The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 8 May 2012

Session 4

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HEALTH AND SPORT COMMITTEE

15th Meeting 2012, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Jim Eadie (Edinburgh Southern) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Fiona McLeod (Strathkelvin and Bearsden) (SNP)
*Nanette Milne (North East Scotland) (Con)
*Gil Paterson (Clydebank and Milngavie) (SNP)
*Dr Richard Simpson (Mid Scotland and Fife) (Lab)
*Drew Smith (Glasgow) (Lab)

*attended

THE FOLLOWING ALSO PARTICIPATED:

John Alexander (Dumfries and Galloway Council)
Professor David Bell (University of Stirling)
Ron Culley (Convention of Scottish Local Authorities)
Andy Martin (East Dunbartonshire Council)
Dr Julie Ridley (University of Central Lancashire)
Janet Spence (Highland Health and Social Care Partnership)
Elaine Torrance (Scottish Borders Council)
David Williams (Glasgow City Council)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 2

Scottish Parliament

Health and Sport Committee

Tuesday 8 May 2012

[The Convener *opened the meeting at 10:47*]

Social Care (Self-directed Support) (Scotland) Bill: Stage 1

The Convener (Duncan McNeil): Good morning, and welcome to the 15th meeting of the Health and Sport Committee in 2012. I remind all present that mobile phones and BlackBerrys should be turned off, as they can interfere with the sound system. No apologies have been received.

Since our last meeting, there has been a change in committee membership. I welcome Nanette Milne to her first meeting as a member of the Health and Sport Committee, although we all know that she has appeared at previous meetings. I am sure that everyone would agree that we take this opportunity to thank Jackson Carlaw for his contribution to the committee over recent months.

Agenda item 1 is an oral evidence session on the Social Care (Self-directed Support) (Scotland) Bill. As people are bound to have noticed, the session is in round-table format, so the witnesses are sitting among committee members rather than at the far end of the table. We hope that that will generate a more open and free-flowing discussion. It would help the process, though, if all participants could indicate to me when they wish to speak.

Richard Lyle (Central Scotland) (SNP): I wish to declare an interest. I am a board member of Phew (Scotland), which is a care provider in Motherwell, in North Lanarkshire.

The Convener: Thank you for putting that on the record.

I welcome David Williams, the assistant director of social care services at Glasgow City Council; John Alexander, the director of social work at Dumfries and Galloway Council; Janet Spence, the programme manager for modernisation and quality assurance at Highland health and social care partnership; Dr Julie Ridley, the project leader of the self-directed support test sites evaluation team and a senior research fellow at the University of Central Lancashire; and Professor David Bell, a professor of economics at the University of Stirling.

I am looking for Bob Doris around the table—he is usually right by my side. We have practitioners here and we are interested in practical experience, so I ask him to gently open the questions on that, after which we will see how it goes.

Bob Doris (Glasgow) (SNP): I thank everyone for coming to our first evidence session on the new bill. I was struck that, after several million pounds and three years spent on facilitating the pilots, only 150 cases of self-directed support were developed as a result. I think that two of the test areas are represented today. I am interested in what the numbers were in those areas and what the barriers were to developing more such arrangements. I am particularly interested in knowing what discussions were held with individuals to decide how best to assess care needs and have some form of co-production for the most appropriate self-directed support. Having that information might be a useful start for the committee.

David Williams (Glasgow City Council): About 30 to 50 of the 150 cases were in Glasgow—as members might imagine, the numbers were very low in the three areas involved. The experience in the east end of Glasgow was probably the result of having a seismic change in how business is done. People were always going to take a bit of time to have confidence in taking up the opportunities that self-directed support provides. One consequence of the pilot's experience in Glasgow was that the council decided that we needed to look at a significant change in how we do our social work business in relation to community care, to encourage and promote the take-up of self-directed support by individuals.

Operating two systems for assessment and the provision of services is difficult, particularly when one of those systems has operated for almost the full life of the community care legislation, which dates back to the beginning of the 1990s. For instance, if adults with learning disabilities came to the attention of local authorities with needs that were assessed and identified, the traditional response of local authorities, including Glasgow City Council, was to commission a package of support for that individual. People are comfortable with that. The notion of people moving to directing their own support and being given a choice and the opportunity to control the arrangements around them is alien to people, particularly in a risk-averse climate that involves the most vulnerable individuals in the community.

We must ensure that the infrastructure is well established to support individuals who wish to take up self-directed support. That involves care managers and social work professionals taking a different view about how they should go about their business. It involves infrastructure to support the availability to service users of the range of resources and provision that is out there and the development of a different marketplace for the provision of services. There are also infrastructure issues to do with how we assess need and involve individuals in the assessment of need so that there is genuine co-production. There is then the question how we allocate an individual budget so that it ensures fairness and equity for all individuals, whether or not they choose to go down an SDS route.

John Alexander (Dumfries and Galloway Council): When the evaluation was reported, there were 36 cases in Dumfries and Galloway out of the take-up of 150.

I will say a couple of things to put that into context. I agree with David Williams, in that a large part of the explanation is that we were not being asked to make a minor tweak or adjustment—this was quite a seismic shift in how we do our business. It is inevitable that we appear to make slow progress in the early stages of implementation. Once the early stage of transformational change has been worked through, there is often a much quicker take-up of the new way of working. In March 2011 the number of cases was 36, by September it had risen to 64, and by the end of the year it was 86. The number is still rising, although I do not yet have verified numbers for the end of March this year.

The traditional way of assessing need and delivering social care is essentially founded on the National Health Service and Community Care Act 1990, which began to be implemented on a phased basis from 1991—more than 20 years ago. I have many front-line practitioners who have known no other way of working. I am old enough to remember social work before 1991. Although my memory is probably not as good as it once was, I can remember doing, in that period, much more of the kind of thing that self-directed support asks us to do. However, my point is that we have to do a bit of unlearning with practitioners before they begin to grasp the opportunities of the new way of working.

Apart from the transformational change, which can mean that progress is slow to begin with, a factor is that the pilot covered only one area in Dumfries and Galloway, even though it was the Dumfries and Galloway pilot. We chose the Wigtown area, which is one of our more rural areas. As you will be aware, the research was trying to find out how SDS worked in urban, remote and rural communities. We were the rural pilot.

We had to invest quite a bit in support, not just for our staff but for the men and women whom we intended to recruit—if that is the right term—to the pilot, because this would be a new experience for them. We also had to do some work with our partner agencies, particularly the providers of social care, because, for all those people, this was an extremely significant shift in how they did business.

Mr Doris asked how we went about talking to the people who might be involved in the pilot. We adopted what we described as a community development model. It was very much about sitting down and engaging with groups of service users, explaining to them in the most straightforward and simple language possible the seismic shift that we were trying to make, and moving at the pace at which they were comfortable to move.

David Williams talked about risk-averse cultures. For many people, the idea of setting off on a different course was quite daunting, and they needed quite a bit of metaphorical hand holding before we could really get the thing moving. The numbers that have come on stream since then show that, once the initial hurdles are got over, the state and rate of progress can be much quicker.

11:00

Janet Spence (Highland Health and Social Care Partnership): I reiterate what my colleagues have said. To put the Highland health and social care partnership experience into context, I say that we had quite a sound record on the old-style direct payments, albeit that the system tended to be quite rigid and did not offer the range of choice and control that people desired. Nevertheless, our staff understood the concept and were quite good, in some places, at promoting the payments. We started from quite a good place.

The SDS pilot project was one of the significant workstreams in a major programme of transformational change—we had 15 different workstreams—in the Highland health and social care partnership. Our blueprint was the new joint community care plan that was published around that time.

We consulted widely, which was important. We heard from the public that what they want is greater access to self-directed support and less bureaucracy. In addition, our workers said that there is a lot of bureaucracy with the parallel system of direct payments that we have at the moment. The pilot gave us an opportunity to grow our self-directed support from that basis.

The numbers involved in the pilot were reasonable. I think that we grew from around 150 cases and more or less attained the aim of 200. Under the equivalency model that we had used up until that point, we would have assessed somebody’s needs, assessed what we would have given them in terms of a traditional service, and then made an equivalent money award. The SDS way of thinking, through the pilot, required a major mindset shift to focus on outcomes. That was the major change. The focus was on identifying strengths and opportunities and building on what people already had.

Our focus in the pilot was twofold. The main focus was on a group of young people in transitions, which is when people move from receiving children's services to accessing adults' services. There was a lesser focus on hospital discharge. The former was very successful but, unfortunately, for a number of reasons, the focus on hospital discharge from one community hospital was less successful. I think that that was largely due to the major mindset shift that was needed, particularly in the hospital and among health staff. Reflecting on what we achieved during the pilot and comparing that with where we are now, I think that we have come a very long way in a short period.

