delivery; we wanted to replicate how decisions are made locally, which is between the local authority and the NHS—and now the Government will be involved. I suppose that what the Government has got out of it is that ministers will be involved in relation to accountability—it will be a joint approach.

We are pretty content with the direction of travel. That said, a lot of the things that we will say today have not been politically agreed, which constrains us a wee bit in what we can say about the negotiations. We have a system of negotiation in place and we are working towards making progress.

Tess White: I will ask one final question. In relation to accountability and responsibility, if the assets, staffing and budget stay with councils, is there not a huge concern that there is a difference and that one party will be responsible and another accountable?

Eddie Follan: Again, that is one of the conundrums that we are grappling with as we move the process forward. Eddie Fraser might want to touch on the assets aspect from a local authority chief executive perspective.

One of the issues is that a lot of the issues that we are dealing with are complex. As members all know, it is a complex area, and we are working to a really short timescale, which is driven by the primary legislation. We are conscious of that and of the fact that we do not want to get this wrong, so we need to deal with such issues.

Perhaps Eddie Fraser could come in, if that would be okay.

The Convener: Of course.

Eddie Fraser (Society of Local Authority Chief Executives and Senior Managers): Tess White raises an absolutely valid question about clarity over accountability. Some of the discussions have been about whether there should be joint accountability. With joint

accountability, the picture becomes blurred, because people are not sure where accountability lies. That is why, when we talk about shared accountability, it should be clear what the Government is responsible for, what local government is responsible for and what the NHS is responsible for. Although it sounds as though we are talking about a simple change of word from "joint" to "shared", that is not the case. Our understanding, from the advice that we have had from lawyers, is that there is an important distinction, which we all need to be clear about and—more important—people who use services and their families need to be clear about in order to understand where accountability lies.

As for where we have got to on that at the national level, I think that the retention of staff is positive for the retention of assets. When I was previously at the committee, I described the fact that, if the staff go, a range of assets, such as the buildings that they work in and the electric cars that they drive, will go. One follows the other.

As things stand, what we have at a national level works at the local level only if the local arrangements allow that. We have still to see the detail on things such as ethical commissioning and the arrangements that will be brought in, so we do not know what that will mean at the local level for enabling local authorities to continue to provide services and make sure that social care workers are valued in what they are paid to deliver those services. We must have that in place at national level, but that must be enabled by what we do at the local level, so that it is deliverable in practice.

The Convener: To pick up on that theme, I am keen to hear panel members' views on the role of the third and private sectors in the governance of social care. Given that they are responsible for providing more than 75 per cent of services, should they have a place in the governance structure for the national care service?

Eddie Follan: We know that it is crucial that we work with the third sector, and COSLA and others do that. We have not worked through how the national board will look in its entirety, but the minister made a commitment on a national advisory group to look at how the national board will operate. Although we do not yet have political agreement on such matters, if that went forward, the third sector would play a big part in the delivery of that.

Third sector organisations are delivery partners, and we work with them regularly, so it is difficult for me to envisage how they wouldnae be involved in the process, but that decision has not yet been made. There certainly needs to be third sector and wider stakeholder involvement in the development of the national advisory board. The advisory group should include people with lived experience having a say on how it will operate.

The Convener: Do any other panel members want to offer their views?

Eddie Fraser: We should remember that, at local level, every integration joint board is already required to have a strategic planning group that does the planning for health and care. There is a wide range of representation on that group.

I absolutely understand why the third and independent sectors feel like second-class members of IJBs, because they do not have a vote on those boards. We have not held votes in our board in East Ayrshire, because we do a lot of work in the strategic planning group and we work within the consensus, but what I described is the perception.

I certainly understand that, on the whole, our independent and third sector organisations employ local people to provide services to local people, and they are therefore huge and important parts of our system. The issue is not just about them as organisations but about the people who work in the organisations. To give an example, all our care homes in East Ayrshire are in the independent sector but, on the whole, it is local women who work in them.

10:15

The Convener: You are straying from my question, which was about such organisations being on a governance board. Can you offer an opinion on whether they should be involved? I have heard about the importance and regard that you give them, but I do not know whether you think that they should be in the room.

Eddie Fraser: From our perspective, such organisations should definitely be in the room. The issue of accountability comes up again when one organisation takes a decision that has an impact on the resources of another organisation. Given the scale of our partnership with the third and independent sectors, I do not understand why they should not be in the room to help us to take well-informed decisions.

Professor Soumen Sengupta (Health and Social Care Scotland Chief Officers): I will add to that point. Ultimately, who is in the room is a matter for elected representatives such as the committee, the Parliament, local elected members and other stakeholders. I concur with Eddie Fraser's point that the earlier question about accountability and responsibilities was not just about the delivery element; it is as much about the responsibilities and accountabilities of the individuals who make up the board, whether it be

the national board, the local care board or whatever version of that is going forward.

No matter who has a vote in those arrangements, it should be clear to the public, as well as staff, that the board is how organisations are held to account for decisions that they make collectively as part of such decision-making bodies. Provided that we have clarity on that, we can move forward constructively.

David Torrance: Good morning to the panel members. Why do local authorities provide and deliver such a low proportion of adult care services? What would it take for local authorities or health and social care partnerships to increase the proportion of services that their staff deliver directly? Could that be an effective route to ensuring consistent terms and conditions for fair work?

Those questions were a bit long winded.

Eddie Fraser: To deal with the range of needs in health and care, we often rely on organisations with specific skills. We rely on partners to meet specific needs in relation to dementia, learning disability and mental health. We have many partners in the third and independent sectors that have specific skills and capacity to operate across all our local authority areas. When we use our organisation partners, it is often because of their specific skills.

