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Health, Care and Sport Committee

Comataidh na Slàinte, Cùram agus Spòrs

Wednesday 9 September 2026

Session 7

The Scottish Parliament
Pàrlamaid na h-Alba

Wednesday 9 September 2026

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HEALTH, CARE AND SPORT COMMITTEE
3rd Meeting 2026, Session 7

CONVENER

*Helen McDade (Mid Scotland and Fife) (Reform)

DEPUTY CONVENER

*Jack Middleton (Aberdeen Central) (SNP)

COMMITTEE MEMBERS

*Heather Anderson (Dundee City West) (SNP)
*Adam Harley (Strathkelvin and Bearsden) (LD)
*Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green)
*Joe Long (Mid Scotland and Fife) (Lab)
*Paul McLennan (East Lothian Coast and Lammermuirs) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Gareth Adam-Hammond (Care Inspectorate)
Jill Laspa (Convention of Scottish Local Authorities)
Professor Donald Macaskill (Scottish Care)
Donald Macleod (Self Directed Support Scotland)
Paul Traynor (Carers Trust)

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health, Care and Sport Committee

Wednesday 9 September 2026

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Helen McDade): Good morning, and welcome to the third meeting in 2026 of the new Health, Care and Sport Committee. We have received no apologies.

I begin by asking committee members whether they agree to take in private consideration of our approach to pre-budget scrutiny, and all future consideration of our work programme and reviews of evidence. Do we agree to do so?

Members indicated agreement.

Key Issues in the Social Care Sector

09:30

The Convener: This is the second of a series of meetings that we are having to enable members to gain an overview of the key issues in the health, social care and sport sectors. Today's evidence session is about social care and we will hear from a cross-section of key organisations and individuals.

We can run until 11.30 am. However, I understand that Professor Macaskill has to leave before that. If we are still running then and you need to go, that is understood.

I welcome our witnesses and thank them for coming. We are joined in the room by Paul Traynor, head of external affairs, Scotland, at the Carers Trust; Rachel Cackett, chief executive of the Coalition of Care and Support Providers in Scotland; Professor Donald Macaskill, chief executive of Scottish Care; Jill Laspa, policy manager at the Convention of Scottish Local Authorities; and Gareth Adam-Hammond, chief inspector for registration and complaints at the Care Inspectorate. We are also joined remotely by Donald Macleod, chief executive at Self Directed Support Scotland. I thank you all for joining us.

We did not ask for opening statements, although I think that everybody submitted additional material for us to look at beforehand. I am happy for you all to give us a brief overview, in the short time that we have, of what your organisations are thinking in relation to the changes suggested in the programme for government.

I will start on my right, with Mr Traynor, and go round the table, coming to Mr Macleod last.

Paul Traynor (Carers Trust): Thank you for inviting us to the committee today.

As the committee may be aware, unpaid carers were not specifically listed in the programme for government, which we are concerned about as an organisation. Carers Trust is one of the national carer organisations in Scotland, and we are a membership organisation of local carer centres and young carer services all across Scotland. A key aspect that was apparent to us in the programme for government was the lack of specific mention of unpaid carers as well as of wider local carer organisations.

One of the biggest challenges is the gap between growing demand and available support. Unpaid carers often take up some of the gaps that are experienced across society when health and social care services are limited or reduced. That is why it is vitally important that unpaid carers are

specifically mentioned in the plans for the programme for government going forward.

One of the key pieces of Scottish Government legislation that was passed in the previous parliamentary session was about a right to a break from caring, which we welcome. However, although it is obviously the intention to continue to progress with that, I was surprised that nothing specific was mentioned on it in the programme for government.

There needs to be more focus on unpaid carers and the vital role that they play as a key part of the infrastructure of health and social care. In Scotland, there is estimated to be between 700,000 and 800,000 unpaid carers. That is a mass of the population providing unpaid care. However, very few carers are receiving statutory support, due to local eligibility criteria for that support, which causes real complications for unpaid carers. Very few meet eligibility criteria for social security benefits, and there is a lack of carers being systematically identified and referred to the support that is available across health and social care more generally.

We would have liked to have seen more presence of unpaid carers in the programme for government.

The Convener: Thank you, Paul.

Rachel, would you like to give your organisation's perspective?

Rachel Cackett (Coalition of Care and Support Providers in Scotland): Thank you, convener. It is good to see you all and to be back around the table after the election.

As the committee will know from our submission, CCPS represents not-for-profit providers of care and support across all age ranges across Scotland, from very large organisations to much smaller ones.

Our response to the programme for government was mixed but open minded. On the one hand, we would absolutely agree that the need for social care reform is way overdue. It was attempted in the previous session, but it did not get through. I will, in due course, briefly lay out why that reform is desperately urgent.

We appreciated an acknowledgement in the programme for government of the precarious state of the sector at the moment. It is under untenable pressure and it is no longer in a sustainable place to take us through to the ambitions that the Government has set out. We need to focus on that.

I will move on to where we were ambivalent, noting that we are still working with our membership to come to conclusions. Something that I suspect took us all by surprise is that we have a three-month period in which to respond. At this point in time, we are not sure whether that three-month period has started, when it stops, what the key questions are, what we are being asked to answer, or how we will be engaged—although I can see that there is a commitment to engage with us and the providers that we represent. It feels like we have to move pretty quickly, because the urgency is there—and that urgency is important. However, we now need to see the plan for how we get to a conclusion, which is, at the moment, missing. The answers to why that really matters come to me from my providers every single day.

First of all, up until the programme for government, the three words that we were using were not "national care service", but "public service reform". It is important to say to the committee that it is important to us that it is "public service", not "public sector", reform. Our big message is that social care provision—most of which is not done within, but commissioned by, the public sector—is an essential part of the public service that is offered to communities across Scotland. Public service reform must be reform in service of the public. That has to be our focus: the focus must be people. We must be a central part of not only the delivery, but also the design of that. Nothing will be designed well without our engagement from the start.

The second point is that, without a doubt, the current funding and commissioning processes in social care are broken. They do not work for anybody. We have shared some reports that we put out a couple of weeks ago on funding and governance of the sector. Not only is there not enough money going into the social care system to deliver on priorities—although there is not—but we have a very fragmented approach. That has emerged over many years, often from good intentions, to try and manage perverse consequences that have been baked into the system. However, we now have a deeply confusing process for funding getting to the front line.

The third point relates to workforce. We maintain a completely unjustifiable differential between what the Government is willing to pay social care support staff in our sector compared to the amount that goes into public sector providers to do an equivalent job. We have to deal with that.

Further, in relation to the programme for government, we were not expecting the First Minister's comments around the national health service and the role of the NHS in a future social care landscape. Those comments were not in the written document, but they were in the First Minister's speech. He said that, if we are to undertake reform, he could not see how accountability, decision making and funding

should not sit with the NHS. We, like everyone else, are now going to have to think about the implications of what that means. That statement, in and of itself, can be read in many different ways; it is not detailed enough to be completely clear.

We are not clear about what is on the table during this three-month consultation. Is everything on the table, such that we can try to find a means of improving the social care system so that people can thrive in their lives, in their communities, with the right support? Or are we looking at how we improve the processes, if the NHS is to be in control? I am not yet convinced that I am clear about which of those we are doing during this consultation period.

If we are going to make a change, and if we are not going to repeat the accountability fight that was the debate on the national care service—which I cannot imagine that any of us want to do—then we need to be clear that the leadership is across our system, and that we have supported people and their carers, who have an essential voice in shaping what comes next.

This cannot be a fight with lines drawn now, before we even begin, about who owns the money. The people who should own the money are those working at the front line using self-directed support, who should be able to get the support that they need when they need it. We should bring the people back to the very centre of the discussion—not the power structures and other structures.

Professor Donald Macaskill (Scottish Care): I do not want to repeat everything that Rachel Cackett has just said, but I would absolutely affirm everything that she has said.

Before I share our organisation's perspective regarding the programme for government, I want to say that it is important that both the committee and wider Scotland understand what we are talking about. We are not talking about a set of services and supports whose primary focus and aim is to support the NHS, however critical that may be; we are talking about supports that enable people to live their lives to the full, regardless of whether or not they may be living with a disability, living with the consequences of frailty, or indeed living with dementia or any other condition.

Social care—the name says it all. It is about enabling citizenship, enabling people to belong to their communities and enabling them to live the life that they want to live as fully as possible. This discussion is therefore not about maintaining people where they are or how they are; it is about enabling structures, systems and supports to allow individuals to live as citizens of Scotland.

It is important, first, to emphasise the social dimension. From the 1960s onwards, Scotland, uniquely, has celebrated the idea that care and support is in community, and it is part of what we mean by "community". Everything else that I will say is predicated on the importance of seeing social care as something distinctive and as something that enables community and that is inherently to do with our human rights as individuals.

As an organisation, we welcomed the First Minister's statement and indeed the programme for government, because we know that social care is not working. I have appeared before this committee on numerous occasions over the past decade in my current role, and I can say that social care is not working today, to an extent that I have never seen. It is not working for the woman in the north-west of Scotland who cannot get a care home bed and has to wait for nine months, at the end of her life. It is not working for the person with a disability who is unable to access care and support in their own home and is recommended to move into residential care, which they do not wish and do not require. It is not working for the thousands of women and men who deliver compassionate, dignified care in our communities every day but are paid the living wage—a wage that does not enable them, as citizens, to thrive and to contribute.