The Convener: It would be helpful to me if panel members could press their microphone button so that I know who wants to come in.

The discussion has taken us naturally to the question why, given all the practical difficulties, legislation would be beneficial in addressing some of the issues. Although I am going on and on myself and I know that these are difficult questions and that the witnesses have been involved in the matter for a long time, I sound the cautionary note that we need more concise answers so that we can get our questions in.

Bob Doris: I will try to be disciplined and ask some questions that seek short responses before other MSPs come in.

You said that between 30 and 50 people took up self-directed support in Glasgow. I seek a bit of clarity. Does that mean that others were offered alternative forms of care services but chose to go for the traditional council model, in which case the number involved will be greater than that? My understanding is that self-directed support is not necessarily about going for an alternative model but is about being given other options and, if someone wishes to go with the traditional route, that is a valid choice. Is the figure higher than 30 to 50?

David Williams: There will certainly have been people who took a different route and had a different form of service.

Bob Doris: My understanding is that such people should be included in the figures. Otherwise, we are channelling people down one aspect of self-directed support.

David Williams: Yes.

Bob Doris: If someone makes a conscious effort to go for a traditional council service, that, too, is a valid choice. Is it the same for Highland?

Janet Spence: Yes. I think that we were fairly poor at recording the number of people whom we engaged with and recorded only the number of people to whom we awarded packages.

Bob Doris: That is useful to know.

Before I let other MSPs in, I have another brief question. The Dumfries and Galloway pilot finished about 14 months ago, but the upward trend continues year on year. Whatever Dumfries and Galloway Council has done in the Wigtown area, it has put some roots down to continue that work. Do you have the figures, or can you make them available to the committee, for what happened in Glasgow and in Highland? If so, has the trend continued? It would be useful for the committee to know about that.

David Williams: In Glasgow, the council decided in October 2010 to roll out the implementation of personalisation, as we have called it, right across the city to include all adults who have learning disability needs, all adults who have physical disability needs, people with mental health issues and children with disabilities. That programme of roll-out and implementation was to take effect over a two or three-year period from 1 May last year.

In the year since then, we have taken approximately 900 individuals with a learning disability through personalisation, which is the process that Glasgow has developed as a consequence of the pilot and through which individuals will be able to direct their support themselves. Approximately 900 individuals with a learning disability have therefore moved from a traditional care package to an outcome-based support plan. A small number of those individuals—substantially fewer than 100—have chosen to direct their support themselves, for the reasons that I outlined previously.

Out of the four options available, the overwhelming majority of service users have gone for option 2 or option 3, through either an individual support fund or a directly provided service.

The Convener: Does Dr Ridley want to come in, given that we have discussed the pilots?

Dr Julie Ridley (University of Central Lancashire): I will add to what the witnesses from the three local authorities have said. We said in the report that, although the numbers seem small, it is probably a mistake to focus too much on the individual packages, because something of this magnitude—witnesses have talked about seismic change—takes a lot of time and requires a lot of investment in individuals' skills and in building up the expertise in the local authority to work in this very different way.

It should be borne in mind that, when the evaluation started and the test sites were first set up, the definition of self-directed support in Scotland was very much aligned to direct payments. It is significant that the situation has developed over the duration of the test sites. It is very complex to measure the number of people who receive SDS packages and capture the number of people who are affected by the new systems. The evaluation addressed that to an extent, but there are limitations. People have mentioned the need to set up different infrastructures to look at the way in which the marketplace is operating, and at new assessment and allocation procedures, which takes a lot of time. The Scottish Government has recently commissioned the evaluation team to undertake a follow-up evaluation to capture what has happened in the past year, which will make some more figures available to you. We must be mindful of those limitations.

The Convener: Before I bring in Fiona McLeod, I will give my view. We are making progress. A big cultural change is needed, and some progress has been made in Dumfries and Galloway, where the change is starting to bed in. Part of the committee’s job is to understand why we need legislation. Why do we need legislation to push that on when it is already happening?

John Alexander: Local authorities effectively operate at all times in a framework of statutes. If there is to be a fundamental shift in how local authorities allocate resources, it will be extremely helpful to have a clearly stated statutory base on which to do that.

We can make progress by means short of legislation—for example, by shifting professional behaviours, encouraging a different culture and working with our partners on what might be termed an informal basis to change the way in which we proceed—but there is no doubt in my mind that clear legislation that places duties on and assigns powers to local authorities is an enormous help in moving forward and consolidating change. It sends a clear signal about what is expected in the way of improved practice.

I do not think that legislation in any field is ever sufficient to deliver change, but it is often a necessary condition to allow change to be delivered. That is my argument in favour of legislation.

The Convener: Are there any other views?

David Williams: I do not want to take up too much time, but there is an issue of fairness and equity throughout the country. Our experience in Glasgow is that, by and large, the level of support and service that was provided for someone with an identified learning disability need depended entirely on the point at which they came into the system. Resources must be factored into that process.

We need to ensure ahead of legislation that, regardless of their disability, people with particular identified needs can be involved in a system that is fair and equitable. The way in which we have developed personalisation in Glasgow provides for that. Other local authorities may not choose to take that route, but citizens throughout the country have the right to fair and equitable services.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I have a couple of specific questions that have arisen from some of the comments from Highland and Glasgow. You may want to give us the answers in writing later, rather than going into detail now.

I would be interested to know more about why hospital discharge was not so successful in the Highland pilot. You may want to write to us about that.

David Williams listed the care groups that had been identified, but those did not include older people. Why is that?

This question is for all the participants. Did you reassess the care needs of folk, or did you base your work with them on their care needs as currently assessed? Did you think about whether an appeals mechanism might be necessary for those moving to self-directed support, given that it is based on people’s perception of their own needs rather than your perception of what they need?

Mr Alexander from Dumfries and Galloway mentioned community development, but have any of you put in place advocacy support for people moving into self-directed support? Finally, what engagement have you had with carers? Have you had only informal engagement or have you looked at how you might support their needs?

11:15

David Williams: I will try to respond to a number of your questions.

We will write to the committee on the older people issue but, in short, we felt that our agenda was big enough with the care groups that I have mentioned. Given that, in total, we have about 1,800 learning disabled adults, 800 individuals with physical disabilities and about the same number with mental health issues in our system, we felt that, with regard to a programme of service reform, we had big enough chunks to deal with before we got to older people. That is not to say that we will not get to older people; the council has not taken any decisions or reached any conclusions in that respect.

We have reassessed every individual with a new outcome-based support plan, which has taken some time. The assessment process contains, right from the outset, a co-produced self-evaluation questionnaire in which the individual has an opportunity to state how they see their needs and what levels of support they require to meet them. An outcome-based support plan that takes account of not only service users' individual views but other responses is then developed. In addition, no professional approach can ignore current or previous assessments that have been made. A combination of those bits of information needs to be taken into account in the development of the outcome-based support plan.

As for your question about appeals, we have built into the process a series of safeguards rather than any mechanism as such and have, for example, developed what we call a risk enablement panel. We have had to put in place a resource allocation system to deal with the amount of money that individuals get to purchase services and if, at the outcome-based support plan stage, there is a shared view that the level of resource for meeting an individual's needs is insufficient, the matter can be taken to the risk enablement panel. Of the nearly 900 people with a learning disability who have been through the process over the past year, about 140 have taken their case to the panel, and the same process will be in place for the other care groups as we continue to roll out this approach.

There is certainly an expectation that advocacy should be available to all those who choose to go to the risk enablement panel. Indeed, over the past year or year and a half, investment has been made in such provision, primarily through funding for adult support and protection.

Finally, on engagement with carers, we routinely meet carers groups in both a professional and a political context. Obviously, we cannot possibly meet with every carer—except, where appropriate, through the individual planning process—but we have established an officers and members learning disability working group that routinely has the issue of personalisation on its agenda. We also have professional meetings with carers groups across the city.

John Alexander: In the interests of time, I will say simply that we had the same approach to assessment as the one that David Williams has described, which means that we carried out a reassessment, taking into account previous information that we had.

On appeals, I think that I am right in saying that no one was refused the opportunity to go down the self-directed support route, so the issue of appeal did not come up. We had a risk-enablement panel of the kind that David Williams described, which was set up to tease out some of the expected outcomes and how best those outcomes might be achieved. There tended to be a consensus about the way forward in that regard. Even though only perhaps 36 people out of around 100 or so were involved in that process, the 70-odd people who were not involved were not aggrieved; they came to a consensus view about the best way forward and, from that point of view, we were following their wishes.