Local authorities in different areas look at their local workforce, but they have different levels of delivery. Some have a large in-house workforce that is normally for older people, while others do not. They may have commissioned that workforce and it has grown over time. However, when we get into specialist areas, nearly all local authorities rely on third sector partners to deliver services.

Eddie Follan: There is flexibility in delivery from the third sector. As we have said, third sector organisations are valuable partners, as is the independent sector, which also provides a vast amount of social care.

Such decisions will be made locally and will take cost into account, but they will also take into account the ability to deliver and the local population's needs. It is a complex picture, and some local authorities provide more than others.

Eddie Fraser: The decision about who provides care will be taken by the individual. Under self-directed support legislation, it is not for a local authority to decide that it will be the sole provider of care. An individual can choose to go with a local authority to get care, they can ask the local authority to arrange care for them, they can make their own arrangements or they can do a mixture of all that. Self-directed support legislation gives individuals flexibility to make their choices, rather than us going from the top down and telling people how they need to get their care provided.

David Torrance: How will sectoral bargaining operate across all sectors of provision, including the public and third sectors? The Scottish Government has pledged a rate of £12 per hour. How confident are you that that will be given to a worker no matter who their employer is?

Eddie Follan: I will take your last bit first. The £12 an hour will be passed on through local authorities to individual sectors and organisations—as we did with the uplift to £10.90.

A range of discussions are going on about sectoral bargaining. Local government already has its own sectoral bargaining arrangements, and there is no appetite on our part to take that apart, because the arrangements are fairly established. However, we are keen to support sectoral bargaining in the third and independent sectors, and we are working with the Coalition of Care and Support Providers in Scotland and Scottish Care on how that can be delivered. I am not going to put a level of confidence on that; I keep talking about complexity, but pay negotiations are a sensitive area. However, discussions are taking place, and we are committed to achieving that. Local government's role in supporting those arrangements will be important, and we are looking at different ways of doing that.

Gillian Mackay: How confident are you that the ethical commissioning and procurement proposals for the NCS will ensure that fair work principles are guaranteed for social care staff?

Eddie Fraser: I suppose my answer will be similar to the previous one that Eddie Follan gave. If we are going to have sustainable social care in the future—and commissioning rather than procurement—we need to understand the capacity that is required in social care, to understand the workforce that is required and to be able to pay staff appropriately in respect of that. We sometimes look at the terms and conditions of local authority and NHS staff and see that they are much higher than those of the independent or third sector. How can we bring that sector up to those levels so that the local women that I spoke about earlier get paid a decent wage?

For me, ethical commissioning is about ensuring that the resources that we put into this in the wider public sector will actually deliver that quality of care and that the money will flow through to provide the required capacity and quality of care for people. Ethical commissioning is about ensuring that we have the right capacity and the right type of skills in place. The only way to do that is by paying people well.

Eddie Follan: I wouldnae disagree with any of that, as you would imagine. Again, I am no

wanting to put a level of confidence on it, but the commitment is there to do this and it is the direction of travel that we need to go in. We may talk later about the pressures in the system and the problems that we will continue to have with recruitment and retention unless we have an ethical commissioning framework in place. Is there a frustration on everybody's part that the process is a bit slower than anybody would like? Absolutely. Some of the financial constraints that we face make it difficult, and so do some of the sensitivities around pay and other things. However, we definitely need to do it as soon as we can.

Professor Sengupta: I would pull out two other elements. One ties into the point that Eddie Follan made about funding. It will be real only if we can pay for it, and committee members will be mindful of the significant funding challenges that we currently face in social care and healthcare, and across the public sector as a whole. We therefore need to make sure that we can follow through on whatever we promise from a funding perspective. That is a big challenge for all policy makers at all levels in relation to where we are going in the public sector.

There is also the element of standards and quality of care, which ties into the point about ethical commissioning that Eddie Fraser made. An interesting element that we should embrace from our discussions with Government concerns the national agencies, such as the national social work agency and what it can do and how we can work with NHS Education for Scotland and other colleagues to develop the pipeline for social care and social work staff.

Members will be familiar with the fact that the NHS does well at, and has a real tradition of, offering career structures and pathways for people when they enter at different levels. We are constantly working on that area—we are increasingly looking to develop portfolio careers in healthcare, and it is important that we develop and strengthen similar arrangements in social care. Ideally, we will get to a position in which people are able to move across roles and deploy their skills differently, because that is important. Pay and conditions are one aspect, but the other element is how we continue to invest and encourage people to move effectively through their careers in health and social care, and to do so with a set of standards that provide our communities with reassurance that they are getting the care that they need.

Gillian Mackay: I take on board the issues around funding, but there are other elements in the system, such as culture, that perhaps do not have as many pound signs beside them as some of the other aspects of terms and conditions that we talk about regularly.

Eddie Fraser talked about the number of employers and the fact that some of them are in better places than others on terms and conditions, culture and other pieces. What work is on-going to bring some of those employers who may be at the lower end up to the standard of others? What work is continuing in local authorities to push some of those areas forward so that we are not constantly waiting for big pieces of service reform and so that we take the staff—who are slogging their guts out doing their jobs day in, day out—along with us?

Eddie Follan: I will let Eddie Fraser pick up on some of the work in local authorities. From a national perspective, the culture bit that you talked about is crucial. We have had some quite challenging discussions between employers and employee representatives and with the sector on how that is delivered. It is a really good point, and as part of those discussions, we will be looking at what we can do now. As members will know, we have the joint statement of intent, which was signed when the Feeley recommendations first came out, and part of it is about the commitment to commissioning. We need to think about what we now have to do around the edges of that.