We recognise that the system is not working. Our health and social care partners will identify a shortfall of nearly £500 million. There will be an opposite view, that the debt level is not as great as that. However, it is not as great as that because, as for the woman in the north of Scotland, it takes three individuals to make a place available—to die—in a care home in some parts of Scotland before someone gets a bed. In many parts of the country today, only 10 or 20 per cent of an individual's package of care is reprovisioned when they no longer require it. That is the Scottish impact; there is also a global impact.

Before I came here this morning I noticed that gas prices opened 6 per cent up on what they were yesterday. Our members, particularly those who are dependent on residential and nursing homes, are now paying twice as much for gas supply as they did this time last year. Oil hit $100 a barrel this morning. Our care-at-home members are struggling to pay petrol costs in paying their workers to deliver the care and support that is so necessary.

In relation to both the global challenge and local circumstances, we need to get around the table. Scottish Care is therefore delighted to accept the invitation of the First Minister and others to have a thorough review. Nothing is off the table. Let us explore the possibility of new commissioning models and a greater role for the NHS—but not a role that diminishes social care and not a role that

turns care into a clinical outcome when it is to do with citizenship.

09:45

Jill Laspa (Convention of Scottish Local Authorities): Good morning, and thank you for having me. As the representative voice of local government in Scotland, COSLA has obviously taken a keen interest in the programme for government and in the announcement and commitments on public sector reform. As a politically led organisation, we take our mandate from council leaders and, more widely, our elected members, so I do not wish to pre-empt anything they might have to say about that, ahead of their meeting at the end of this week.

Local government has always been up for, and really clear about the need for, improvement and reform across the system. In particular, across social care, we have been really vocal about the challenges that health and social care partnerships, and those who we commission to provide those services, face. As we move forward, local government needs to be right at the centre of the discussion on public sector reform. Local government has a strength in relation to integration and our democratic link to communities, but also in relation to the services that we deliver that are place based and which keep people well. That goes much wider than social care and includes housing and employability, so local government has a really key role with regard to the democratic link to our communities and integration.

With regard to the next few steps in the programme for government on public service reform, COSLA's key interests include the extent to which the reforms enable us to deliver the early intervention and prevention that we have talked about for so long; the extent to which they allow us to invest in our workforce—which has been touched on already—and in supporting unpaid carers to continue in their roles; and, crucially, whether these national reforms enable local government and wider community-based partners to continue to build capacity and deliver services. As all the submissions have outlined, there are significant challenges in the system, so we will be watching closely, and we will be keen to understand the next steps.

Gareth Adam-Hammond (Care Inspectorate): Thank you for the opportunity to be here to help support the committee's understanding of social care, social work and the provisions in that regard. The Care Inspectorate is the independent scrutiny issuance and improvement body for social care, social work and childcare across Scotland. In that context, we bring a unique perspective on how well those systems are operating, where improvement is required, and how well the systems support that improvement at service and sector level. We understand that the programme for government has set out a number of key ambitions for social care reform, and we duly note that the word "social" has been dropped from the committee's and minister's titles. However, we are keen that any consultation in that regard makes the people working across those services in social care, social work, early learning and childcare central to any conversation and consultation.

The workforce that supports people using services such as social care and social work has expert knowledge, experience, capabilities and competence, and an understanding of what is required. It is incumbent on anyone who leads any consultation to ensure that those people have an equal place at the table as part of that work. It is crucial that individuals who experience care and use social care services are also central to any conversations on change or reform in the social care sector.

The Care Inspectorate places great emphasis on the experiences of people who use care services and uses that experience to support our understanding of how well services are operating. Those individuals naturally have a great deal of expertise and understanding in relation to resilience and future proofing the sector, which should be part of any conversations about what the social care landscape looks like now or in the future. As the independent regulator for social care, social work and early learning and childcare, we will continue to carry out our role in that structure, or any structure that moves beyond that accordingly, and in the context of public sector reform.

The Convener: Mr McLeod joins us remotely. We are grateful that you found a way to join us.

Donald Macleod (Self Directed Support Scotland): Good morning. I do not want to reiterate what has already been said, but I will go over our primary concern, which is, as others have said, the comments that have been made about the challenges that are facing social care without there being a single line of decision making, accountability or funding, and with the NHS taking the lead.

Although our organisation is charged with improving and implementing the self-directed support that is in legislation at a local level, we are also a disabled people's organisation. We represent 70 member organisations, which represent the people. We come primarily from the independent living movement in Scotland, where the notion of personalised support was developed.

Our members expressed a fear of the medicalisation of social care. They fear that the

medical model will be imposed when people are given treatment due to illness rather than the social model of disability, which views a disabling world, rather than impairment, as being the inhibitor. Unfortunately, we increasingly find that, in times of austerity—as we are in now—when eligibility criteria tighten, so does flexibility, but that is the only area that we have for manoeuvre just now. The recommendations that came from our recent research into cuts to direct payments and from the national care service advisory board prioritised a need for improved data and increased flexibility. However, a risk-averse culture works contrary to that.

We are currently operating a self-directed support improvement plan, which is coming to an end this year. That was developed through a body called the National SDS Collaboration, which was formed with representation from disabled people's organisations, social care, social work, the third sector and independent support—they all intersect there. We are heading towards a time in which we will not have a strategic driver, and it is critical that the National SDS Collaboration and all its members are involved in developing a new strategic driver.

The Convener: Thank you. We will move on to questions that committee members have about a range of things that have been mentioned and that have not. We will try to keep the questions structured. If people can keep their questions and answers short, we will hopefully get through what I see is quite a list in front of me. Adam Harley, you had a question specifically following up on some of the issues that were raised.

Adam Harley (Strathkelvin and Bearsden) (LD): My question is for Scottish Care. In your submission to the committee, you said that you recognise the opportunities that are presented by reform of the system, but you also highlighted a projected funding gap across health and social care of almost £500 million. Would addressing the financial gap do more than or as much as restructuring the system?

Professor Macaskill: We need to do both. From our perspective, social care is critical infrastructure for the whole of Scottish society. Our language and even the way in which we have addressed social care has traditionally used words such as "deficit," "drain" and "cost". We do not see social care like that, nor do we see that in the daily experience of the women and men who benefit from support and who deliver paid and unpaid care and support. Social care enables our communities to thrive and keep going.

We have not been able to maximise the potential of social care because there has been insufficient funding in the system. I have great sympathy for the commissioning and contracting officers who need to make decisions that are not about meeting their statutory duties but about choosing which duty to meet on any particular day because there is not enough resource available. We cannot ignore the reality that there is not adequate resource in the system, which everyone knows when they are waiting for a care and support package or, indeed, delivering one. It is up to the Government and others to decide whether there is a cap on the totality of resource and how we better spend that resource. From our perspective, if we want there to be preventative care and support, early intervention and reduced delays in discharges, we need to invest in social care.

At the same time, the way in which we structure social care is clearly not working. We recognise that we need to reform the system—I have always recognised that. The problem has been that efforts at reform have not been fully inclusive: some voices have been more dominant than others, and there has not been honesty about the fact that you cannot reform without adequate resource. It is as if the engine of social care, which I believe is at the heart of our community, is no longer running in the red but is running on empty. There is fatigue and exhaustion both on the part of those people who are receiving care and on the part of those who are delivering it. We recognise that things need to change and we want to do the work of reform, but we want a realistic, honest conversation about the inadequacy of resource as we do so.

Adam Harley: You have said that, when there have been attempts at reform in the past, some voices have been more dominant than others. Which voices do you feel have been unheard?

Professor Macaskill: We can learn lessons from other jurisdictions. The one that I know best is Australia, in which reform has transformed social care. After a very challenging royal commission, not unlike the Feeley review, we did the work of thinking about what the future could look like, and everybody was included around the table. We have not done that in Scotland, where, in my opinion, we rushed to a legislative answer when we had not at that time built on the consensus that existed.

With due respect to everybody in this room who is a member of a political party, we politicised the debate about social care reform. I, along with many others, have called for the removal of party politics from this most crucial and critical social question. That is not to demean the value of political contribution but to say that the lessons from elsewhere show that we gain consensus and movement and bring change only if it becomes an issue for the whole of society, instead of the vehicle for one political opinion against another. It is important as we move forward that the process

be as collective and inclusive of as many voices as possible, and I hope that the First Minister will work in that way.

The Convener: I think that Jack Middleton has a follow-up question on that point.

Jack Middleton (Aberdeen Central) (SNP): Roughly. It is mostly directed to Ms Cackett, but it is open for anyone to answer. You have said in your submission that you are looking for parity of esteem in relation to pay and conditions between social care and public sector workers. Will the NHS taking the lead and absorbing some accountability help in that regard, and how do you hope that the NHS will action that?

Rachel Cackett: If that were to happen, at this point in time, I do not know, because we are only working off the statement that the First Minister made, and I do not know the scope of what it would mean. I do not know whether we are talking about mass transfer under the Transfer of Undertakings (Protection of Employment) Regulations 1981 and the end of third sector organisations, or about a different way of commissioning. I think that it is very open.

From our perspective, we have been talking about that for some time. Donald Macaskill and I have been in rooms for a very long time trying to get a process of sectoral bargaining agreed with the Government to enable a move to improve the terms and conditions of staff. I do not think that the public always understand that it is Government funding that determines the baseline rate of pay for commissioned providers of social care and support. There is very little wiggle room there for providers to then enhance that pay, particularly as providers are propping up public sector contracts through the use of reserves. If we are going to have parity, we need to be serious: why is it acceptable for the Government to pay a band 3 NHS agenda for change worker—who, let us remember, is not a regulated member of staff—£3,000 a year more, as a base rate, than it is willing to pay social care staff on the front line, who are professionally regulated to do that work? That is the situation that we are in.