On the issues of advocacy and carers, we had a personalisation programme board, which I chaired. It contained representatives from one of our key citizen advocacy organisations and from the Princess Royal Trust for Carers in Dumfries and Galloway. That enabled us to take strategic decisions about what advocacy support could and should be provided, and the programme board could take that away and deliver it. It also meant that there was proper formal engagement with carers.

The carers' involvement was critical. Although we were not limited only to men and women with learning disabilities, they made up the majority of the people who were being considered as part of the self-directed support pilot, and it was particularly important to engage with and gain the confidence of carers with regard to how that process and the risks around it would be managed. The formal involvement of the Princess Royal Trust in the work that was done around the table and the subsequent groundwork was invaluable.

Janet Spence: Fiona McLeod asked for additional information about the hospital discharge aspect of the project. I would be happy to provide some written information about that.

Like the other local authorities, we undertook reassessments. We had specific arrangements in place for appeals that were quite similar, also.

We did not invest in advocacy as a result of the pilot, but we already had good access for people to advocacy agencies, including carer advocacy. I am aware that advocates were involved in the process.

With regard to carer support, because the pilot's main focus was on transitions and young people, carers were very much involved, and there was a great focus on engagement with carers at all stages of the project.

The Convener: We have heard from the bill team, prior to today's meeting, and from witnesses this morning about some of the issues, such as assessment; reassessment; the time that needs to be invested; skills; training; and the transitional cost. Professor Bell, you represent the voice of hard reality. What do you have to say about the suggestion that the proposal is cost neutral?

Professor David Bell (University of Stirling): The work that we did showed that the recorded costs of SDS were not that different from those of standard packages. That was the same result as had been found in the IBSEN—individual budgets evaluation network—studies in England. The costs are extremely skewed. We did not have a big enough sample in Scotland, but I did similar work in Wales and found that 10 per cent of the people accounted for 40 per cent of the costs and that 40 per cent of the people accounted for 10 per cent of the costs. I do not have the exact figures, but the situation in Scotland is similar.

With SDS, there is not much take-up yet among older people; take-up tends to be from younger people, so the commitment is longer than would be the case with older people. What I would call transaction costs arise on both sides of the market. Local authorities are trying to adjust to the new situation and are almost running two systems in parallel, which is clearly difficult for them. On the other side of the market are the providers, who are trying to deal with a situation in which they do not know exactly what level of demand they will face, because clients are largely free to choose whom to ask to supply services to them.

We are looking at quite a different situation. It looks as though the recorded costs are pretty much the same, but we found it difficult to get good-quality costing information that would allow us to say hard and fast that the figures were comparable across local authorities, or even allow us to compare the SDS against the standard type of package. However, the figures are not wildly out of line. Clearly, some of the costs will be transition costs. There is a learning process that will eventually be embedded in local authority systems. Hopefully, on the other side, providers will adjust to the new situation, too.

Dr Richard Simpson (Mid Scotland and Fife) (Lab): That is very interesting, because it raises the point that other partners—the third sector and independent providers—are involved in all this. Those two groups are critical for the shift that will occur.

Although they are nothing more than murmurings, I have had one or two e-mails on the issue. I got some e-mails on the Glasgow situation—I think that the Church of Scotland was one of the groups involved—which said that there were concerns around the process and what its effect would be. It is clear that there will be a big adjustment for the third sector, as well as for the local authorities.

I wonder whether the evidence from the three research sites, both from the research period and consequently, shows that there are concerns in those areas. If so, how are they being dealt with? How is that element of the partnership being drawn on so that we do not destabilise the independent sector? On the other hand, how do we ensure that we do not place too great a burden on it? The situation works both ways. In other words, how does the market adjust? That is what David Bell was really talking about.

The Convener: I think that Gil Paterson will continue in a similar vein.

Gil Paterson (Clydebank and Milngavie) (SNP): Yes, I have a question for Professor Bell. You said that, in effect, two systems are running at the same time. Is that not a cost in itself? Or do you take an individual who is running in one system and put them into the other so that, in effect, there is no additional cost? If my judgment about that is wrong, have you looked at what the potential is if many people turn to the self-directed support system? Is there a tipping point at which the system that the council provides would fall down because there would not be enough traffic through it and the costs would be relatively high?

Professor Bell: On your last question, there comes a point at which what you suggest would happen. I listened to the earlier discussion about how take-up had been pretty slow in Scotland and, indeed, very disparate and massively different across different local authorities. My feeling is that growth in the market will continue and that, as the baby boomers come into the care situation, they will expect to have more control over the support that they get.

11:30

The question is then, what is the role of local authorities if a large proportion of the clients want self-directed support? Local authorities will become enablers rather than providers as their enabling role increases and their providing role decreases. There are lots of difficulties associated with that. The support may move to personal assistants who are not necessarily trained to the same level as social workers, and the way in which support is provided through the system may change. There could come a tipping point if there were a rapid acceleration in demand; therefore, it would probably be better to try to keep a reasonable amount of control so that the transition takes place over a reasonably long period. However, I take on board Richard Simpson's point. If take-up is quite low, the providers may not achieve sufficient scale to be able to operate effectively in the market—they may have to operate across several local authorities, which would be especially difficult in rural areas where there are lots of transport costs as well as the cost of the provision of care.

John Alexander: The convener's question to Professor Bell was about the proposal being cost neutral, and Professor Bell's response teased out some of the uncertainties about that. We must continue to keep the issue of costs under review, because local authorities, like other parts of the public sector, are under significant financial pressure at a time of growing need. We need to look at that area closely.

Even supposing that there were no increase—or, indeed, saving—in cost through the implementation of self-directed support on a more widespread basis, it could be argued that there would be a best-value benefit from the introduction of self-directed support in the sense that there would be much more control in the hands of the individual citizen of the outcomes that would be delivered for any given investment of public funding and they would exert more control over how that funding would be deployed. It might still cost £20 to do whatever we are doing, but I expect that £20 that was spent by a citizen would deliver more for that citizen than I, as a social worker, would deliver if I spent £20 on that citizen's behalf. There would be a best-value benefit.

The Convener: We have heard in evidence a concern that family members could deliver the service and the individual's ability to complain about or change the service would be limited by the closeness of that relationship. We have also just heard from Professor Bell that there could be a dilution of the profession and that, rather than a fully trained social worker or professional person providing the care, we could have someone providing the care who is cheaper but who is not trained to the same level.

I am trying to tease out the certainty about the outcome. I am sure that there is evidence from down south, where people have maybe done more of this and can be more certain of the outcome of the legislation. Are we just perceiving the care to be better because somebody has eventually made the choice? Someone could be victimised twice over—they chose that care, so why are they complaining? Does no one want to respond to that? No? I will let Gil Paterson back in on outcomes.

Gil Paterson: I will ask Julie Ridley a similar question. Is there any research into how self-directed support is perceived by the users in the pilots? Are we trying to provide choice or better outcomes? I had better not say what my view is. If we are searching for better outcomes and better use of tight budgets, is there any information on that from the three pilot sites?

Dr Ridley: The evidence on outcomes is fairly limited. We examined 10 case studies in each of the three local authority test sites. People's experiences of assessment and the kinds of packages that they got, as well as how they felt about the support that they were getting, were overwhelmingly positive.

As evaluators, we were limited because some of the packages had only just been set up because of the time that it took to get systems under way and for people to experience the new system and receive SDS packages. However, our findings have resonance with other research from England, in relation to people's experience on choice, control and flexibility.

I will pick up something that was said about advocacy. To be honest, we found extremely limited evidence of the involvement of independent advocates in helping people to work through what should be in their assessments and what they wanted. That meant that assessments were sometimes tailored around carers' perceptions. That was quite a gap.

Gil Paterson: Are you saying that the receivers of the benefit felt good about it?

Dr Ridley: Yes, I am. If there is time, I could share with you a couple of case studies.

Gil Paterson: I would be happy if you could provide them in writing.

Dr Ridley: Right.

The Convener: That would be good if it is additional evidence that we do not have.

David Williams: I return to Dr Simpson's questions on providers. His use of the word "murmurings" for complaints was very diplomatic. It is fair to say that a significant level of anxiety has been expressed over the past year and a half in Glasgow, particularly by providers. I think that that is just because of the scale of the change that we have endeavoured to implement in Glasgow. It is important to acknowledge and recognise that.