I reiterate that the frustration has been partly down to the funding issue, which is at the core, but you are right that we need to do more around the edges, and we will be working with partners to do that. Eddie Fraser may be able to talk a wee bit about the work that is going on in local authorities specifically.

Eddie Fraser: There are different levels. At one level, we might talk about the role of the Care Inspectorate. No matter what the sector, whether it is the local authority, private or independent sector, it is about ensuring that organisations are run properly. Part of the joint statement of intent, outwith any legislative process, is about improvement in social care, and a national improvement board has been established jointly with local authorities, the Government and the NHS to look at improvement in social care and community health services. Eddie Follan and I chair that board, along with Government representatives.

There is a recognition that improvement in social care and our community services cannot wait on a legislative programme that could take a number of years. We have to move forward outwith that by making improvements and supporting organisations. I do not think that any organisation or individual is trying to deliver poor-quality services, but there will be circumstances in which they can be supported. We need to ensure that improvement is not kicked into the long grass

because of the legislative programme that is being worked on. We should focus on improvement now.

Gillian Mackay: Thank you.

10:30

Tess White: I register my interest as a fellow of the Chartered Institute of Personnel and Development.

My question is for Professor Sengupta. You said that it will be real only if we can pay for it. Most staff—76 per cent—are employed by private sector providers. The current model involves outsourcing to the third sector, and it focuses on cost and the lowest price for those providers. One of the consequences of that has been that, historically, wages have been kept low—if there is competition on price, wages are kept low. In your view, how does that conflict with fair work and ethical commissioning? Does the new model need to involve a significant change?

Professor Sengupta: I apologise—I have a bit of a croaky voice this morning.

We spend quite a lot of time thinking about that issue locally, and I am sure that that will be the case across all areas of Scotland. Value for money is a key aspect of our procurement processes, so I would not characterise the situation as going for the cheapest option all the time. I cannot speak for all areas, but I would say that the main consideration is value for money, which involves balancing a number of elements. Cost is absolutely one component, but others include clarity on reliability of provision, quality and the degree of flexibility depending on the nature of what we are getting.

As has been said, we are talking about a wide variety of services and supports. Such support can be highly personal to certain individuals, particularly if we are talking about complex packages of care that sometimes last years and require a high degree of consistency of provision for the individual. Other aspects—for example, a care-at-home package—can be provided by a range of individuals, provided that that is done properly and it is well organised.

As long as we make best use of the public pound for citizens, we will continue to make best use of that resource. That ties into the point about ethical commissioning, because that involves ensuring that we have a committed workforce, that incentives are in place for staff to do a good job and that they pay attention to the needs of the individual in front of them. However, we must also ensure that that is done in a sustainable way.

From a delivery perspective, we can approach the matter from any number of angles, but the resource needs to be in place to ensure that a range of services and supports are available to the people who need them. The more resources we have, the more options we can provide on the nature and the length of the contracts that we offer. An issue for a lot of providers—this ties into the point about fair work—is whether a contract is for one year or longer. If we have greater stability of funding, we can provide them with a sense of certainty that will allow them to provide a greater degree of clarity for their workforce on pay and conditions and other aspects related to fair work, such as environmental sustainability commitments as we work towards net zero.

We cannot move away from the fact that funding is critical in relation to both the money that people get in their pockets and the sustainability of service provision. Does that go some way towards answering your question?

Tess White: It does. I have a quick follow-up question. At a previous committee meeting, we heard about the model that is used in Shetland. The minister said that it is a great model, so let us use that as an example. Hypothetically, if Shetland's model was a great one to go for and there was a one-size-fits-all approach under the new national care service, local authorities would be forced to apply a model from another area, so costs would increase. Is that a major concern? How would that be managed?

Professor Sengupta: I am working on the basis of the consensus position that was agreed over the summer, which, as I understand it and as has been articulated, emphasises the need for local solutions in that respect. I do not want to speak for the minister, but this is what I understand from when she gave evidence to the committee. She highlighted the experience of Shetland, but she did not propose that that be applied across the piece. The aim is to build on the assets in a particular community—in that case, Shetland—seeing what organisational arrangements are in place that can be deployed, critically understanding the needs and priorities of the individuals who live there, being realistic about how those assets can be deployed from a logistical perspective and otherwise in that environment, and then moving forward in a way that is, we hope, consensual.

That is difficult. I mean that absolutely—that is part of why all of this is difficult. However, we keep coming back to the notion that social care in particular needs to be person led, which means that we need to provide enough flexibility in the system, particularly at the local level, to ensure that we can come up with arrangements that will enable people to get person-led services that can be adapted to their particular circumstances. That will vary from community to community and from client group to client group, depending on the level of needs.

Do not get me wrong—there is a lot that we need to do in Scotland to share learning. The Health and Social Care Scotland chief officers are spending an awful lot of time engaging in sharing information, bringing in speakers who will tell us what they have done and giving a lot of consideration to how we can reflect on our performance to scale up better. The same thing applies across local government, health boards and other parts of the public sector. We all recognise that we need to do better here, but we also recognise that a challenge that we continually get within our local areas from elected representatives and local communities is how we can make sure that the services that we provide are credible and personalised to people in the places where they are provided with them.

Stephanie Callaghan: Thank you for joining us this morning. I am really interested in co-production and regional forums. Have any of you or your staff been along to any of the regional forums? It would be really interesting to hear about any feedback and learning from that. What are your thoughts on co-production and co-design and how they can achieve transformational change?