In 2019, the Government made a commitment to fair work and social care; we are further from that now than we were in 2019. We have such amazing staff working in the sector; we need to encourage people to stay in and new people to enter the sector. How we do that is to get to parity so that we are not creating a strange and unhelpful internal market for staff in health and social care. I do not know whether the structural change that was hinted at, but which is not really clear to me yet, would change the situation. However, whatever the structure is, we still have to address the fact that we should be paying people fairly in our public service, with equity for the job that they do.

10:00

Joe Long (Mid Scotland and Fife) (Lab): I note again that my register of interests shows that I was the director of a social care organisation in the third sector until 18 May.

I will ask Rachel Cackett and Donald Macaskill about commissioning. You both mentioned that in your submissions and in your opening statements. The Feeley review, which was carried out in 2021, led to a lot of discussion about structure and governance, but one of the key elements of the review was collaborative and ethical commissioning. That might be about culture and process as much as it is about structures of governance, so I would like to tease out what you think good, ethical and collaborative commissioning would look like. How does it differ from the status quo? Let us start there.

Rachel Cackett: We did some work a couple of weeks ago and, as part of that, five of our providers anonymously shared how money flows into their organisations. It is very arresting to see how complex the situation is for providers, and to see how many different funding streams with different reporting mechanisms and contract terms there are while we are being asked to be efficient. Therefore, the first thing that we need to think about is how we simplify the system so that we have money going from the public purse to the people who need support with the least friction possible. It has got to be simple. At the moment, there are too many variables across Scotland. Colleagues will say that local democracy matters, and I understand that things are different in different parts of the country, but it is not beyond the wit of man or woman to simplify the system and make it easier and more efficient for organisations that are trying to make provision.

The other issue is that competition is rooted in our system. Derek Feeley was very clear that we should be commissioning for public good, but we often use the same competitive tendering approach for social care as we would use for widget production or tarmac production. In that system, third sector organisations are pitted against each other in competitive tenders where the tendency will always be to have a race to the bottom. That should not be our aspiration. I understand that our local government colleagues and those in our integration joint boards have issues with the amount of funding that they have, but price has become too heavy a burden in a sector that is meant to allow people to flourish as part of a social contract.

The other thing is that the way in which money flows is difficult. We have talked for years about the number of organisations that are constantly waiting to be paid for work that has been done, but it comes across strongly in our report. Delayed payments should not happen. There is a contractual obligation to pay. In our report, you will see a quote from one provider that said that it was waiting for half a million from one council and a similar amount from another.

We talk a lot about accountability, and the First Minister talks about accountability, but with accountability comes the owning of risk, and at the moment risk is pushed through the system to the front line, where the people holding the greatest risks are the workers and the supported people and their families. They hold the risk of not getting commissioning right.

We need to look at the best examples of the most collaborative commissioning. We need to free providers up to work in a way that is not the same as commissioning baked beans. Instead, we should trust them to know the people they are working with and make the right decisions.

The process has to be a much more outcome focused. We should ask whether public money is helping people to improve and live their best life. That should be what we aim for. That is not how commissioning is currently running.

Where money is flowing, it has to be paid on time. Disputes have to be resolved quickly, and we have to be clear by reporting simply to show that the taxpayer is getting a good deal. Our sector can do that.

The Convener: Paul McLennan, your questions on staffing follow on from that. You can address your questions to particular panel members or panel members can indicate if they would like to answer.

Paul McLennan (East Lothian Coast and Lammermuirs) (SNP): I will pick up on the point that Rachel Cackett made, and then I will talk about staffing.

Rachel, I think that you are right. I spoke to colleagues from Penumbra about a month ago, and they talked about commissioning and the difference for the viability of their business that having a two or three-year contract made—it was chalk and cheese. That is an important point, which they asked me to stress. I agree with Rachel Cackett's point on that.

My first question is probably for Jill Laspa. You have all spoken about staffing issues and we all know that there are demographic challenges not just in the here and now but for the next 10, 15 or 20 years, so whatever we do has to work in the years ahead. There are procurement issues connected to demographic pressures, in which I know that there is a role for local authorities because I spent 15 years as a councillor and council leader. How much assessment has been done at COSLA level and how much does that feed into the process and into what everyone else does? Can you say something about the demographic challenges that you are seeing and how those impact on staffing requirements? How can we have a workforce plan to deal with that? I will open the question up, but I would like to hear from COSLA first.

Jill Laspa: I will start with the local situation and then touch on the national one. Members will be aware that, at local level, integration authorities—the IJBs—are responsible for strategic planning, in line with needs in their areas. They look at demographic pressures while planning the services that they need to commission.

A lot of discussion at national level—particularly regarding the work focusing on ethical commissioning that has been shared between COSLA and the Scottish Government with involvement from providers, trade unions and people with lived experience—is about how to engage with local providers so that they understand which services they need to be able to offer to commissioners. Work on that is under way.

At national level, we probably need a better understanding of what Scotland will look like in five, 10, 15 or 20 years' time, not just in terms of the demographic profile but in terms of the workforce available to meet growing need and existing unmet need. People are living for longer and with more complex conditions and needs and we also have individuals who are transitioning into adult services. What does our housing need to look like?

Integration authorities are critical to that planning, as is local government. We need to focus on that at national level over the next year. I believe that the Care Reform (Scotland) Act 2025 includes a provision for ministers to look at projected levels of need, which I think will be really valuable in understanding what Scotland needs to plan for both locally and nationally and how to get a workforce that aligns with that. COSLA would be keen to be in the middle of that.

I will close by mentioning social work. We talked about the social care workforce but must also be mindful of how we are planning for the social work workforce. The Scottish social work partnership is a strategic partnership between COSLA, the new National Social Work Agency and Social Work Scotland. Workforce planning is key to that and will draw on data about future needs and demographics so that we know what our social

work workforce needs look like now and in the future.

Paul McLennan: I saw you nodding your head, Donald. Scottish Care made a few recommendations, one of which is to have a validated true-cost-of-care framework. One recommendation that stuck out for me is to have a fully funded fair work and workforce strategy for social care. You are right that that should be fully funded, but it has to meet the challenges of the next 10, 15 or 20 years. Can you say a little more about the importance of those issues?

Professor Macaskill: The first point relates to the fact that we must cost care adequately and independently. I have had the joyous task of leading the annual negotiations on our largest social care contract, which is the national care home contract. I am being slightly euphemistic in using the word "joyous" and it has not actually been a negotiation for at least the past five or six years. Instead, it has been a "take it or leave it" situation because, although we are basing our decision on a cost model, providers have not accepted that model for half a decade because it is inadequate and all of us, publicly and privately, accept that it is not adequate. This year's cost model does not pay residential or nursing care providers any money for their technology or digital infrastructure costs. How is that possible nowadays?

We need a radical review of existing cost models; I would put forward the national care home contract as an example. The review needs to be based on the ethical commissioning principles that we have all worked on and agree with. At the end of the day, it comes back to the adequacy of the resources, because you cannot negotiate if there is an empty packet in front of you. That clearly relates to the workforce. Most of us who provide care and support, whether in the not-for-profit, private or charitable sectors, recognise that our greatest assets are the women and men who work in the sector. We need to and want to do more. That is why Rachel Cackett and I have been working with the trade unions and others over the past few years to try to move to that position.

I have no doubt that, were we able to better remunerate and reward the women and men who work in the sector, we would retain them and would do better at attracting others. However, one of the other demographic truths about Scotland that we ignore too easily is that we do not have enough people and we have a growing demand. Yesterday, I was privileged to take part in a global nursing event in Edinburgh, with participants from India, Nepal, the Philippines, and all over the world who contribute to the Scottish care economy because those women and men have come here and decided to commit to being part of our communities and to offer the most astonishing care and support. Yet, as independent providers, we are finding it increasingly difficult to hold on to our staff and to attract international workers because of the toxicity in the environment.

I want someone to show me where, without attracting people from outside Scotland and making it a hospitable place, the working population is going to come from so that we can plan for our future demographic needs. In case someone does a rough arithmetical exercise, statistically, you could say that we would have enough people, but anyone who has seen a person hold the hands of a woman in their last moments of life, support an individual who is doubly incontinent, or communicate with someone who struggles to use language will know that the job of care is not for everybody—it is for those who are gifted, unique and special. Wherever they come from, they are the people who we need to support and hold on to. It is not a simple yes or no. There is a complex picture that we need to build our workforce strategy around, and it needs to be fairly and adequately costed.

The Convener: Jack Middleton has a follow-up question. I do not know whether he wants to address it to anyone in particular.

Jack Middleton: I will direct it to Professor Macaskill. To build on the last part of your answer, your submission noted a survey showing that about 26 per cent of the workforce was made up of international workers. It is clear that the current system makes growing that almost impossible. What do you think needs to happen in order to offer tailored routes for immigration to encourage more people to come to Scotland? We have an ageing population and will rely more heavily on international workers to support the Scottish social care system.

Professor Macaskill: A while ago, I gave evidence to the health committee arguing that we needed to learn the lessons from Canada and Australia. Those countries have systems that recognise, first, that some sectors have particular needs and, secondly, that it is possible to operate a national model of immigration control with regional diversity. As an organisation, we are in favour of a Scotland-specific model that would enable individuals to be attracted to this country, put down their roots and contribute to making us an even better society.