I was a director of one of the country's largest voluntary sector providers up until I came to my current post three years ago, so I understand that side of the world clearly. We have endeavoured to engage with the provider sector regularly and clearly. We do not do that to direct the sector, because that is not the local authority's responsibility. Providers need to take responsibility for their own destiny in how they adjust to the marketplace. The local authority's responsibility, which we have tried to fulfil, is to set out the vision of what the world will look like as a result of personalisation and self-directed support within Glasgow and for a number of providers nationally, with or without the bill.

There may be increased demand from individuals not to focus on an inputs-and-outputs contract. Under that type of contract, which is, historically, the type of contract that local authorities have had with providers, a number of needs for a number of individuals have been identified and the local authority has commissioned a provider to give those individuals support to meet those needs, but there has been no focus on outcomes. Providers need to focus their attention on outcomes to retain business. They need to ask themselves, "What do we need to do to ensure the continuity and consistency of business?" It is about delivering results.

On the delivery of outcomes, in Glasgow we have focused on things that came through the talking points initiative, which related to the national agenda to seek the views of adults about the kinds of things that they would want local authorities and statutory services to provide. There were questions such as "Can I be kept safe?", "Can I be engaged?" and "Can I be involved in communities?" The voluntary sector and independent providers need to address how they deliver their services in a way that will ensure that needs are met and outcomes are delivered. By definition, that will create a business and a marketplace. If those providers can then profile themselves as providers who can deliver outcomes and their profile is in the general perception and the general marketplace, people will go to them.

In Glasgow, we are developing a portal of information to which there will be web-based access. We will have an information-sharing session with providers at the end of this month or the beginning of next month, I think, which I will introduce. The portal or web-based provision will be demonstrated for service users and citizens in Glasgow. People can say, "I've got this need. Where can I go to find a provider that can deliver services to meet it?" The portal will have all the information, including costs, in due course.

Dr Simpson: That is exactly the enabling approach—

The Convener: Mr Alexander wants to say something, Richard.

Dr Simpson: I am sorry.

The Convener: The view that we have heard might be a city or Glasgow view, but there are other issues. Portals have been mentioned, but in some communities we would find that there is nothing—the capacity is not there—and that needs to shift. Perhaps Professor Bell can address that issue as well, but Mr Alexander wants to say something first.

John Alexander: I want to return to Dr Simpson's question about providers. There is no doubt that the seismic shift that we have talked about poses a number of challenges for them. I will simplify matters. Rather than providers facing one commissioner—the local authority—and having to work very closely in partnership with that commissioner, they could face hundreds of commissioners, and perhaps thousands in cities; I refer to the men and women who will have control over their direct payment or individual budget. How on earth can that process be managed? That is a challenge for the providers.

In Dumfries and Galloway, we have the added challenge of rurality. Some of our providers' unit costs are that bit higher. If we put that into the mix, there are concerns among providers.

We have a series of forums for providers for particular care groups, whom we meet regularly to talk through the strategic challenges that we have to address severally and individually to bring forward self-directed support. Many of our biggest providers are national organisations with local branches that deliver the services, and they are plugged into the debate at the national level. I know that the Coalition of Care and Support Providers in Scotland has done a significant amount of work on what the challenges of self-directed support are for the sector and that it is providing support centrally to a number of organisations to do such work.

However, just in case people think that we are moving from a situation of 100 per cent security for the market to 100 per cent insecurity, I should say that, over time, we have moved away from a situation in which local authorities let block contracts to provide. I am old enough to remember situations in which we had block contracts. Very often, providers were guaranteed the money. The money went to them whether or not they provided a service, or whether or not the service was what we wanted them to provide. Like all the other local authorities, Dumfries and Galloway Council has moved to spot-purchase contracts. We fund organisations only if we have assessed that there is a need and if the service that the organisation is able to provide is the right type of service to support the need and deliver the right outcomes.

Organisations in the market, whether they are in the third sector or the independent sector, are already in an uncertain environment, so the bill does not represent a seismic shift from security to insecurity. Perhaps we are moving a little further into insecurity in that there will not be a single door to knock on to have the conversation. We will need to be more flexible and subtle in how we go about delivering services.

11:45

The Convener: That leads me to a question for Professor Bell. In order to exercise the choice that the bill gives them, people will need to have a door to knock on. Through Gil Paterson's question, we examined the issues that local authorities are facing, but charitable organisations in the third sector and organisations in the independent sector also provide a lot of care. Under the legislation, people might decide that they do not need those organisations and that they will turn to a close friend or relative, who will provide all the care. Have you done any work on the challenges that all the providers—not just the local authorities—are facing?

Professor Bell: Only a little. The issue is exemplified by Mr Alexander's point about the difference between a block contract and a spot-purchase contract. If a provider has a sum of money assured almost irrespective of what it does, it is in a pretty good situation, but with a spot contract it has to focus on the outcomes. That is a beneficial aspect of the bill. With my Finance Committee hat on, I point out that that committee is looking for measurable outcomes, and a web-based portal about what providers are providing seems to be on the right lines.

Clearly, individual providers are facing many challenges in areas such as training, how they attract people into the workforce, how they retain them, and investment. If a provider is not sure what it will have coming through the till next week, how much should it invest in training, physical capital and so on? There are undoubtedly many challenges and we cannot be certain what the outcomes will be. It is important for local authorities to make the market as transparent as possible by interacting with the providers and somehow ensuring that there are helpful measures of outcomes that potential clients and their carers can see so that they can make reasoned judgments.

Drew Smith (Glasgow) (Lab): I am interested in who supplies services and to what extent the method of procuring them will drive down costs. What has your experience been of the decisions that people have made so far?

The convener gave examples of who people might approach to provide a service, and I can think of others. Someone's choice might depend on where their advice came from. For example, a person might fill in a questionnaire with the help of their home carer or someone else, who said, "If you tick that option, I'll come and provide the service for you, but I'll do it on my own, outside the local authority. I'll be a private provider for you." There seem to be a range of possibilities for abuse in that situation. That is an additional concern, on top of the fact that the independent sector or the voluntary sector might provide a service at a lower cost compared with the public sector, in which case there might be an assumption that the level of service will start to decline.

Do you have any thoughts—or experiences based on what has happened in the pilot areas—that could reassure me about those concerns?

David Williams: We should not lose sight of the role of the care manager, which remains central in ensuring adult protection and ensuring that people's rights and responsibilities are not overrun by the home carer's ability to say, "I'll do it myself." Certainly in Glasgow, the outcome-based support plan has to be signed off by the resource screening group, so it could not be organised through back-handers or wheeling and dealing. As I understand it, the scenario that you described has not been the experience in Glasgow to date.

There have been situations in which people whose package of support came from one provider have moved on to a care plan that involves their receiving provision from a number of providers, including the existing provider, which it is to be hoped will result in the outcomes being delivered. That is not necessarily about care; it is about the existence of the opportunity to gain access to a community. Does it need to be a professional voluntary sector social care provider that we encourage to become involved in communities? I guess that the experience that people have had through the development of their outcome-based support plans is that that is not the case. The local sports centre or a range of other community-based resources can do that. A cost still needs to be attached to the service that is provided, but it does not need to be a professional social care agency that delivers it. Such arrangements are in place.

Glasgow City Council has taken the position, however, that family members or neighbours would be engaged as personal assistants only in exceptional circumstances, for example, when people have palliative care needs. In such circumstances, the engagement of a family member or a neighbour to act as a personal assistant would not be unreasonable, but I presume that it would be time limited. On the whole, that is not a route that we would go down.

Given that there are people who have personal assistants, one of the questions that the committee needs to consider in the context of the development of the bill is the role of the regulatory bodies in relation to personal assistants and professional qualifications. Does the Scottish Social Services Council have a role to play as the regulatory body? I am not sure.

Janet Spence: I have two points to add. First, it is important that we invest in community capacity building. In Highland, we are in the process of finalising strategies on community development and volunteering, which will be important in running alongside the work that we are doing around SDS.

Secondly, in very isolated communities, it has often been the case that we in the statutory sector have really struggled to find resources to support individuals. The SDS work has helped to identify that there are neighbours, friends and extended family members who may be in a good position, on both a short-term and a longer-term basis, to support someone who, for example, has come out of hospital. There is greater flexibility in that regard and, in recent times, we have seen some very good examples of local communities coming together to support an individual, where hitherto we have been unsuccessful.

The Convener: Do you have a view on the regulation of personal assistants and to what extent they are covered by things such as Scottish Criminal Record Office checks? Should personal assistants be regulated?