Eddie Follan: Our staff have certainly been along to the co-design sessions. One of the things that we were able to move forward on with the political agreement that we came to in June was our involvement in co-design. As you know, our leaders had taken the decision not to do that because at that point we were opposed to the approach. It has been really good to be able to get involved in that work. The Government has done a huge amount of work on it, including through the summer forums, and I know that the minister talked to the committee about that.

From our perspective, it is really important that those sessions are taking place locally. We have a range of voices nationally who will have views on how things need to progress and what sort of system we need to have, and that is absolutely valid. However, the aim with the co-design sessions was to hear locally the voices of people with experience of the system and to find out how people feel about how it is delivered. The crucial thing about what came from those co-design sessions is how it informs the discussions that we are having nationally.

I absolutely get the fact that there were people and organisations who saw the bill going in one direction and then we took a position on that. In fact, it was not just us, but also trade unions and others. There were a wide range of views on the bill. We really welcomed the change of direction and where we have got to. However, I know that that probably caused a bit of concern among people with lived experience and some of the disabled people's organisations. Our commitment is to make sure that, whatever system we end up with at the end of the process, it is informed by those co-design sessions, by those organisations that represent people with lived experience and interests, and by people with lived experience themselves. We are entirely committed to that.

A lot of the stuff that came from the co-design sessions was really helpful. It reflects our thoughts on prevention, getting in early and ensuring that care follows the person to achieve consistent outcomes. One of the big things that we heard about was the need for care packages to be transferred when people move. That is all hugely valuable with regard to how we take our work forward when we are in discussions with the Government and other stakeholders.

Professor Sengupta: Similarly, I have had staff attend the sessions. It is to the credit of the civil service that it has put such energy into that work in a relatively short time. We have had good feedback with regard to what has been shared. However, the proof of the pudding will be in the eating, which speaks to Eddie Follan's point. We have a critical interest in how the issues that have been raised through those processes will be factored in to the next round of draft material that comes from the Government.

Elements of what has been highlighted were quite reassuring, because they demonstrate that there is still consensus on the issues that we need to do better on. However, there are aspects that are just hard. An example is early intervention and prevention. All chief officers across Scotland would absolutely emphasise the importance of our doing better in that space and redesigning the system to do better. However, members of the committee will be familiar with the fact that that issue has been talked about in Scotland for years. We could talk at length about the Christie commission, which talked about early intervention and prevention. The real challenge lies in being able to translate the appetite for working in that space into consistently doing that in practice, ensuring that we have the funding for that and transforming services so that we can move upstream. I do not envy civil servants that task.

That is why the co-design process continues to be so important. We need to recognise that we have a series of principles that—broadly speaking, from what I can see—stakeholders can mostly get behind. The challenge is to see how to embed them in a system that will deliver consistently.

Stephanie Callaghan: Last year, the Scottish Government said that co-design would produce a charter of rights, a national complaints process and an electronic health and care record, but not services. At this point, are you clear which aspects of the national care service are being co-designed,

who will be involved, and when and how they will be involved?

Eddie Follan: The change of direction has probably had an impact on that aspect. We are working with the Government on the single shared record, which is a really important initiative, and on a range of digital initiatives. However, I go back to the point that we are still trying to come to a political agreement on some of the big areas that we have talked about, such as commissioning, procurement, funding and other aspects and how those will be delivered, including through care boards, the national board and aw that.

Discussions are continuing on the single shared record and Anne's law. We have never had an issue with those areas from a local authority perspective. It wisnae that we said, "We're no gonnae do anything to do with the NCS." We have been working with the Government on that and, as far as I am aware, it has been discussing the areas through its co-design processes. At the moment, our focus is on ensuring that we can politically get a lot of the big stuff over the line with a fairly limited timescale. The discussions on the other things, such as Anne's law and the shared single record, have been going on for a while.

Stephanie Callaghan: That is fantastic. It is good to hear that there is that positive commitment and shared focus.

Sandesh Gulhane: Professor Sengupta said that some elements will be hard and Eddie Follan said that you are dealing with a very short timescale. Is that timescale not arbitrary, given that we have already had a delay to stage 1? Would it not be better for all of that to be ironed out in advance so that we get agreement, rather than the process being fast?

10:45

Eddie Follan: I guess that we are working with what we have. It is really important that we put in every effort to meet the timescales for the bill, which is what we are doing. It is also really important that we get it right and ensure that whatever system we have at the end of this will be effective.

Primary legislation is important. Elements of what we are talking about will require primary legislation and we do not want to lose that opportunity, but you are right—the main thing is that we get it right for people. We will continue to work in partnership with the Government on the areas that we are working on at the moment.

Sandesh Gulhane: You said that, if packages of care are transferred when people move, we could get some standardisation. Do we need co-design and a process like this in order to achieve that? Is it not something that we should be doing right now?

Eddie Follan: There are a range of constraints on how we deliver at the moment. Everybody is committed to reform and everyone has recognised that we need reform of the social care system. There is no doubt about that. There are things that we do not do well that we need to do well, and we are in a reform process at the moment. There is a legislative element to it, but there are also things that we need to be doing now, as Eddie Fraser and Soumen Sengupta touched on in relation to the statement of intent. We do not want to simply stand still and say that we will wait for the legislation. That has never been our position. I agree that there are things that we need to do now.

I do not know whether my colleagues want to add to that.

Eddie Fraser: From SOLACE's perspective, we are clear that we would rather have had a lot of these conversations before there was a bill—for example, conversations about whether children's services and justice services were to be included. However, we accept that we are where we are, and we are making progress in our discussions. This really matters. It matters to the people who get services and the people who work in health and care. In relation to where we are just now, it is important to understand what needs to be in primary legislation and to make sure that there is trust about what will be in secondary legislation and guidance.