I have been public in my comments about some of the toxicity in the language from the previous United Kingdom Government. We need to move on from that, which I hope might be a possibility with the new Prime Minister. Many of our members employ international colleagues. Sadly, their experience is of a system that is designed to make

it as difficult as possible to retain existing workers and attract the women and men who we need for the future. It is urgent that the Scottish and UK Governments work with social care providers in all Administrations to develop an immigration policy that is sensitive, addresses needs and is also humane. I do not think that we have that at the moment.

Jack Middleton: If we do not move in that direction and double down on efforts to counter the toxicity that you have talked about, what will be the impact on the social care sector, maybe not tomorrow, but five, 10 or 15 years down the line?

10:15

Professor Macaskill: The impact is already here. We are seeing organisations being unable to recruit and therefore being unable to deliver support and having to close. The people who suffer from that are, obviously, the workers and the employers, but they are also the women and men who cannot get the service, care and support that they need. There are pockets of Scotland, particularly in rural areas, where you have to travel 100 miles to get to a residential care home. The issue is not a lack of need; it is a lack of adequate staffing in those areas. As Jill Laspa highlighted earlier, that links to housing and to community infrastructure, with, for example, local village schools having to close because individuals have not been attracted to live in those communities.

The issue needs a whole-system approach. It is not just about workers. Also, lest anybody external suggests that these gifted women and men are working on the cheap, I say that they are not. They are working for the same wages and with the same terms and conditions—however inadequate we all might agree that those are—as anybody else. These people are the fabric of our society, and some people out there want to rip that fabric apart. Social care providers will not allow that to be the case.

The Convener: Kayleigh, I think you might have a question on this topic, and then I have one—or has yours been answered?

Kayleigh Kinross-O'Neill (Edinburgh and Lothians East) (Green): Yes, it has.

The Convener: I want to ask—this is for anybody, really—about training our own Scottish people and whether there is a case for expanding further education in this area. Coming back to the point about people getting rewarded, we tend to want a certificate so we can say, "Right, they've got something equal to that." I am talking about people working in care homes but not only them—I will come back to Mr Macleod, perhaps, on his own area. I would just like to hear, from COSLA and others, what you think about whether we need to expand courses in those areas. Coming back to Professor Macaskill's point, if we think that we need more of those people, we obviously need to encourage them in various ways.

Jill Laspa: As part of the fair work and social care agenda, one of the key things that COSLA has looked at, alongside the Scottish Government and stakeholders, is the real value of the social care workforce. I think that a fundamental way of valuing the social care workforce, regardless of whether they are internationally recruited or born in Scotland, is the professionalisation of social care. We have heard about the valuable and important work that the social care workforce carries out. Often, they are with people throughout the final days of their lives, so anything that improves the value and the professionalisation of the social care workforce is important.

However, that also comes back to the issue of pay. If we are going to add demands for further professionalisation and training of the workforce, we need to be realistic about what we are paying the workforce. I will not repeat what Donald Macaskill and Rachel Cackett have already eloquently said, but, for me, although training to achieve that professionalisation is absolutely important, there is also the issue of the pay that follows that.

The Convener: Mr Macleod, I do not know whether you wish to contribute anything here. I realise that, as you are joining us online, you are kind of sitting outside the circle, and I do not want to fail to give you an opportunity to follow up on this issue or on anything that you feel has been missed.

Donald Macleod: Thank you very much. We have a focused programme of work on the personal assistant, or PA, workforce. There are around 10,000 personal assistants in Scotland, and it is a critical workforce for ensuring that disabled people can live independently in their communities.

We have been training social care workers for 30 years and certifying that training. Self Directed Support Scotland has been involved since the start of the process with the personal assistant workforce over the past few years, with the PA programme boards that we chair. We have a sub-group that is focused on the needs of employers and personal assistants—that is, for people who take option 1 and receive a direct payment. We have a national training framework for personal assistants, and we provide training modules and a training locator that personal assistant employers can access. It is a developing area for PAs, regardless of nationality.

The Convener: Is that training popular? Do you have links with the further education colleges? It

would be interesting to know what they are thinking about providing.

Donald Macleod: Yes, we have those links; that is part of our training locator work.

Training is a sensitive area, and it is highly individualised. When you look at the demographics of personal assistants, the majority are women aged 55 to 60. There is a negotiation between the employer and the individual as to what training that particular employer requires the person to have, rather than imposing anything mandatory on PAs.

We are taking a very individualised approach to ensuring that the tools are there for employers to fulfil that role, without it being a burden.

Rachel Cackett: I emphasise to the committee that we are talking about a trained and regulated workforce working in this system. I agree with everything that was said about welcoming highly skilled people into what is a highly skilled job, whether they are an existing citizen of Scotland or a future new Scot, and giving them a real welcome and recognition in the communities in which they live. That really matters.

We have written a report on priorities for workforce training and qualifications, which we can make available to the committee. To pick up on something that Jill Laspa said, we have a workforce plan in the NHS. For social work, we now have a new agency that is responsible for planning the social work workforce. We do not yet have the ring being properly held on workforce planning for the 200,000 or so people who work in the social care workforce.

I know that conversations are going on about how to do that better, but your questions about whether we have enough courses, whether they are in the right places and whether we are attracting the right people are really important, because we all want to be looked after by people who are passionate about doing the job. That piece of work needs to be done, and we are certainly calling for, as part of the reform—whatever that looks like—a concerted effort to bring together all the factors that would give us a vibrant workforce for the future. We need that now and we will all need it in the future, whatever our age. We need a highly skilled workforce that is enthusiastic about the job.

When I go out to meet my member organisations, what I always come away with is a feeling that the quality of the people who work in this sector is exceptional, but that we are asking too much of them for too little. More than 80 per cent of the workforce are women. Perhaps that is why we have got away for so long with paying the workforce too little at a national level through the Scottish Government, despite the incredible job that they do for our families.

We should recognise that, wherever anyone began life, the issue is whether we are getting the right people and ensuring that they are trained in the right way and properly remunerated and rewarded.

On the immigration discussion, one thing that I would say is that we should stop talking about low-skilled workers in this sector. People in the sector are not low-skilled but highly skilled at what they do, and we would do well to recognise that.

The Convener: I am sure that we recognise that.

I think that Paul McLennan wants to come in briefly before we move on.

Paul McLennan: Yes, I do. I want to raise an experience in East Lothian on the back of the points that have been made about staffing and recruitment. Working with Enable Scotland, we held a round-table event to discuss the issue. Enable was offering a wage of £17 or £18 an hour to some workers in an effort to attract people to East Lothian, and it recruited a certain number, but not a huge amount. There is about a 20 per cent capacity gap.

We struggle to recruit people in the more remote parts of East Lothian. For me, the recruitment issue is not only about how we recruit but about how we recruit in both remote and urban areas. I am talking about areas that are only 15 miles from Edinburgh. We are even struggling to recruit in North Berwick and Dunbar.

Will you say a bit more about that specific challenge? We can talk about recruitment, but the strategy must cover all parts of Scotland; it cannot just focus on the areas where we think action is needed. That is a really important point for me to get across.

The Convener: I would be grateful if you could answer that quickly, because I have a long list of members wanting to ask questions.

Rachel Cackett: As you said, Mr McLennan, we have an issue with pay and, actually, you can see organisations doing their best to raise levels of pay, but that also creates a differential space with regard to pay. As a country, we need to speak quite differently about social care. We need to be really clear about the enormous value and reward that there is in it as a profession and we need to make sure that our pay structures allow for it to be a career choice for people, so that they can work through the levels. At the moment, the differentials between, for example, management and front-line roles have been eroded so far, because of Government pay policy, that people cannot

necessarily see career progression in their future. All of us need to talk quite differently about social care. We need to promote it as a really valuable career choice and then we need to back that up.

The Convener: Moving on, Heather Anderson has a question on the medicalisation of care.

Heather Anderson (Dundee City West) (SNP): Thank you, convener. We have heard very powerful testimony this morning from everyone. Paul Traynor made the point that there are 800,000 people who provide care but are not paid to do so, and they also need considerable support and skills development. I also want to pick up on what Professor Macaskill said at the start about the fact that it is not the job of social care to ease the pressure on the NHS. In this conversation, it is very easy to slip into the area of prevention, but that is about preventing the NHS being overburdened.

What advice could you give us about how we protect the principle that care—not just social care—is equivalent to health? We tried to achieve that by having the national care service at the same level as the national health service, but we did not get as far as we wanted to with that discussion. In this discussion, going forward, how do we ensure that care is seen as equal and not as a hand servant to the health service? Professor Macaskill, I also picked up from you a real concern about the medicalisation of care.

Professor Macaskill: The way in which you prevent the risk is to identify the distinction between them. It is not that clinical services in acute, secondary or even primary care are less than social care. These are complementary sectors that dovetail into each other, and you can reform the totality only if you understand the distinctiveness of each part.

At times, we fail to properly understand the communitarian dimension of social care. I often use the analogy that, if I have an accident, break my leg and go to hospital, I will receive great clinical support and will probably not be all that bothered about who treats me, as long as they are appropriately qualified. However, if, as a result of an accident, I will be incapacitated and will require care and support for the rest of my life, then I do want to have choice, agency, voice and the ability to determine who will care for me—often in the most intimate way. Both services are providing care and support: one is much more clinical and often takes the form of an emergency response; the other is lifelong. The way in which you deal with somebody who is living with a lifelong clinical condition has to be different from the way in which you deal with them in an emergency situation, and the way in which we prevent an inappropriate conflation is to celebrate the distinctiveness. The approaches are not competitors; they are two parts of the system that require parity not just of esteem but of treatment and resource. That is not what we have had.