Janet Spence: At the moment, there are no plans for personal assistants to be regulated through the Scottish Social Services Council. It is a difficult issue. We are talking about people who provide personal care to vulnerable people, so I think that we need to look at regulation.

Drew Smith: That leads to my next question. Did you carry out an equality impact assessment of the sort of people who were taking advantage of options 1 and 2 and, in particular, direct payments? If so, did you find that certain kinds of people were more likely to make choices than others? For example, were individuals with a single condition more likely to understand their needs than those with multiple conditions or whose situation was more complicated? I am no care expert, but I think that we can all appreciate that it is not necessarily likely that the most vulnerable in these settings will be those most able to make choices and to be informed consumers. What assessment was carried out in the pilot areas in that respect?

Dr Ridley: First, I note that the situation is changing and that such changes should be picked up in the follow-up study. Our evaluation of the data that we collected from the three local authorities on individuals with SDS packages showed that the majority—64 per cent—had learning disabilities and that, overall, more men than women took up the option, although the proportions differed between local authorities. In Dumfries and Galloway, for example, the majority were men; however, the reverse was the case in Glasgow.

The age profile differed quite a lot but, as you will remember, Highland focused on young people in transition, which meant that in that area the profile was made up of young disabled individuals. There were very few older people and the individuals were all white British or Scottish. However, although no one from a black or ethnic minority community was captured at that time, I believe that the situation has since changed. We will find out the extent of that through the follow-up study.

With regard to the options, the vast majority—107 of the 132 people involved—chose to have a direct payment, while 24 chose to have an individual service fund. The funding streams were predominantly funded by social work and client contributions, and we saw no evidence of mixed packages funded by, say, housing, health or other streams.

Does that answer your question?

Drew Smith: Partly. I would like to know more about the issue, and I am sure that a lot more reading will be required as we consider the bill further.

Going back to what Mr Williams said about providing people with a choice, I do not think that a lot of people in this group will be likely to access an online provider portal, which raises the question of who will advise these individuals and where the provision of such advice should sit. I know from my case work on the personalisation process in Glasgow that people are expressing concern about these moves. Given the cuts that they perceive are being made in other services—day care was mentioned earlier—and their fears about changes to the benefits system, there is an issue of lack of trust in the public sector and government in general and in the local authority's objectives. If, when presented with such a choice, individuals simply assume that it is all to do with giving them less, surely a representative from the local authority cannot take them through the process and say, "You should choose this or that option," because the individual in question might well not trust their advice. Equally, however, the local authority might be best placed to provide independent and informed advice about what is available, whereas a carers organisation might not have all that information. Is there any general view on how people might be assisted in making such choices?

The Convener: Can we have brief answers, please?

David Williams: Transparency, by definition, will assist the process, because it takes away from care managers the opportunity to direct things. Of course, there is a co-production issue, but as a result of the transparency in the portal the individual can discuss the available options with an advocacy worker, a family member or a provider's key worker. It is all about transparency and who is involved in co-production.

12:00

Nanette Milne (North East Scotland) (Con): Given the on-going integration of health and social care, the bill would provide for regulations so that health boards providing social care would take on the full duties of the SDS powers. Is there any information around the table about the extent to which the national health service is currently involved in SDS provision? Does the panel think that the bill will encourage greater involvement, to give a more holistic result for users?

Janet Spence: I am here today representing the new Highland health and social care partnership. Our SDS team transferred from Highland Council into the NHS and has responsibility for adult and children’s SDS work.

In the lead-up to the integration going ahead on 1 April, we seconded three nurses into the SDS team—which was of course in the council at the time—with a view to rolling out training for health staff. There has been a lot of anxiety on the part of health staff, particularly nurses, about SDS, which I think is largely because of lack of knowledge. We were therefore keen to get in there at grass-roots level and start talking to health staff about SDS and what it is and is not.

I mentioned earlier the huge shift needed in mindset and culture. I do not think that it is unfair to say that a lot of health staff, community-based nurses and hospital-based nurses, who are quite protective people who are keen to be seen to be doing things for people, are quite risk averse. It is difficult for them to get to grips with enabling risk. Over the past few months, we have begun a dialogue with health staff. It is just a very different way of thinking for them.

We—the people from the social work side who have transferred in—are on a journey, too. There is still a lot of learning for our staff and a huge challenge on the health side.

Nanette Milne: So the culture must evolve.

Janet Spence: Yes.

David Williams: The agenda in Glasgow has been primarily a social care agenda led by the council. We work with our colleagues in health at an executive level through the joint partnership board, which is made up of elected members and non-executive directors of the health board. That board is well aware of our initiative in relation to the personalisation agenda and the implementation of personalisation in Glasgow.

I guess that we need to see where the legislation on health and social care integration takes us, and what local arrangements are developed as a consequence of that before we can make any commitments or determinations about how this agenda will be impacted on in the new arrangements.

The Convener: Should the bill take into account that relationship or does it focus too much on local authority responsibility?

David Williams: To my mind, self-directed support is primarily a social care function. Janet Spence is correct in recognising that. The implementation of the community care legislation in 1990, which Mr Alexander mentioned, moved us from what was called in the business a medical model of provision to a social care model of provision. It is fundamentally and primarily a social care business, but there will be people who have medical needs, so we must have a continuous dialogue with health boards at a strategic level and at a practice level.

John Alexander: The short answer is that, in Dumfries and Galloway, involvement from health has not, to date, been a significant factor. The process has largely been driven by the local authority and, within that, by social work services. The bill’s Sunday title is the Social Care (Self-directed Support) (Scotland) Bill, but that raises the question whether the way in which the legislation is framed should recognise that a broader contribution can be made to the delivery of the aspirations on self-directed support. Social work will have a key role in leading the process, and we are well placed to do that, but we do not have all the answers, and many others have a big contribution to make, as the 21st century social work review told us six years ago. That means not just other universal providers beyond councils, such as the health service, but other council services and services that councils commission for things other than social care.

For example, there is an increasing understanding of the link between deterioration in the health and wellbeing of older people and isolation. In rural communities such as Dumfries and Galloway, if, through good transport links, people have the capacity to stay in touch with relatives or friends who live several miles away, that can make a significant contribution to their health and wellbeing, and they will have been nowhere near a social worker to get the benefit. We must recognise that, to get personalisation or self-directed support right, we need a broader range of activity. That touches on some of the themes from the Christie commission, which went way beyond what any one particular public service can deliver—it had a much broader approach that we need to take on board.

Bob Doris: A few issues have arisen during the discussion. I will try to be as concise as possible, so I will run my questions together. Concise answers would be good, if that is possible.

Drew Smith made good points about the role of the home carer or person who does the care assessment and review in considering the best outcomes from self-directed support. He talked about the scenario in which a person says, “If you tick that box, I could do the job for you independently.” Of course, the converse is that the person who is looking for the service might ask, “What happens if I tick that box?”, to which the answer might be, “I won’t come to your house any more, because a third party will provide the care.” Do we need clear guidance on whether we should break the link between those who provide the service and those who discuss and review the options for alternative services? There is perhaps a conflict of interest between those who procure services and those who provide them and who do the review and reassessment. I would like your opinions on that.

A diverse range of services must be available before a person can exercise their rights in relation to self-directed support, otherwise it might be Hobson’s choice. What role should local authorities have in promoting diverse provision in the voluntary and independent sectors? Where is the incentive for local authorities, as core providers, to do that? There will necessarily be a disincentive for you to promote alternative providers.

With the convener’s indulgence, I will ask a third question. Might those who exercise their right to self-directed support box themselves into a corner? Someone might pick a care package with a provider—it could be from a family member, as we have discovered—and then not be happy with it. Will there be a statutory or routine reassessment every year or two years in which you sit down with the person to ask them how they are getting on with their care and to tell them that they have a right to review, monitor and change the package that they have chosen? Should that be built into the system, perhaps through guidance? Do local authorities do that already?

I have thrown a lot at you, but the questions are on key issues and your answers will help us to map how we will scrutinise the bill.

David Williams: We should not lose sight of the influence of the transfer of undertakings legislation in relation to individuals. A provider might change a service but, if the provision was the same, providers would need to discuss the transfer of staff under the legislation. The provider might change, but the service user might be comfortable with the staff who come in to provide services for them and might just want a change of direction in the support that is provided to them. The transfer of undertakings legislation cannot be discounted in relation to people’s changing arrangements.

As for Hobson’s choice about the range of diverse services, the local authority’s role is in enabling and in providing information, as I said. We in Glasgow contribute substantially to the funding of the Social Care Ideas Factory, which is a Glasgow version of the Coalition of Care and Support Providers in Scotland—if those two organisations will permit me to use that analogy.