The transferability of support is really important but, again, some of that comes down to what is available in local areas. For instance, one area may have a lot of supported housing available while another area may not. The types of support that people get will differ between areas, but the outcomes for people should not. People should be able to define what outcomes they want and use the local infrastructure to get that.

You asked about the time that has been taken. It will take time. Just now, it is about determining what needs to go into primary legislation and making sure that there is that trust. That extends back to the co-design question, because I think that we have lost some trust and understanding. People feel as though there are rooms somewhere where decisions are being made that they will not get a say in. It is about emphasising to people that this is still at the framework level and that they will get a say in how things will be. We need to get that important message across to people or they will lose trust not just in the Government but in the situation and all of us as partners.

Sandesh Gulhane: I turn to my final question. I have twice heard you say, "We are where we are",

but we are not, because we have already had the delay, so I fail to see why we could not have another delay in order to get things right. When it comes to the co-design process and trust, are you happy that there is enough transparency in that process? Are you happy that the things that are said will be reported and that there will be transparency in how they are amalgamated and brought into the general work that will go on afterwards?

Eddie Follan: From our perspective, they have to be brought into the process. There would be absolutely no point in having a co-design process if it doesnae inform what we do. Why would we do that in the first place? I am sure that the Government created the process in order to get those voices in. As I said to Ms Callaghan, it also ran a series of sessions over the summer to try to address some of the issues about the change in direction. As Eddie Fraser said, we need to build trust again, because that change in direction left people wondering what had happened and why we were going one way but are now going another way. If we have to rebuild trust, part of that negotiation—whatever happens in Parliament—must be about ensuring that the views that have been put forward are reflected.

One of our initial criticisms of the bill was that it was a framework bill and a lot of the detail would be left to secondary legislation. I do not want that to be the same for people who have put time and effort into the co-design process. They need to know why decisions have been taken. Some decisions may well not reflect the views that people have fed in, but there has to be some sort of trade-off. Our view is certainly that that should be the backbone of how we design the service. At the moment, as I said, we are trying to get political agreement on the framework so that we can move forward, because we werenae moving forward previously, as the committee knows.

The Convener: Paul Sweeney has some questions.

Paul Sweeney: I thank the witnesses for their contributions so far. The minister gave evidence to the committee prior to the October recess and her officials confirmed to the committee that the co-design process for the charter of rights is still on-going. Have any of you been involved in a specific example of co-design in relation to the bill?

Eddie Follan: We have been involved at officer level in discussions about the charter. I do not want to say that I am pretty sure about our involvement and then have to come back to you to confirm it, but our team has at least been involved in sitting in on some of the co-design sessions on the charter. I know that discussions about the charter of rights are on-going at official level.

Paul Sweeney: Do you feel that such an inherent part of the legislation and such a critical part of the ethos of how it will operate should be formed as a product of co-design with local government? Should that be a principle?

Eddie Follan: I think that it should. It has to be, because many things in the charter of rights will have implications for service delivery. Those implications might be structural or financial, but we are never going to realise rights if we do not have the infrastructure and resources in place to deliver them.

I know that Eddie Fraser will have a view on that, but we absolutely want to be involved. We must be clear about what people's expectations are. They will, absolutely rightly, have expectations from the co-design process. I am not making excuses about money, but we must ensure that we deliver on those expectations, and we need the resources to do that.

Eddie Fraser: The independent review of adult social care focused on human rights, as did the discussion with people who use services and with family carers, so the charter has to reflect some of that. It has to come from what the regional forums are saying. After that, there will be a place for local and national Government to look at what they have been asked for, then take that back to people and ask whether it really reflects what they have said. Does it really reflect their aspirations for human rights? If some of that fits within the framework of what we can do and when, that is fair enough.

I spoke about trust. If we are asking people in regional forums for their views, and if those people have aspirations that come from the independent review of adult social care, it is important that that is written down and that people will be able to see their aspirations in the charter, which should show what they can expect. There is a role for us in local government, but it has to be to ensure, at the right time, that we are looking at what people have actually said.

Professor Sengupta: One of the interesting challenges—I use that word a lot—in respect of the issue concerns the reform piece that we have talked about. Eddie Fraser talked about it in particular when we were discussing packages of care. For me, one of the interesting elements around a charter of rights is the shift to thinking about those rights in terms of outcomes and, to some extent, structures instead of thinking about them in terms of activities or processes. That is a big shift. The independent review speaks to that when it talks about moving away from what is essentially a system of quasi entitlements to thinking about how we can make people as independent as possible and enable them within their communities. Some of that ties into the

feedback, which has been received through those processes and others, that people want to be as independent as possible.

A point was made earlier about the culture and the ethos around social care and social work. The issue is how we bring that ethos and the feedback that we continuously hear from community voices and others into such a charter. The approach is less about whether someone is entitled to products X, Y or Z and more about us working together with the person to get them to X level of independence or Y level of another outcome so that they can enjoy their life. That is really tricky, but it strikes me as being slap-bang in the centre of what the Christie commission talked about, and it is central to a human rights approach to social care, social work and healthcare. If our work is to be person led, a focus on outcomes in this area is crucial.

Paul Sweeney: I appreciate those points. Please keep us updated on your co-design activity and whether you feel that it is useful and sufficient.

Do you feel that, once the charter of rights is codified—to a satisfactory standard, hopefully—it should in principle be on the face of the bill?