The conversation that we are about to have—Rachel Cackett and I perhaps know as much as some people in this room about where that will lead—is an opportunity for us to treat things in a much more holistic way, because the citizen does not really mind the colour of the uniform of the person who is caring for and treating them. What they mind is having to repeatedly tell their story to multiple actors and having “Groundhog Day” experiences. We want a seamless, integrated system where there is respect among professionals and an understanding of the unique contribution of each part of the system. Naively, I do not think that that is all that difficult to achieve.

Heather Anderson: As some of you have said, there was a line in the programme for government speech about the lead agency being the NHS. If that is the case, how do we protect parity with, and the integrity of, the care sector to ensure that there is no subordination of one part of care to another?

10:30

Rachel Cackett: What is important is that that sort of thing is included in the design from the beginning. If that is the intent, we need those who receive support and care—and leaders in the sector who know how the system works and what we have to do to make support better—to be involved at the design stage, rather than letting that be seen as an afterthought.

If you want to design something that improves flow through the health and social care system, please do not have only clinicians in the room, because they will think only about what happens between the front door and the back door of a hospital. Please design the approach with us—let us bring to the table our members and the people who are actually involved in providing a huge amount of the care and support that is required.

We also have to think about language. The NHS talks about patients, but patients are people who happen to be in contact with the NHS. We do not have patients—we have people.

The Convener: I am sure that doctors have people, too.

Rachel Cackett: But if you look at policy, the policy landscape and the language used in the public domain, you will see that it is very common for our NHS colleagues to talk about patients all the time. Patients are people who might be in contact with the NHS. We need what I would describe as an almost Copernican shift—away from thinking that our centre of gravity is the NHS

and shaping things around it, and instead towards seeing our centre of gravity as being the people who need various types of care and support at different points in their life and shaping our entire public service around them. We might say that we do that, but I would say that we do not really do it. However, let us enter into that space and do things differently.

The Convener: As a follow-up to that, how confident are you that if we get two health boards for the whole country, as has been proposed, that approach will result in better integration? After all, they will be very big organisations.

Rachel Cackett: My answer is that I do not know—I do not know enough of the detail, and I do not know the plan that underlies the two regional strategic health boards. I am not sure whether will keep our existing integration joint board structure and how that will relate to the proposal for two large territorial boards on the mainland. I am also not sure where our local government colleagues are on how that will work or, indeed, on the local dimension that goes beyond the NHS—for example, the connections with housing, which are really important to the people supported by our membership. Indeed, many of our members provide housing support and homelessness services. How will all of that work?

At the moment, we have a sketch. It might be a great sketch, and there might be a lot behind it that I have not yet seen, but I cannot be confident about anything until I, first, see more of the direction of travel and, secondly, feel really confident that members like mine and our partners, such as unpaid carers, disability and children's organisations and beyond, have a part in shaping this. Maybe, once we see it, we will have come up with something that is genuinely what Derek Feeley suggested we should do all of those years ago.

The Convener: Jill, I think that you wanted to come in.

Jill Laspa: As Rachel Cackett said, it is hard to know what the future will look like with the two health boards that were announced last week.

However, I come back to the point on the role of prevention. COSLA very much welcomed the emphasis on prevention and early intervention in the programme for government. Indeed, it is an approach that local government is very much committed to, as has been articulated in the population health framework and a variety of other areas of work.

What is really important to us in local government is how we frame prevention and ensure that we are broadly talking about the same things. We have already talked about prevention not just being about preventing something happening in hospital, or preventing somebody from appearing at hospital. The vast majority—as much as 80 per cent—of services that keep people well in their communities are delivered by local government or our community partners and organisations. By that, I mean housing, income support and employability services and so on. Whatever the structure looks like and whatever discussions we will have nationally over the next few months, that is really fundamental to ensuring that social care and the wider prevention agenda are reflected.

The Convener: That leads me to IJBs, which have not really been mentioned. They provide a critical interface. How should we go forward in that regard? Do people feel that IJBs have worked to a degree? I think that everyone feels that there needs to be reform. I will bring in Jill Laspa first, given that she covers that interface.

Jill Laspa: COSLA is interested in understanding how IJBs would interact with the two proposed health boards. As members will be aware, there are 31 integration authorities and 30 IJBs. They represent the formal legal partnership between a council and a health board, so, right off the hop, that demands quite a few answers about what having two health boards would mean in that regard.

We recognise that there have been challenges with integration, which is relatively new, and we had a pandemic during it. In our discussions, including those we had on the draft national care service legislation, we have recognised that improvements could be made to people's understanding of integration, that is, of how members of the public, individuals who access care, unpaid carers and members of the workforce fit within the structures of integration.

We are keen to understand the local democratic accountability component of integration. At the moment, that component comprises councils. It is a case of waiting to see what the outcome of having two health boards will be.

The Convener: I have a final question on IJBs. As you said, integration is relatively new, and I have heard that IJBs have improved things—that may or may not be the case, but that is certainly what I have heard. If it has taken, I think, 10 years for things to bed down, is it wise to throw everything up in the air again? Is there a way of making the system work with whatever proposals are made? You might not be able to answer that, but you can try.

Jill Laspa: With any reform, a priority must be understanding the challenges up until that point and targeting changes at addressing those challenges. I would reflect on the themes that

come through in almost all the written submissions for today's meeting: the resourcing of the system and the workforce challenges. Those are key priorities in improving outcomes for people and their experiences of care. Work could probably be done to improve people's understanding of IJB governance and how IJBs interact with the services that people experience every day. However, we will get nowhere with improvements if we do not consider the significant challenges with resourcing the system.

The Convener: I think that Joe Long has a related follow-up question.

Joe Long: It is more of a provocation. We have heard that health and social care integration has not really been an integration of equals. We have heard various terms—Donald Macaskill talked about dovetailing services, and Rachel Cackett talked about "flow"—but what we have really heard is that social care is a distinct sector in its own right. Is the trope of "integration" still a useful term for us to use in policy?

Professor Macaskill: Care has an accent, and I do not mean that the person giving care or supporting somebody has an accent. Care happens in a place—it does not happen nowhere; it happens somewhere—and that place influences the nature of the care and the community in which it takes place. That is what makes social care distinctive. It takes place not in a building but in people's homes or in a homely setting in a community. With any reform process, the trick is to understand how we enable the local neighbourhood or place to influence the decisions on resourcing the care that happens in that place.

Having been around integration for a long time, I think that the structures have worked effectively in some places, but they have not worked effectively in others, because, in a sense, the integration has been about the mechanics and the process, not about how the system is felt by people.

I remember that the architects of integration said that we needed to remove the postcode lottery, which we have not succeeded in doing, and that we needed to stop people having to tell their story countless times to different people, which also still happens. That is because, even in the integrated structures, we have not yet got right that sense of place or neighbourhood, in other words, of how to develop a structure where the local is the leading dynamic.

I hesitate to suggest it, but there are parts of the world that have achieved that. One example is in South Korea, where the use of new technology is enabling citizens to influence decisions about their care and support and democratising decision making. Such democratisation is at the heart of, for instance, the self-directed support legislation—whereby I am the person who is leading, in control and in charge, not the professionals around me. We need to be much more adventurous than just thinking about whether or not IJBs have worked. If that is a structure for yesterday, let us reimagine a structure for tomorrow.

Joe Long: Rachel Cackett, I think that you wanted to comment on integration.

Rachel Cackett: Yes. When we talk about integration, which we use as shorthand to refer to the Public Bodies (Joint Working) (Scotland) Act 2014, we are really talking about the integration of only some social care and of only some health services. The 2014 act is clear that it is not the whole of the NHS that is being integrated, nor, often, is it the whole of social care. There are formal delegations, and IJBs sometimes go beyond that and integrate more.

A couple of weeks ago, we published a piece of work on the local governance process. We have community planning partnerships and alcohol and drug partnerships—all these structures, some of which are statutory and some of which are not, some with power and some more collaborative. What we have is a system that is so focused on integrating parts of a system, but not on doing what I think Donald Macaskill is suggesting, which is integrating on the basis of local need and people's needs. One of the distinctive features of social care and the way that it has emerged is, as Donald said earlier, the absolute emphasis on choice and control. That is written into SDS legislation: people should have choice and control, and that is quite different from the NHS.

My concern is that the link between the NHS and social care is strong and important, although I agree that they are quite distinct. However, only integrating those two things through integration authorities has had two impacts. First, there is the risk of an enormous power differential, and that plays out. Secondly, the other thing that integration was meant to do, which I do not think that it ever did, was create a budget without identity. The idea was that money would come from the two partners into the IJB and would then be spent as required by the local community, according to a strategic needs assessment. I would wager that that has really not happened. As somebody who sat on the bill group back in 2013, I do not think that that has happened in anything like the way—or got us to anything like the place—that we all imagined.

On whether that structure remains the right one, I agree with Jill Laspa that we need to be clear about the purpose and then look at the problem and decide how we fix it. I am not sure that IJBs have been able to work and flourish without the feeling that they have their hands tied behind their

back, because of the level of constriction in terms of both the available resource and how flexible they can really be with regard to changing how money is spent.