The Social Care Ideas Factory is an umbrella organisation that brings providers together and looks at how they can facilitate the development of innovation, new ways of working and creative ideas and responses for service users. That organisation has held a significant number of events for providers in the past 18 months, which have been well attended. Those events have also provided service users with opportunities to see what providers are prepared to deliver, so not all the activity has been web based.

As the evidence develops on what service users ask for to meet their needs in different ways, we will need to make that information available, to give providers the opportunity to see what service users ask for and feed back to us and what has been really good for them. The more we do that, the more providers will have information that allows them to think that they too could provide such services or that they could develop something that is slightly different and which might interest people.

The third question was about service users being boxed into a corner. As I said, none of the changes takes away from local authorities the responsibility to continue to review individuals’ circumstances and care plans. We in Glasgow are committed to doing that at least annually and we expect that. Under the old system, we were not as effective at that as we should have been. That was partly because we focused—as I said—on commissioning an inputs-and-outputs type of service, which means less inclination to review how well or otherwise that is going. By definition, if outcomes-based service provision is set up, how far or otherwise we are going towards achieving the outcomes must be reviewed, so a review mechanism must be in place.

We have committed to annual reviews for individuals. If they are experiencing difficulties, if they wish to move their arrangements or if they do not feel that their outcomes are being delivered and are asking how to make their outcomes more likely to be delivered, the review will provide a range of responses.

John Alexander: I will look at the first and third questions together, which were about how to avoid a conflict of interest between a potential provider and a person who provides support or helps with an assessment, and about being boxed in—about whether we should have a formal framework in which reassessment and review take place. Existing good practice takes care of both those concerns. My view is that the issues might not require to be covered by regulation, but they might be touched on in guidance that reiterates good practice.

The point about Hobson's choice is important. Sometimes carers will say to me, "Mr Alexander, if this service is not going to keep on being delivered in this way, what is the alternative? We live in a very quiet rural area. What will happen?"

12:15

We have looked at developing a network of microproviders. In other words, we are not replicating a huge infrastructure of voluntary organisations, but working closely with local communities and drawing on their resources.

Many of the smallest communities in Dumfries and Galloway are extremely resilient and resourceful, and they can be supported to deliver little networks of support for people who require such assistance, with oversight and a degree of monitoring from the local authority.

We are working to progress that model with our colleagues who are responsible for economic regeneration in Dumfries and Galloway. We want to ensure that there are other options available to people who are asking, "Well, if it is not this, what is it?"

Gil Paterson: I have a quick question on the 150 people who participated in the pilots. Were there some people who sought self-directed support, but then pulled back and stayed with or reverted to the old system? If you do not have the information available today, it would be good if we could get it at some point, as it would give us a truer picture of what we have been presented with.

The Convener: We have mentioned providers such as local authorities and the third and independent sectors, but the biggest providers of all, as the committee is fully aware, are carers themselves. The bill has implications for the carers' needs assessment, including cost implications. Carers are getting older. Will there be cost implications as that works through?

David Williams: That has the potential to contribute to the achievement of the cost-neutral process overall, at the very least. I dare say that it also has the potential to increase costs, if, as you say, carers increasingly take on responsibilities or become involved in people's lives much more so than hitherto, and are then less able to provide care as they get older.

In Glasgow, we recognise the role of carers in the provision of support. The self-evaluation questionnaire, which is the very first stage of the overall assessment process, contains questions that relate to carers.

The review process, which happens annually, will begin to identify and outline much more regularly the position and involvement of carers and whether their needs have changed.

Those processes ought to lead to a much greater level of involvement, if carers request that. We should recognise that not all carers want to be formally involved in the system, but if carers request that involvement, opportunities will be provided for it to happen.

Professor Bell: With regard to carers, the trends are changing. Fewer middle-aged women, who have traditionally been the carers, will be involved, and more parents will be carers. Parents have been having fewer children, and a lot of parents have had no children—no, that is not right; that is impossible. A lot of older people have had no children.

As the gap between male and female life expectancy is narrowing, there will be much more spousal care in the next two or three decades as the baby boomers age. More care will be given in the house by the spouse, and such care will be the focus of this type of legislation.

John Alexander: Given the forward view that Professor Bell has just given, I think that it seems pretty straightforward that local authorities must examine carers' needs assessments in a more focused and structured way. Although there might be additional transactional costs in the first instance, this move might allow us to make the best use of our increasingly pressured resources over the next 10, 20 or 30 years. As a result, we have to take that more strategic view.

The issue of carers' needs also links back to the Christie commission's views on community engagement and earlier intervention. If we can intervene earlier to support carers and perhaps plan with them the management of their relatives' care and support needs over a longer horizon, we might get a better return on the investment of public resources that we have put in to allow that to happen. However, it would be very short-sighted and unhelpful of us not to take the issue more seriously and, as I said, we need to take a more strategic, focused and structured approach.

The Convener: I know that we have received a lot of written evidence but it always seems that, despite our best efforts, these evidence sessions are constrained by time. I have highlighted the implications for carers, but if any of our witnesses feel that there are other implications that have not been drawn out in this evidence session they may put them on the record now or put them in writing to the committee later.

Professor Bell: Just to put this in context, I think that the last time that the Scottish Government measured direct payments—which, as we have heard, are not all that far from what we have been discussing this morning—the total cost was about £40 million, which, given that local authorities' net spending on older people's care is £1.2 billion, is less than 3 per cent of the current budget.

The Convener: On behalf of the committee, I thank our witnesses for giving up their precious time to give us their evidence.

12:23

Meeting suspended.

12:29

On resuming—

The Convener: I welcome our second panel of witnesses: Ron Culley, chief officer, health and social care, Convention of Scottish Local Authorities; Andy Martin, manager of adult and community care services, East Dunbartonshire Council; and Elaine Torrance, acting director of social work, Scottish Borders Council. I am sorry to have delayed you.

Our first question is from Fiona McLeod, who will be followed by Richard Lyle.

12:30

Fiona McLeod: I have to leave shortly—that will in no way be a reflection on the testimony that I hope to hear from the witnesses.

Given that Andy Martin is here from East Dunbartonshire Council, I declare an interest, in that I receive direct payments from the council on behalf of my mother.

My question is for all the panel members. The policy memorandum makes it clear that, for any of the four options, the bill will allow a person to employ a family member as a personal assistant, which is different from the current exceptional circumstances provision. However, local authorities are worried because PAs, be they family members or otherwise, are not regulated or controlled. Given your position on the protection of vulnerable groups, how do you balance those two aspects? Specifically, do local authorities think that requiring—probably through guidance rather than by statute—a PA to be registered with Disclosure Scotland and on the PVG register would go some way towards resolving their worries?

Andy Martin (East Dunbartonshire Council): You properly refer to the balance of responsibilities that local authorities have. We support the bill's enabling aspect. The previous arrangements perhaps erred too much on the side of being restrictive and prescriptive. However, the responsibilities still remain. We must ensure that circumstances do not occur in which vulnerable people are exposed in ways that are not consistent with our responsibilities. Regulation in that regard might be a local authority aspiration, but it is beyond my remit to say whether that will come in the fullness of time.

In cases involving vulnerable people, children and adults who lack capacity, we would be strongly in favour of—to the point of insisting on it—people having a level of disclosure that is appropriate and safe.

Elaine Torrance (Scottish Borders Council): There has been great debate in our local authority about people employing family members as personal assistants. With direct payments, we recognise that in a rural area such as Scottish Borders there will clearly be times when employing a family member as a carer will be appropriate. However, we have yet to take the view as to whether that could be any family member. There must be further discussion about whether there should be a line in that regard. Clearly, if family members are employed as carers, that would have significant cost implications for our current partnership working with carers. The area needs further debate.

On the regulation of personal assistants, we need to consider how best we can support people who employ their own carers to go through the checks that they need to make to ensure that their carer is a safe person to care for them. We need to think about the best way to take that forward. The people with whom we work are often vulnerable in times of need, so we must ensure that they are able to take on the right person to meet their needs but that the process is not so bureaucratic that it puts people off.

Ron Culley (Convention of Scottish Local Authorities): I do not have much more to add to what has been said. We chose not to say an awful lot about that issue in our written evidence. Suffice it to say that many local authorities highlighted it as an issue. We hope to be able to work with our colleagues in the Scottish Government to ensure that all the issues that Fiona McLeod raises—which are real issues—are properly accounted for as the bill moves through Parliament and we move to regulation.