Eddie Follan: I will have to come back to you on that, Mr Sweeney, because I need to go back and check where we are on it. However, in my view, if we are going to have a charter of rights, it needs to have the strongest possible effect.

Paul Sweeney: Okay. Thank you for that.

Evelyn Tweed: Good morning, panel, and thank you for all your answers so far. Your evidence has been illuminating, as ever. My first question is for Eddie Follan. You have been very positive about the Government's further engagement over the summer. Do you feel that the bill is going in the right direction? Do you feel that some consensus is now being found and that we can move on positively?

Eddie Follan: That was the whole point of the agreement that we made on 30 June. We were not moving forward, so we genuinely appreciated the Government's change of direction on where we are going. Over the summer and up to now, we have continued to have fairly intensive negotiations on a range of really complex issues. They are moving forward and we are moving forward with them. As I said, the timescales are extremely challenging because of the complexity of the issues that we are addressing—there is no doubt about that—but we remain committed to moving forward on the timescales that we have at the moment.

Eddie Fraser: I will add to Eddie Follan's positivity on that a wee bit of my scepticism. It goes back to the fact that the first that we saw of the bill was on the day when it was published. The bill involves a huge part of the services that local government is responsible for providing and that I am responsible for managing. We have worked well on how we can bring forward further proposals for our politicians at both local and national Government levels to consider. When I see what has come out of that and how much we are engaged in reforming the bill between stages 1 and 2, I will feel more certain about things. Given that we saw a bill with such a big impact on local government only on the day when it was published, we do not have a high level of trust. The work that we do must rebuild trust to ensure that, when we see changes come through in the next iteration of the legislation, we feel that we have been included in the process.

11:00

Professor Sengupta: I will try to find some middle ground here. Civil servants have been engaging regularly with the chief officers group, and we appreciate seeing them. However, Eddie Fraser's point about the timing of some of the announcements is well made. We are public servants, and one of our roles is to provide expert advice on such issues, be it to our IJB members, local elected members of all persuasions, the health boards of which we are a part, or indeed our constituency MSPs. We are available as a resource, not just because we understand how the services run and the needs of the local populations for whom we are responsible but because, frankly, we are experts in different aspects of our field.

We are therefore keen to contribute to the process, not just because this is a vital piece of legislation and a significant area of reform for Scotland, but because we want to help to get it right. We have a massive amount to contribute in that respect. So far, I am encouraged. I am hopeful that our civil service colleagues will continue to engage with us on that basis, and I very much look forward to ministers continuing to lean into our advice and expertise alongside all the other voices that they are listening and paying attention to.

Evelyn Tweed: Do you have any insight into whether the recent changes to access to funds for unpaid carers have made a difference? Eddie Fraser, would you like to come in?

Eddie Fraser: I do not have any insight, data or anything else to enable me to tell you whether the changes have made a difference. To be honest, I think that significant changes will need to be made to funding for unpaid carers if any difference is to be made. We must try to support people who use services or unpaid carers and find out what their aspirations are, in that respect.

The resources that are received by unpaid carers are still low, if we are talking about recognition of their work. I recognise that the Scottish Government has put in additional resources to support them, but we need to work with, for example, our local carers centres and ensure that resources are going in that direction. I totally welcome resources going to unpaid carers, but if we want resources to be life changing, significant changes will need to be made.

Eddie Follan: I certainly agree with what has been said, and given the representations that we get from unpaid carers and the organisations that represent them, I say that they would concur. More resource is needed to support them.

We also need to guarantee sufficient capacity in the system to support unpaid carers. Local authorities and health and social care partnerships play a crucial role in supporting them—I assume that we will be talking about that, too—but the fact is that things are stretched. Without unpaid carers and the important role that they play, it would be almost impossible for the system to operate at all, in many respects. We need to ensure that we have the capacity to support them, which brings us back to the right to breaks and so on.

I know that Soumen Sengupta is closer to the matter than I am.

Professor Sengupta: I am happy to pick that up.

I will tease out the point about stretched capacity. As members will be well aware, we are facing a massive workforce supply challenge in social care and social work and the infrastructure around it. To an extent, that ties into the earlier point about improvement to support in the independent sector. In my area, we are stretched very thin in respect of our ability to engage in all areas. We want to do that and we have networks in place, but because of the level of demand, engagement is getting harder and harder. That is partly, frankly, about money—I know that I keep on saying that, but we have massive funding shortfalls to deal with, which members will be familiar with—but it is also about our ability to recruit staff to fill vacancies and to have time for the staff group to develop and grow.

That is a massive change that we are looking to take forward. That is true across all areas, but it presents challenges in terms of the support that we can provide in the here and now for groups such as carers. Carers centres are massively important in that respect, which is why it is so important that we have in place local arrangements that make sense for carers in various communities. That point was made in relation to Shetland. We need to be very wary of one-size-fits-all arrangements. We need to be familiar with different histories and with different sets of assets, preferences and geographies.

As well as carers centres, our third sector interfaces and other key groups help us, as a system, to work effectively and to understand better what local carers need. I accept that we are talking about a range of carers, and that there are no homogeneous groups. We are increasingly seeing that people who are older are caring for elderly relatives. We also need to be familiar with young carers and the increasing demands and challenges for them: we need to ensure that we can properly support them at all stages.

As our understanding of the complexity of the issues increases, so does the challenge for us in respect of having the capacity to come up with personalised solutions. Money is part of that, but it is also about having the flexibility and, frankly, the time at the local level to engage properly.

We have had quite a lot of discussion about co-design; I believe that its principles strongly apply to how we work with our carers. We need to ensure that we co-design arrangements that are sustainable and realistic.