The Convener: Thank you. I will follow up on Professor Macaskill's point about services being designed around place. Is that an argument for unitary authorities? The islands are going to be unitary authorities, and the NHS is a big thing, so is it possible that, instead of all these things, we could go back to local authorities being in charge, except in relation to specialist care, such as for cancer and so on? Does anybody think that that is a possibility?

Professor Macaskill: It is an argument for collaborative working. If we look back to the creation of the NHS all those decades ago, we can see that the essential model was a community and local model. Certainly in the committee stages of the debates running up to the creation of the NHS, it was not a national hospital service that Aneurin Bevan spoke of, but very much a localised service that would respond to the neighbourhood and to the community—he even used such phrasing.

The NHS has significantly moved away from that model. The challenge is perhaps not so much for the world of social care and social work to move towards that model—because we never left it—but to redesign the NHS so that it is more local and more responsive to the needs of people and population. That is not me being overly critical of those who work within the NHS as a structure, but I think that it has become somewhat detached and distanced from the vision from all those decades ago. Perhaps, with respect, the question is the other way around.

10:45

The Convener: Joe, do you have a follow-up question on that area?

Joe Long: I have a question on profit in the sector.

The Convener: We can move on to that. I thought you had something on integration, but perhaps it has been covered.

Joe Long: No, that is why I asked that one. My final question is for Donald Macaskill, in particular. We have talked about the financial constraints on the sector and the fiscal situation that we are in. I am aware that the private sector is a diverse sector, with everything from small care homes to very big conglomerates. We have heard from other people who have given or submitted evidence on the question around profit in the sector and whether there is room for that in such a fiscally constrained situation. Do you have a response to those who think that there probably should not be a place for profit in the care sector?

Professor Macaskill: We have a national care home contract that allocates £1,074 per week per resident for 24/7 nursing care and support. Seventy per cent of provision is paid for by the public purse, and providers utilise other capacity, including private. The cap on profit that exists in the national care home contract is 4 per cent so, if you want to make a profit from publicly funded care, you are on a hiding to nothing; it would be better, give or take, to invest your £1 million in an individual savings account—ISA. The reality is that we have a private care sector that is meeting the needs of people who can afford to pay something closer to the true cost of care. The state pays £1,074 for care and support, but the cost—for a public authority, local authority or NHS board—of delivering that is roughly between £1,800 and £2,500. In effect, the gap between what the state pays and the true cost is growing each year.

It is a matter of societal principle whether you create a system in which profit or return does not happen. Scottish Care represents private, not-for-profit, employee-owned and charitable providers of care and support and, if I think back to when I started this job, I visited a deeply respected charity that ran a care home and had done for 80 years. At that stage, 10 years ago, 80 per cent of its residents were paid for by the state under the national care home contract and 20 per cent were not. When I visited last year, 90 per cent of its residents were private because the charity could not make the sums add up and it could only afford to have 10 per cent of residents funded by the state.

I do not think that the issue is profit. Take the private sector out of this; there are private care homes that do not offer care and support to state-funded individuals. However, for those people who are funded by the state, there must be an adequate level of return, whether that is for a charity, not-for-profit provider or private business. Remember that, in Scotland, the vast majority of private businesses are small or medium-sized, and many of these are family-owned generational homes. The sad reality that I see—and it is getting worse—is that that group is shrinking. Our charitable members are going to the wall and our small private members simply do not have the economy of scale to make things work, even if they maximise private income. Therefore, we are removing choice. A decade ago, Scotland had a gloriously mixed market, but that market is becoming narrower and more constrained, which is in nobody's interest.

The Convener: What percentage of care homes are now owned by the bigger corporates rather than smaller providers and charities?

Professor Macaskill: I can look at the data to confirm this for the committee, because it literally changes every week, and, in the past six weeks, there have been significant buyouts by larger bodies. The bigger corporates in Scotland account for about 38 to 40 per cent, which is significantly more than it was a decade ago. I can submit that data to the committee.

The Convener: That would be good, thank you. Kayleigh Kinross-O'Neill, I believe that you want to come in. I ask everybody to keep questions and answers short, because we still have quite a lot to get through.

Kayleigh Kinross-O'Neill: My question is for Paul Traynor and Donald Macleod. It is a pretty big-picture question. What asks related to self-directed support and unpaid carers do you wish were included in the programme for government, as neither were explicitly referenced?

Donald Macleod, you spoke about the call for improved data. What specific data are you looking for? What questions should we be asking?

Paul Traynor: I start by recognising that when formal services are unavailable, delayed or difficult to access, there is more reliance on unpaid carers to fill that gap. In policy, unpaid carers are often portrayed as a resource in the system rather than people with individual rights.

In some of the conversations that we have had this morning, I have reflected on that through the unpaid carer lens. One in three of us will be an unpaid carer at one point in our life, and many of us will be unpaid carers at multiple times during our lives.

Aspects of choice have been discussed, but unpaid carers often do not have a choice. Although the Carers (Scotland) Act 2016 covers that, as part of a conversation about an adult care support plan or young carers statement on someone's willingness to provide care, in reality, when services are not available, unpaid carers often have to fill that gap.

That was a real gap in the programme for government—we would have liked that issue to have been reflected on in it. When we talk about the professionalism of the sector, we recognise how many unpaid carers receive formal training for the care that they provide, often fulfilling duties that paid carers would require specific certification to be able to perform, but they are doing it because there is no other choice for them. There is no other option, and there is a lack of services for unpaid carers.

We talked about people being regarded as patients. Often, unpaid carers are regarded as families and not recognised as unpaid carers. Identification of carers is a real systemic issue. There is a responsibility across health and social care services to identify carers and let them know that they have rights as an unpaid carer and that there is support available.

The key aspect that we would have liked to have seen reflected in the programme for government is the 2016 act. I put that in my submission to the committee. We have been calling for post-legislative scrutiny of the 2016 act. We know that the policy intent of the 2016 act at a national level is, in principle, good and strong, but, in reality and in delivery, that is not being felt by unpaid carers.

We also wanted the committee to consider that in advance of the Scottish Government's flagship policy this parliamentary session around the right to breaks for unpaid carers. The right to breaks is tied into the 2016 act, or at least what has been proposed is tied into the Scottish Government's consultation, which is that the right to a break would be assessed through an adult care support plan or young carer statement. However, we know that thousands of unpaid carers do not have adult care support plans and young carer statements. They are not being offered those statements, and they are not being identified and made aware of the support that is available through that.

There are also fundamental issues around the 2016 act more generally. A key one that I highlighted is that around £20 million of the £88 million is unaccounted for. We do not know where the funding for the 2016 act goes. There is no transparency around that funding.

One of the key aspects of that issue is that, even when a carer is identified and perhaps gets a good service through their local carers centre, is provided with a range of support services and undertakes an adult care support plan or young carer statement, they have to basically be in crisis to meet local eligibility criteria for any statutory support provision. Only 3 per cent of carers in Scotland meet local eligibility criteria for a break.

That element of the programme for government really could have addressed and recognised unpaid carers more strongly and showed an understanding that it is perhaps not always about creating new policy but about ensuring that the policy that has been delivered has been delivered as intended.

The Convener: Thank you—we will take that up. Donald Macleod, do you want to come in?

Donald Macleod: In relation to data across the board, from the earliest point of intervention to delivery, one of the things that we do not know is the percentage of people who are offered the full range of options when they have discussions about self-directed support, and the kind of conversations that those people have. The model

of social care since the National Health Service and Community Care Act 1990 has been about care management: it has moved the role of social workers from relational or therapeutic intervention and relationship building to a more transactional role of organising packages and support.

As Paul Traynor just pointed out, it has become more about what you cannot get. There is a move towards dealing with critical and substantial needs instead of asking how we can meet people's support needs. Many social workers report spending increased amounts of time undertaking administrative functions associated with budget management, social resource allocation and compliance process; as a result, less time is available for relationship-based practice, preventative community-based approaches, safeguarding and therapeutic strengths-based work. That has contributed to the perception that social workers are becoming gatekeepers of scarce resources instead of professional agents of social change and support.

We need data across the board about the range of options that are being offered. We are hearing more and more that when pressures on the system exist, it is about the range of options that are available. In some areas, we know that pressures exist because no resources are available, but it is becoming a default to offer people option 1. Option 1 should be a considered choice made by people who are willing to take on the administrative and operational responsibilities that it involves, but we are hearing that it has been allocated in areas where no local resources are available, such as personal assistance, transferring the responsibility and risk to the individual and putting pressure on the model. That creates a perceived need for external regulation, when it should be the person's responsibility.

I mentioned flexibility earlier. We conducted research about the cuts to direct payments recently. We get the negative stories, of course, but not those helpful, positive bits of data around how to operate a direct payment flexibly.

The Convener: Adam Harley has a follow-up question.

Adam Harley: I have a quick question for you, Mr Macleod. You just mentioned gatekeepers, which you also mentioned in your submission to the committee. Often, people in need of support are experiencing that gatekeeping instead of someone who will enable them to get the support that they want and need. Who exactly are the gatekeepers in that scenario? Is it those people on the front line who feel compelled to do that gatekeeping because they do not have access to the resources that they need? What would help us move from that gatekeeping to the enabling of care?

Donald Macleod: Yes, it is the people on the front line. Social workers on the front line are gatekeepers to what is available instead of the agents of social change and support that I was referring to.

A whole-system approach is required. I have made some suggestions in our submission, one of which is about removing some of the administrative burdens around the financial aspects of, certainly, option 1 and direct payments, by potentially moving them to the Independent Living Fund Scotland. That would allow social workers to do that early intervention work, so that, rather than being administrators, they can be agents of social change and focus on crisis and early intervention.