Richard Lyle: At the end of our questioning of the previous set of witnesses, Professor Bell gave some good figures. He said that direct payments would cost £40 million but that councils have £1.2 billion to spend.

According to our briefing, Scottish Borders Council comes first in the take-up of direct payments and East Dunbartonshire Council comes ninth, so we have picked our witnesses well. What are the witnesses' views on the bill? Are they supportive of it? Will some councils turn round and say that they need more money, although the evidence indicates that they do not?

Elaine Torrance: Scottish Borders Council has a good track record in relation to the number of people who receive direct payments. That is reflected in the amount that is spent on such support.

One issue is how we ensure that the money that is tied up in traditional services is made available to individuals who receive self-directed support. There is an issue with and—probably in every local authority—there are concerns about transitional costs and how they will be funded. If an individual chooses to have an activity in the community, as is right and proper, and not to take a day centre place, the cost per head can go up substantially until the number of places drops and we can free up that day centre or do something different with it. There are issues about how we fund that.

In Scottish Borders Council, we have tried not to have a capped budget for direct payments, which are mainly for home care, and have tried to enable people who want to receive a direct payment to use the budget flexibly. That is important. Getting to a point that is cost effective for everybody means a bigger transformational change in the way that we manage our budgets.

Staff training is another issue that we have identified. Some money is allowed for that in the budget, but we wonder whether it will be enough as we go through the change.

We are absolutely supportive of the principles in the bill, but we are to go through a fundamental change in a quick period of three years and we will need to do some careful work on costs, given the funding that has been made available up to now.

Ron Culley: COSLA had the difficult job of trying to craft a position on behalf of all its 32 Scottish local government members and, on the general question, came to the view that it was premature to reach for legislation. Our political leadership decided on that position because, in some respects, legislation is an admission of failure. In other words, it is an admission that, collectively, we have not been able to achieve a set of common objectives within the current statutory framework.

In 2010, we developed along with the Scottish Government a strategy on self-directed support. That was a 10-year strategy and we want to implement it over that period, so we feel that it is premature to legislate. Of course, that is not to say that we would never arrive at that point but with such a relatively young agenda, we wanted to take things forward in a more developmental way. That was the rationale behind our overall position of not endorsing the legislative route.

The second question related to cost, which is a really difficult issue. If I understood him correctly, Professor Bell said that £40 million of the £1.2 billion spend on social care was drawn down in direct payments. However, that is separate from the cost of implementing the bill, and I believe that there are genuine difficulties in identifying that. Although the Scottish Government has set aside a generous £23 million for implementation, our survey work with our member councils indicates that that amount is insufficient to cover the bill's objectives. In fact, our lowest estimate for a more appropriate figure, given the bill's scale and ambition and the timeframe, is £50 million. That said, we have an on-going political partnership with the Scottish Government and will continue to work within the current realities of public finance.

I guess that, as a response to the question whether we will be asking for more money, that is a slight cop-out. I will say, however, that we think that the money that has been put up so far is insufficient.

Andy Martin: Just to supplement Ron Culley's comments and to reflect the position in my local authority, I point out that the heartland for the £1.4 million that has been identified is older people's services. I think that, as far as Elaine Torrance in Scottish Borders Council and myself in East Dunbartonshire are concerned, I am right in saying that we have managed to drive direct payments into such services in a more proactive way than might be the case nationally. Older people's services provide more of a co-production opportunity, with families coming together to try to maintain increasingly vulnerable older people at home. Certainly, among families and carers in my locality there is a growing recognition that direct payments can allow vulnerable older people to be kept at home and supported in the community. You need only look at the figures: 58 per cent of our direct payments go to older people, and 20 per cent of all our direct payments—a quite significant sum—go to older people with dementia. The £1.4 million is not the totality of the spend; you have to put on top of that the informal care dimension and the co-production value that families can bring. This is an important area where self-directed support can be promoted.

Finally, notwithstanding the demurring either by individual local authorities or by COSLA on behalf of all Scottish local authorities, I think that there is strong commitment to and support for not only the principles of SDS but the practicalities of delivering it across social work in Scotland.

Richard Lyle: Given that you knew that the bill was going to be introduced, have you started to do what I know officials generally do, which is to find out what it will cost individual authorities? Perhaps at this point I should highlight some statistics that we have been given. At the moment, about 36 people in North Lanarkshire get direct payments. Do you know how many people in the Scottish Borders get them?

Elaine Torrance: Approximately well over 200.

Richard Lyle: I listened to Ron Culley's non-answer but what costings have your individual local authorities put together? Have you not started that work yet?

12:45

Ron Culley: We have; in fact, it formed the basis of our survey work. In working with our colleagues in St Andrew's house on the bill's potential costs, we surveyed local authorities on the issues that they might be thinking about with regard to costs. We would be happy to provide the committee with a copy of that survey.

We focused on a number of issues, including workforce development and the potential increase in care management—case review and so on were discussed with the previous panel—as well as withdrawal from existing arrangements, entering into new arrangements and the dual running costs that come from maintaining existing services until they can be closed or scaled down. Professor Bell highlighted those issues.

In fairness, we would be the first to say that the cost is highly uncertain. That is partly because we are postulating about the consequences of individual choices when aggregated. That makes determining the bill's cost difficult and is why Professor Bell said that he was not in a position to say absolutely what the bill might cost.

We asked our member councils about the costs that might arise from the areas that I listed. We aggregated that data, which is how we arrived at the figure that was cited. We are extremely keen to highlight the caveats about how challenging the situation will be, because it is contingent on individual choice.

The Convener: As you were right to point out, the costs are uncertain. We have also heard about uncertain evidence of outcomes. Have you done work on the bill's outcomes for the people whom you serve and who will have the services?

Elaine Torrance: We have done quite a lot of work with individuals to reflect on how they have found the direct payments system. More recently, we have done a pilot study on SDS, which offers more than just direct payments. We have a number of people with an individual service fund who are making arrangements with other providers.

We have just evaluated that study. The people to whom we have spoken have found the process helpful. They feel that they are more in control of the decisions that are reached and have more choice about the services that are provided to them. People have been able to identify the outcomes that they require, such as feeling more independent, feeling safe or engaging more in the community.

It is early days, so a year or two on we will have to go back to highlight the evidence base, because we have only the sense that people feel that something is happening and that they feel better about it. We have work to do on how we evaluate outcomes more systematically. However, in our discussions and the work that we have done with individuals, their perception has been that the process has been positive and that they have got a lot of positive outcomes from it. When people spend their individual budgets, they feel that they are much more in control of how their care is organised and have more say over what happens through the process.

The Convener: Mr Culley, you surveyed councils on the cost impact. Before you supported the principles of the bill, did you seek information on whether choice was a good idea and on whether outcomes would improve?

Ron Culley: We did not come at the matter from an empirical perspective. We felt that we needed to test the finance issue with our member authorities and to test the working assumptions that were being put in place, but COSLA has for a long time been signed up to the personalisation agenda in health and social care. The outcomes agenda is more a question of principle than practice.

Your question is a good one because, notwithstanding the fact that we would want to start with the principle of giving people choice and control and the opportunity to express that in the way in which they interact with public services, there is, of course, a logical distinction between the principle itself and the outcomes that are achieved. However, we can factor that in over the longer term with the roll-out of self-directed support—over the 10-year period that is imagined in the strategy—to determine whether choice in and of itself delivers certain health and wellbeing outcomes.

There is, of course, another way of looking at the matter. The very act of choosing is, in some respects, a positive outcome for the individual in giving expression to their personal autonomy and so on.

The question is a good one, but I do not think that anybody is really ready to answer it. That is for the longer term.

The Convener: So we are again getting to the point at which we are uncertain about the costs and the outcomes.

Ron Culley: Yes.

Andy Martin: All of us in local authorities have been on a journey since the introduction of direct payments, which was a fair bit back. Infrastructure building has been on-going through the years. At the start of the journey, there was certainly a strong sense from people who elected to take direct payments that there could sometimes be a burdensome and difficult maze to negotiate and that the responsibility of employing people and all that goes with it was a daunting challenge. To a degree, that is still the case. We have strongly focused on developing a user-led support service, which we commissioned from the Centre for Inclusive Living in Glasgow. That service has grown and metamorphosed to the point at which the procedure and the infrastructure are more robust and flexible and things happen more easily than they did five or six years ago. My intuition is that that will be consolidated over the next period.

Positive choice brings reciprocal responsibility. Working with service users and carers to draw out those issues so that people are fully aware of what will be asked of them in going down the road in question is an important challenge that should not be ducked.