That also applies to the supports that people know they can get from us, but we need to enable carers to support themselves and each other as far as possible. Some individuals who have caring responsibilities are, understandably, looking for a lot of support, but—as members will all know from constituency work—other carers need just a bit of help at specific points, then need the state to back off and let them get on with it. Again, that is why personal conversations and a person-led approach are so important.

Tess White: Professor Sengupta said earlier that it will be real only if we can pay for it. We have talked about the balance between the one-size-fits-all approach and variety. The one-size-fits-all approach is a lower-cost model, but when you add variety you add complexity and cost, so you cannot have both. I realise that that is a dilemma. With the NCS, we started off talking about a one-size-fits-all approach, but we have now moved completely to a different model—I could say that it is a fudge, but we are saying that we will have variety and we will individualise, but that has a huge cost.

Professor Sengupta: So, what is your question?

Tess White: My point is that you cannot have both. Your point was that it is not real if we cannot pay for it, but the new model talks about variety and individual needs, while the one-size-fits-all approach is a low-cost model.

Professor Sengupta: I hope that, as the bill and the approach progress—this is reflected in

some of what Eddie Follan has said—we will be looking at a continuum that will vary for the different groups for which we provide care. Some needs can be met with fairly standardised approaches, but others require a high degree of individualisation. We need to be much more sophisticated in how we articulate that as we move forward. We need to move away from talking about our population being homogeneous, because it is not, just as we need to talk about our social care services in terms of the full span of what they deliver, rather than in terms of single banner headlines.

The challenge in the world that we live in at the moment—it will be a challenge going forward—is in striking the right balance. I do not envy policy makers such as you the challenge of working out the right level of elements that need to be managed at national level to get the best value, the elements that are best dealt with at local level and the areas that are best progressed at neighbourhood level. Obviously, that all falls under aspects of the Community Empowerment (Scotland) Act 2015 and other legislation.

I suggest that those are the challenges for any area of public policy development in Scotland at the moment, but we need to be more nuanced in our thinking about health and social care, rather than choosing between the binary options of the one-size-fits-all approach and flexibility.

As we do that, it is important to recognise that we are working on areas that would have more value if they were done nationally. Some of that would be to do with the national standards being agreed, and other elements would be to do with workforce development and professional support for our social care and social work workforces, based on understanding and recognition of what they do, and work on national campaigns.

I am conscious that one of the elephants in the room is winter pressures, which relates to the point about timescales that was made earlier. We like working and living in a democracy, so we will work with whatever timescales Parliament deems to be appropriate, as we would with local government. However, we are doing all this work as we stare down the barrel of what will be another tough winter, having come out of the worst winter on record, which followed what we thought then had been the worst winter on record.

We need to be thoughtful about where we prioritise our efforts and whether there are areas in which we can do better nationally, and we need to have the humility to say that it would make sense to do some of that work at the national level. We could certainly consider some national procurement through the Scotland Excel model. If the committee were to have a conversation with colleagues from Scotland Excel, I am sure that they would talk about a range of areas in which we could work better if we had the appropriate arrangements in place.

By the same token, in funding, for example, if we had greater flexibility in how we use the resource at the local level, there are aspects in which we could probably act in a much more agile fashion and personalise services for local communities much more.

The Convener: We move on to our final theme, with questions from Paul Sweeney.

Paul Sweeney: Our notes say that delayed discharge has cost the NHS £190 million in the past year. That is clearly an opportunity cost. A lot of it is to do with the lack of efficient integration of healthcare with social care and hospice care. Do local authorities receive sufficient financial resources to deal with social care and efficiencies in the here and now?

Eddie Follan: There are always challenges with the financial packages that we have, and we can talk from a health and social care perspective about the deficits that many boards are carrying. COSLA has been clear that we need more resources.

As we have said previously, many of the issues around delayed discharge relate to recruitment and retention of staff, and to what staff get paid. Delayed discharge is not just about social care; we need to think about a whole-system approach to tackling it—from primary care right through to social care. We have been clear that the social care system isnae there just to support the health service—it is a whole system of care from GPs right through to care homes and care at home.

There are financial issues and there are also recruitment and retention issues. It is about the flow of people through hospitals, conveyance by ambulance, the accessibility of GP and primary care services and making sure that we get our hospital discharge processes absolutely right. It is about having a planned date of discharge. There is also a range of issues around discharge without delay.

There are other issues, such as arrangements for adults with incapacity. Lots of people are stuck because of the arrangements for them. From a COSLA perspective, and from a national perspective, we need to work to support local areas in that regard. However, we need to ensure that we are taking a whole-system approach and are not just looking at the situation from one end. I know that both people sitting next to me have views on that, too.

11:15

Professor Sengupta: As Eddie Follan said, delayed discharge is about flow through our system. However, to begin with, I would like to take a step back from that. For the avoidance of confusion, I will say that we do not want individuals to be delayed unnecessarily in hospitals. It is not good for the individual in terms of deconditioning and their ability to get back into their lives and be with their families. Being delayed unnecessarily in hospital is not an attractive proposition for anybody, and that is one of the reasons why our systems and services spend hours and hours every week trying to see how we can get people home at the best time.

However, I suggest that focusing on delayed discharge as a singular measure of success of our health and care system is problematic. I feel strongly that, as Eddie Follan said, we need to think about the entire system. In fairness to Government and civil service colleagues, I note that the national hospital occupancy and delayed discharge plan reflects the necessity of a whole-system approach, with a focus very much on the principles of discharge without delay—in other words, reducing the length of stay for everyone in hospital.