The Convener: Thank you very much, Mr Macleod. We move to questions about the inspectorate role.

11:00

Joe Long: My question is for Gareth Adam-Hammond of the Care Inspectorate. Your submission gives an overview of what the Care Inspectorate does and who you are. You have specific criteria to use when you carry out inspections, but I am interested in the big picture that you see when you inspect care services. What makes a good service? I am thinking about not just the criteria but the culture and leadership. What patterns do you see across the system? Are there particular areas or sectors where you see good practice? How does provision compare in the third, private and local authority sectors? I am interested in those big-picture trends.

Gareth Adam-Hammond: As you will see from our submission, we have a number of quality frameworks that we use when we undertake inspections or improvement interventions, and those help us to establish how well services are performing. We believe that there are mechanisms and building blocks of good care provision across the spectrum. From care homes for adults and older people to daycare services for children, all of us will come into contact with social care services in some shape or form during our lives. Our quality frameworks set out clear expectations about good governance arrangements; management and leadership; appropriately recruited, skilled and competent staff; and the environments that are set up to support independence and help individuals to live well in residential services or when they are receiving support elsewhere.

An understanding of the outcomes for individuals must be central to everything that we do in social care, social work and early learning

and childcare. The experiences of the people who use those services must inform how the services are shaped, run and managed and how staff are supported to learn and to gain skills that are linked to those individuals' needs. There must consistently be positive outcomes, an enhancement of experience, the upholding of rights and the meeting of people's needs whenever they engage with a social care service.

I do not have information with me today to break the big picture down into more granular detail, but, if it would be helpful, I would be happy to write to the committee in order to distinguish where there is better performance and where there is room for improvement, and to show whether that is linked to certain service types or to particular provision.

The Convener: Heather, did you want to ask about the role of the inspectorate?

Heather Anderson: I think that my question has been answered, but I will have a couple of questions for Donald Macleod and Paul Traynor about self-directed support.

The Convener: Kayleigh, do you still have some questions about the inspectorate?

Kayleigh Kinross-O'Neill: I have a quick question about a specific statistic. You said that there was a 28 per cent increase in complaints. That sounds quite jarring, but might that be due to streamlining of the complaints process and to more people having a voice? Can you talk us through that in a bit more detail?

Gareth Adam-Hammond: That increase in complaints was specific to care-at-home services. Overall, the national trend shows the number of complaints reducing in recent years, and I think that we had 5,700 submissions across the whole of the system last year.

Complaints are a valuable source of information for the Care Inspectorate, particularly when we look at the totality of intelligence and information that we have about services and about how well they are performing. They are one facet of the multitude of information that we get. We get notifications directly from services, from local partner agents who can give us information, and from people who are experiencing care and are able to submit complaints to us.

We recognise the value of complaint submissions. The Care Inspectorate is unique in that we are one of the only regulators that has a statutory role of receiving complaint submissions as well as investigating them. We assess complaint submissions and strongly believe that complaints are best resolved as close as possible to the point of care. However, if there are significant and substantial risks to the health, safety, and welfare of people who are experiencing care, the Care Inspectorate will intervene and undertake an investigation. From that, we will set any recommendations for required improvements.

Over the past couple of years, the Care Inspectorate has helped to state that people who are experiencing care and using care services have a right to raise complaints with us. We have been actively involved in the national care service charter of rights, which specifically sets out the complaints mechanisms and processes and the support that people should expect when something goes wrong in their care provision, whether that is using advocacy services to help their voice to be heard and understood, or making their submissions to us. Different complaint pathways exist across the spectrum of the social care sector.

Heather Anderson: Donald Macleod, you were talking earlier about the role of the independent living fund and your concerns about how option 1 was being viewed in terms of gatekeeping. I thought that I heard you say that ILF Scotland could play a stronger role in managing packages of care. If that is correct, what would the difference be between ILF Scotland doing the job and there being an option 3 care package from the council? What would be the difference in the way that those budgets would be handled?

Donald Macleod: It is about separating the direct payment administration from social work intervention by transferring the administration to ILF. That would allow social workers to focus on assessment, intervention, and all the other things that I mentioned earlier. As I said, it is an administrative task that ILF is used to doing and could take on. It is also used to doing assessments and administering payments. It would allow people to take on an independent role in terms of managing a direct payment.

Through the PA programme board work, we have set up a range of tools to support people who want to do that. There is a range of PA employer handbooks, document resources, contract builders and all those kinds of things. We also have a recruitment portal and a range of other supports. The administrative aspect is about administering the money. If that could be done quickly, it would be straightforward. Personal assistants are not registered and their employment is not regulated. We ensure that there is support for employers in that regard.

I know that concerns about a bespoke scheme for monitoring and registering personal assistants were raised in the independent review of inspection, scrutiny and regulation. We spoke to the minister at the time about that. She felt that, given that there was a programme of work to

mitigate those concerns, no action would be taken while the programme of work was in place. That work is going from strength to strength and we are building on it.

We desperately need more PA recruitment, which I could go on about. We have advertised 1,600 jobs for personal assistants in the past year on the myjobscotland website, which were not available before.

Sorry, I have probably drifted away from your original question, but I hope that I have answered it.

Heather Anderson: Yes, I hear you saying that the independent living fund is easing an administrative and technical problem.

Earlier this year, housing legislation was passed that introduced the principle of ask and act, which means that the public sector must ask people about their living situation. Paul Traynor, you talked about having a systematic way of identifying carers. Could there be any useful parallels there?

The Convener: Sorry, it would be good if you could answer that question quite quickly, because Professor Macaskill needs to go in five minutes—

Professor Macaskill: I am able to stay.

The Convener: Right, okay.

Paul Traynor: On the point about the systematic identification approach, it is important to note that there are various systems regarding unpaid carers. For example, unpaid carers have the right to be part of conversations about hospital discharge, but that is not happening for the majority of unpaid carers. Similarly, at the point that a young carer is identified in school, they are supposed to be offered a young carer statement, but we know that that is not happening for a lot of children and young people with caring responsibilities.

We are also aware that only half of carers who attend general practitioner appointments with their cared-for person are being recorded through their surgeries. When carers are identified, they must retell their story in each situation, be that through their interactions with social work teams and social care teams or when they try to be part of the conversation as an equal partner in the care and treatment of the person that they care for. We are not identifying carers in a systematic way that lets them know that they have rights and builds an approach so that they can be supported.

There are examples of where more systematic identification has worked. For example, Wales has trialled a national young carers identification card, which has worked well for identification in schools, colleges and universities. We can look at models such as that and scale them up for carers, so that they are not required to consistently battle. When you speak to unpaid carers, they say that they feel that every conversation is a fight to get round the table to discuss the care of their cared-for person, and that they are often not recognised as an equal partner in that care conversation. They say that they need to fight to get social security support, to get support for their cared-for person or to get a care package when they are trying to arrange hospital discharge.

There are examples of where more systematic identification has worked, and we can tackle the issue if we look at it in a systematic way, such as with national identification approaches.

The Convener: Thank you. Jack Middleton, you had a question on national insurance.

Jack Middleton: I will quickly circle back to the financial landscape that is being faced just now in social care and ask about national insurance contributions, an issue that was reflected in virtually every submission to the committee. Ms Cackett, for our benefit, will you expand on the impact that the rise in national insurance contributions is having on workforce numbers and those who receive care, as well as on not-for-profits, which are perhaps needing to dip into charitable reserves?

Rachel Cackett: I am happy to do that. We are just today submitting our evidence to the UK Treasury in advance of the UK budget, in which we are once again asking for our sector to be excluded from the rises that previously came in. It is worth remembering that the change in employer national insurance contributions was a twofold change; it was not just an increase in payments but a reduction in the threshold. We must also remember that, because we are talking about a relatively low-paid workforce—for all the reasons that we have previously said—many of whom work part-time, the reduction in the threshold has had a particularly acute impact in our sector.

Colleagues at COSLA who have worked across many of our organisations have estimated that, in the first year that the change came into effect, there was an £85 million cost to the sector, for which there was very little relief anywhere. Unlike in the public sector, where there was at least some relief written into the chancellor's budget, nothing came to us. Therefore, providers have had to absorb those costs. It is not a one-off cost but an ongoing cost that increases each time that we increase salaries or try to bring more people into the sector, which becomes particularly difficult to do.

I am going to give you some figures about what our members have been facing, but, in and of themselves, ENICs are not the only thing causing financial stress in the sector. I say that because, in

a very political environment, it is easy to say that ENICs are the problem and to point to our UK Government colleagues for having made that decision.

11:15

Do I think that that was the right decision? No. Are we still asking for it to be changed? Yes. However, that decision fell into a landscape in which there was already significant financial strain, in the Scottish system, for all the reasons that we have been discussing, where contracts and commissions for delivering care did not actually reflect the true cost. The situation with regard to ENICs was just another pressure on top of that. I point out that we worked very hard with colleagues in the House of Lords and that amendments were passed that would have removed the ENICs liabilities from our sector but that those were overturned in the Commons. Therefore, we are in a highly politicised environment.

Our members estimated that, between them, in the first year of operation, they would have to find £30 million of that overall £85 million cost to the sector. We carried out a survey of our members in November last year and have been talking to chief executives, who have been trying to make every possible change to their organisations in order to preserve services, which is their ultimate aim. However, that has often meant swingeing cuts to back-office services and changes to terms and conditions in order to keep the wheels on the bus, so that the people who need support get it.