The increase in length of stays in hospital varies by area. Some data that I have seen on that, which I am happy to share, suggests that, over the course of the pandemic, the average length of stays in our hospitals went up by one day. If we were to move the length of stay down to pre-pandemic levels, that would have a massive impact on occupancy levels across the piece. That ties into people turning up at our emergency departments in higher numbers at various times; we need to ask about the reasons for that. The matter is to do with the flow through the hospitals, so we need to make sure that colleagues within all areas are properly supported to work in different ways and that they have sufficient staff on hand.

What we do in relation to the discharge process is important, but we also need to make sure that we are providing packages of care only to the people who need them most. I feel strongly—as, indeed, do my counterparts—about realistic care. The committee will be familiar with the chief medical officer's approach to realistic medicine: the same approach can be used with regard to care. We should not provide packages of care to people who do not need them, and we should be providing packages of care in a way that enables people to live as independently as possible.

That is one of the reasons why, for example, the home first approach that has been rolled out across Scotland is important. It is about providing wraparound care to the people who need it most, so that we provide the core supports that they need but no more than that. That is important, because the more support that is provided, the greater is the potential for the individual to become deconditioned, but there is also less resource available, which means looking after fewer people. The approach requires reform across the entire process.

Again, delayed discharge affects a relatively small percentage of people who move through our hospitals. The vast majority of people who are discharged from our hospitals do not require complex packages of care and are discharged effectively. However, there is a big challenge around thinking about the totality of system capacity. I am sure that the committee has, on other occasions, discussed at length primary care capacity, the capacity of hospitals and so on. We cannot look at those issues in isolation.

There is an issue about the message that social care is not there to provide support to health care. That speaks to Eddie Follan's last point. I say that as somebody who is—putting aside the hat that I am wearing today—an executive director of a territorial board and someone who has responsibilities on behalf of the council for delivery of social care as part of an HSCP. Our staff who work within social work and social care do not join that profession to help hospitals: they do it to help people in our communities who need help in their homes and, sometimes, in our hospitals. They increasingly work well with our healthcare colleagues, including our colleagues in hospitals; many of them work in our hospital-based social work teams.

Nonetheless, it is important that we send a strong message to our social work and social care workforce that they are valued for who they are and for what they bring to the system themselves, rather than suggesting that, somehow, the only credit that they bring to the system is to do with whether a delayed discharge figure has gone down. Again, I say that on the basis that, although we all want delayed discharge figures to come down, there are, in the system, other measures of value to which we need to pay attention.

Finally, I agree about the money: we need the resource. I say that partly because, as Audit Scotland has highlighted, IJBs are running significant recurring deficits. To a greater or lesser extent, most of us are now able to balance our books this year, and some are planning to do so into next year on the basis of non-recurring moneys. That is not sustainable—we know that it is not sustainable, and our external auditors have told us that it is not sustainable.

Therefore, we are having to look at how we can cut our cloth accordingly right now. In addition to dealing with the winter pressures that are in front of us, we are having to think about significant

service reform, given the significant cost increases that we are experiencing as a result of, for example, inflation and what that means in real terms for the resources that are available to us. That was not to the same extent a challenge that we faced last year or the year before, but it is a very real challenge that we face here and now.

Paul Sweeney: I appreciate that outline and your helpful explanation of the complex interfaces between the acute hospitals and social care settings. The fixation on delayed discharge might be to do with the fact that it is a clear measurement, whereas something such as avoidance of hospital admission is harder to quantify in firm numerical terms. That is a fair challenge.

However, I highlight the fact that Scotland's acute hospital expenditure relative to expenditure on the healthcare system overall is probably among the highest in the Organisation for Economic Co-operation and Development. How do we pivot that back towards a more sustainable ratio that is more in line with OECD averages? How will the health and social care integration that is proposed through the national care service help to improve processes such as design processes, and to improve integration by pivoting the system away from the acute hospitals and more towards community settings?

Eddie Fraser: A charter of rights has been mentioned. Soumen Sengupta is right to talk about where we can be just now, but we have spoken about the importance of prevention and about the human rights that came out of the independent review of adult social care. Nearly £200 million is spent on dealing with delayed discharge from acute hospitals. If that was spent in the community on delivering things differently, that could provide much better outcomes for people.

You are absolutely right—but what is the trick when it comes to moving that money across? We have not achieved that. The Public Bodies (Joint Working) (Scotland) Act 2014 called that "set-aside" money. Under the 2014 act, the plan was always that, if the IJBs were able to plan differently for the community, they would be able to draw money down, but that has not really worked. Because of the continued pressures on delivery on the acute side, there has never been any money to release to be drawn down.

The core issue is how we spend money in the right place to get the best effect for people. That is what will determine whether the bill will make a difference, and will follow on not only from the independent review of adult social care, but from self-directed support. I spent seven years as a chief officer at an IJB, so I totally understand the day-to-day pressures. We all absolutely accept that, as Soumen Sengupta said, leaving people in hospital for lengthy periods, which results in their health deteriorating, is not what anybody wants.

It is a challenge for us all to ensure that the money moves to the right place. To be frank, despite the 2014 act, we have not yet achieved that. One argument would be to say that that is because there is not enough money in the system overall. Another challenge is to do with where the money is in the system and how we might move it.

The Convener: Thank you. I thank the witnesses for their attendance and their evidence to the committee, which I am sure we will find very helpful.

At next week's meeting, we will take more evidence in the committee's on-going stage 1 scrutiny of the National Care Service (Scotland) Bill. That concludes the public part of today's meeting.

11:24

Meeting continued in private until 12:20.

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