Despite that—I think that this is in our submission—we saw significant projections of more than 800 job losses among our membership and significant projections of people's care and support being negatively impacted. I am talking to members who are handing services back to local government because they can no longer make them work. All of that compounds the issues that we are dealing with. The ENICs issue is really important, and we still hope that the UK Treasury will create an exemption for social care, given that our new Prime Minister has made this his absolute priority. It would certainly be a massive shift towards increased sustainability, but it is one factor among many that has caused the problem that we now have and which we need to fix through the review process that has been announced.

Professor Macaskill: If I may come in on that quickly, I completely agree with Rachel Cackett. We have written to the UK Government asking for that provision to be removed or withdrawn completely. Again, there are additionalities, which I have already mentioned, such as rising fuel costs. One that profoundly impacts residential care is the sharp rise in food costs, which has been widely reported today. Another, which has not been on the radar but which we are deeply concerned about as we move into the winter period, is the change in requirements in relation to infection prevention and control. That change makes it a requirement for care staff in any social care setting to have face-fitting masks, which is going to cost any individual provider tens of thousands of pounds. We have not factored that cost in. I should add that it is the right change to make, on the basis of epidemiological and infection evidence, but it is yet another factor, together with the costs of fuel, food, the sharp increase in insurance costs and the cost increase in relation to clinical waste. Individually, any of those, together with the ENICs issue, would have been the straw that broke the camel's back, and they will, in my estimation—especially if we have a winter with a bad flu, coronavirus, respiratory syncytial virus or norovirus outbreak—undoubtedly result in some providers going to the wall.

The Convener: Is that a new requirement in relation to face masks?

Professor Macaskill: Yes, it came into force on 3 August. Providers can scale up until February 2027, but, if an infection breaks out, which, sadly, is just a fact of life in residential settings, staff will be required to adopt best practice. Again, the sector is not disputing the need for that, but it requires us to make significant investment to address a particular need. As Rachel Cackett highlighted, it is not one factor that is causing social care provision to be literally running on empty—it is multiple factors. That is why we will talk about reform but we also talk about survival.

The Convener: I was not aware of that particular issue. Will you send us some information on that?

Professor Macaskill: Yes, no problem.

The Convener: That is great.

Jack Middleton will move us on to another topic. We have 10 minutes left.

Jack Middleton: I have a specific question for Mr Traynor. I cannot find the submission in front of me, but section 8 covers the impact on unpaid carers who are looking after those with alcohol and drug issues. I tried to unpack that at last week's evidence session. Will you expand on that and explain which communities and areas of Scotland are most affected? In relation to the Scottish Government's alcohol and drug strategy, what are your asks in relation to giving the issue greater recognition, and what more can the Government do?

Paul Traynor: Thanks for bringing that topic up, because that aspect of carers' support is not often discussed.

There is a real issue in relation to carers who are caring for people affected by drugs and alcohol. Most unpaid carers do not recognise themselves as carers in this context. Even among those carers who are accessing local carer services, there is usually a relatively small number who access direct support services or are even aware that such services are available.

Perhaps the stigma that is associated with that means that such carers do not know about their rights. They do not recognise that there is legislation, such as the Carers (Scotland) Act 2016, that gives them rights that they can access. I have highlighted concerns in that regard.

In Scotland, one in five adults uses alcohol harmfully, and more than 46,000 people have problematic substance use issues. We do not know how many carers are caring for people who are affected by those issues. Little work has been done in that area. We have just finished a study with the University of the West of Scotland and Scottish Families Affected by Drugs and Alcohol. We are finalising the research, and it will be published in the next few weeks. It will highlight some of the unique issues affecting those carers.

One key aspect that we have highlighted is that policy development often does not include consideration of unpaid carers, and that is the case in mental health policy development, too. We want to ensure that, in the work on the new strategy, unpaid carers caring for someone affected by drugs and alcohol are part of, and dominate, that conversation.

I spoke earlier about the need for a systematic approach to identification. That is even more important for this group of carers, who are often forgotten. I have highlighted some concerns, which even extend to policy on breaks. Many carers caring for someone who is affected by drugs and alcohol say that, although they could physically take a break, emotionally and mentally they can never do so because of the changing circumstances of the person they care for.

The element that does not get discussed, and on which there must be a greater focus, is that the people surrounding a person who is affected by drugs and alcohol are often unpaid carers. We must have that conversation so that those people recognise themselves as carers, are made aware that they have rights and that support is available to them. Wider drug and alcohol policy needs to reflect that, too.

Jack Middleton: I appreciate that this is a difficult question, and probably one that the Scottish Government is facing itself, but how do we best identify those unpaid carers? If they are not engaging with existing organisations and services, how do we identify them so that we can get their views and feed them into the strategy?

Paul Traynor: I will be quite honest with you. When we were doing the research, that particular group of carers was really hard to engage with. Carers often do not want to come forward to talk about these issues because of the associated stigma. There are specific organisations, such as Scottish Families Affected by Drugs and Alcohol, that carry out bespoke work with families who are affected by drugs and alcohol. However, even in that context, they rarely regard themselves as carers, and that is the disconnect.

You can call yourself a brother or a father, but identifying with the concept of being a carer opens up doors in relation to the support that you are entitled to. You do not need to recognise yourself as a carer day to day—that is down to personal choice—but using the phraseology of caring opens up rights and support. Where someone has a long-term condition, disability or mental health problem, anyone in their family circle will likely have a caring role at some level. Where they are supporting that person, they can be identified in the ways that I set out earlier. They may be "family members", but I would use inverted commas, because they are in fact unpaid carers. The Carers (Scotland) Act 2016 says that an unpaid carer is anyone

"who provides or intends to provide care".

That is all that it says in our legislation, so all the family members that we are talking about are really unpaid carers.

The Convener: We have run out of time. I give you all a challenge: you can each give us one sentence, or speak for one minute, if you think that there is something that we have not covered. If it is a more detailed point, please feel free to send us something in writing.

I start with Donald Macleod. Is there anything you think that we should be looking at that has not been mentioned? There is probably a lot, but perhaps you can pick one thing.

Donald Macleod: I have nothing to add. The main areas have been covered, so I will hand over to the others.

The Convener: Okay. Thank you for attending online.

Mr Hammond, do you wish to say something?

Gareth Adam-Hammond: I just re-emphasise that social care, social work, early learning and childcare are distinct and unique within the totality of a system that supports people to live well. It is important, and incumbent on any of us who are moving forward in the space of reform and change, to ensure that that voice is equally heard and equally represented at the table in that discussion.

Care services provide valuable support to individuals and, overall, those services perform extremely well—88.1 per cent of services that we evaluated last year were awarded evaluations of good or better on our six-point grading criteria. That expert knowledge and skills, and experience and competence, ought to be tapped into. The Care Inspectorate welcomes any opportunity to be involved in consultations on any change or reform as we move forward.

Jill Laspa: Fundamentally, with some of the commitments in the programme for government, the principle of localism and local democratic accountability will be important. Again, we welcome the emphasis on early intervention and prevention, but we have heard today about some stark challenges in the social care sector in particular and a significant financial gap that has been plugged just in order to stand still, so I make a plea for that context to be brought into discussions on reform.

Professor Macaskill: The women and men who receive care and support every day, together with those who offer it, are among the most amazingly creative, entrepreneurial and innovative people in the country. They have to be involved in the co-design of a reformed system of social care, not least in that they have the necessary imagination, which many of us in the room perhaps do not have, because they live the experience of care and support every day.

In particular, that community is using technology, innovation and artificial intelligence in ways that I could not have imagined two or three years ago. Any reform today has to look forward to the abilities that arise from putting real care and control in the hands of citizens, moving from a person-centred approach to person-led support. We should walk with them on that adventure.

Rachel Cackett: We have focused quite a lot today on many of the issues in the sector, and it is important to know what those are in order to know how to change them. To reflect some of the optimism that has just been expressed, however, I remain optimistic that our sector can offer much more to the people of Scotland who need support.

If we want a reformed system that enables people—whether they are supported people, unpaid carers or members of the workforce—to genuinely thrive, my plea in the whole process, to all partners who are involved, is to get us around the table. The ability of our sector to come up with ideas and demonstrate what works is enormous, and I think that we can do much better than we are currently doing if we have a genuinely open conversation and are willing to put everything on the table and look at what will serve people better than what we already have.

11:30

Paul Traynor: I just want to highlight that Scotland cannot achieve such sustainable social care change without involving unpaid carers and local carer organisations. The preventative approach is important for unpaid carers, in the sense that, if we are not investing in unpaid carers now, they will potentially require care themselves in the future. We have highlighted as a key area that we would like annual health checks for carers to be introduced. That conversation is important. We hear about many unpaid carers who delay their own health appointments because they cannot find replacement care or services and because there are no flexible appointments available to allow them to do that. We need to focus on ensuring that unpaid carers are able to stay well, so that, if they are willing and able to continue in their caring role, they can do so.

The Convener: I thank everybody for coming today. We have had a good discussion of the subject, and I am sure that we will come back to it as it becomes clearer what the programme for government will bring forward. We welcome submissions from you if there is a specific point that comes up. Everybody is consulting in a three-month period, which is a short time, so if something comes out of that process and you wish to put it forward, please feel free to send it in to us.

Next week, we are taking evidence from the Scottish Government on its priorities across our whole remit of health, social care and support, so the relevant ministers and the cabinet secretary will be here.

That concludes the public meeting for today, and we move into private session.

11:31

Meeting continued in private until 12:19.

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