The Convener: I was a member of the Health Committee in 2006 when it considered this sort of stuff. The impact in your area and throughout Scotland has been pointed out not only by Richard Lyle but in papers from the bill team. It is easy to understand why the Scottish Government is at the stage at which it feels that it needs legislation to get the progress that has not occurred on direct payments since then.

Andy Martin: I cannot speak for other areas and I do not know what progress—

The Convener: We have received evidence this morning that the provision is pretty patchy.

Ron Culley: We distinguish between direct payments and self-directed support. Direct payments are one expression of self-directed support. They are an excellent way to manage the process for some people, but less so for others. Therefore, we have always been cautious about connecting the two. In other words, we do not think that the uptake of direct payments is in itself a measure of the success of the roll-out of self-directed support.

Elaine Torrance: I want to come back to outcomes. Perhaps we do not have big empirical research studies around them, but we did a small pilot that offered options for respite care, for example. I will put matters into context for the committee. People who had used residential care were using other forms of holiday support—caravan care and so on—and they were absolutely clear that that was a much better experience for them. I would not like to indicate that the evidence was not good. When you speak to individuals about their personal outcomes, I think that the new approach makes a difference.

The Convener: I was focusing on the outcomes for the person who is receiving the services, not the wider—

Elaine Torrance: Yes, and I am just saying that there are a lot of case studies that show that it makes a big difference to their lives. That is important.

On the roll-out, we should not underestimate the difference in the approach that needs to be taken by care managers and social workers. We are used to an assessment and care management process, in which we conduct an assessment of need and arrange services. Now there is a different process in the middle. It needs to be understood that we are undertaking a big change and that it is not straightforward. As my colleague was saying, we are on a journey and are taking people with us, so we need to get into the next gear in order to move things forward more quickly.

Dr Simpson: COSLA has told us that it does not think that this is the time for legislation, as we are on that journey. The second reply that we got from Scottish Borders Council today was that the evidence that we have got with regard to direct payments—which are what we are monitoring—is not correct and does not reflect the experience on the ground. As a committee, we are slightly hamstrung if we cannot get the evidence that will enable us to examine the situation properly. Why do we not have that evidence? Why are we still sitting here debating the actual evidence of what is going on on the ground?

The papers indicate that COSLA and East Dunbartonshire Council have serious concerns about the responsibility side of the equation, in terms of ensuring that self-directed care does not lead to users and carers using the money inappropriately. We heard earlier that there is not much evidence of that happening, so I am not sure why it is such a major concern. Section 14 of the bill talks about recouping the payments if they are misused, but allowing that that might happen is slightly different from the situation about which concerns have been expressed. We must accept that the overwhelming majority of individuals have a pretty clear idea of what is important to them and that that must be paramount, if they advise people of it. Could we hear a little bit more about the issue of responsibility?

The first question concerns statistics: if we do not have them, how do we get them? The second question concerns responsibility.

Ron Culley: During the evolution of the debate around self-directed support and direct payments over the past five years, there has been consistent measurement of direct payment uptake across Scotland. However, while that was being done, the broader concept of self-directed support was being developed in the professional social work community and the policy community. That involves a much more nuanced set of ideas and concepts than direct payments. As the committee knows, self-directed support gives expression to the principles of choice and control in a much less focused way than direct payments do. The evolution of the debate around self-directed support has left unanswered some questions about the outcomes that are achieved in that context, which go beyond direct payments.

We have some limited information on direct payments and can make some judgments on that basis, but we do not have enough information to enable us to properly assess the range of options that are available under the self-directed support philosophy. The point that I was trying to make was that we cannot judge the whole of that philosophy based on one type of choice that can be made in that context.

On the second part of your question, for me the issue is less about responsibility and more about reciprocity. That comes back to the issue of the relationship between the individual and the state.

In the move towards an outcomes-based approach, while encouraging choice and control in the relationship between the individual and the state, it must be recognised that there is a corresponding duty on the individual—I do not necessarily mean that in a legalistic or legislative sense—to act towards those outcomes. In other words, it must be recognised that there is a partnership and mutual commitment, even if we cannot express that in the bill. We need to be clear that the bill is about a partnership between the individual and the state in relation to how the individual is supported. It was that more general point that I was trying to express in the COSLA submission.

13:00

Andy Martin: I echo Ron Culley's points. I hope that our submission did not read as if we were in some sense suggesting that widespread misuse or default is likely. Local authorities will continue to have powerful and critical responsibilities for this model of service, which will have to be delivered and negotiated. There is no unease or misgiving, but there is properly advised caution about how the responsibilities are to be exercised. In the broader sense, the potential loosening up in the system that ought to come about through the bill is proper and laudable. It will foster co-production and allow appropriate risk enablement. However, risk remains and, at the end of the day, local authorities will be held accountable for the management of that risk, which includes financial risk. We were not expressing an irresolvable antipathy to anything that is, or could be, in the bill; we were simply highlighting that the issues need to be thought through.

Nanette Milne: To what extent is the NHS involved with SDS at present? How does the panel see that developing as the integration of health and social care proceeds?

Ron Culley: The consultation on that integration is launched today, so now is an appropriate time to reflect on the question. COSLA discussed the issue in our submission. We start from the position of the individual and argue that if the bill is to confer on individuals a right to access self-directed support under the Social Work (Scotland) Act 1968, it seems to be odd to restrict that solely to social care and not to include healthcare.

We would add caveats in relation to how and where the NHS could provide through SDS. If I were to be knocked down by a bus tomorrow, I would not want someone to ask me about personal outcomes—I would want to be taken to accident and emergency. Clearly, for some areas of health service activity, self-directed support is not appropriate. However, an awful lot in the NHS, particularly where there is a clearer join with social care support mechanisms, could benefit from that type of arrangement. That might, for example, include palliative care or physiotherapy. There is a range of examples that we could explore.

For us, the issue is about how the individual interfaces with the bill. The individual will have a right to ask for self-directed support in respect of social care services, but will not have that right in respect of NHS services. In other words, the social work community will be obliged to respond to individuals' requests, but the health community will not. That is slightly retrograde at a time when we are trying to ensure that the join between health and social care is smoother and that there are fewer issues separating the two communities. We should be looking more ambitiously at the matter. That is our position.

Nanette Milne: Section 18 will amend the Community Care and Health (Scotland) Act 2002 and will allow ministers to amend regulations that are made under that act that dictate which functions can be delegated from the NHS and local authorities—

Ron Culley: Section 18 pertains to a specific set of arrangements that might be put in place in respect of integration. You heard earlier from the Highland partnership; it has decided that it wants, in pursuit of the integration agenda, to use what it refers to as the "lead agency model", whereby the NHS delivers adult social care on behalf of the council. I understand that the legislative provisions under SDS solely allow that to happen. The crucial difference is that it does not get anywhere close to the type of far-reaching legislative changes that will be introduced in respect of the individual citizen. We are saying that, if the individual citizen is to have a right to access self-directed support and social care, there are other areas of the health service in which that would be just as appropriate.

Nanette Milne: Do you think that the bill should be amended to cover that?

Ron Culley: Absolutely.

Elaine Torrance: I support that position. This is about how we can engage more with our health partners. We have commissioned joint packages of care in certain circumstances, but if we are to be working much more closely with them, we need to think about how we can join those packages together much more effectively. We make the point in our written submission that we would like to see that strengthened.

Bob Doris: Some interesting points have been made about the scope of the bill, but I am reminded that the bill is about social care and self-directed support. I take on board Mr Culley's points and hope that COSLA widens the agenda but stays focused on how to deliver the agenda in partnership.

I have a couple of fairly short questions on the stats. I agree with Mr Culley that it is not as simple as saying that self-directed support is direct payments, although direct payments are one option within self-directed support. Some local authorities may have more confident individuals demanding direct payments, which may explain some of the differences in take-up, but there are still some striking differences.

I believe that there is evidence to suggest that more has to be done. Can COSLA or the local authorities provide additional information so that we can see the wider picture? For instance, we are told that, in East Dunbartonshire, 12 people in every 10,000 receive direct payments. I am keen to know what other forms of self-directed support are provided in East Dunbartonshire and their incidence per 10,000 people. Local authorities do not appear to have given us such data; Glasgow City Council could not give us it.

Ron Culley: Such data will have to be developed over time. There are different types of information that we might want to seek in the future including, first, information that is collected by the Scottish Government, of which information on direct payments is an example. There may be a question about whether we want to widen the scope of the information trawl. There will also be information about personal outcomes—that takes us back to an earlier question—which we need to do a better job of collecting and aggregating in order to determine whether we are achieving what we want to achieve under SDS.

The spirit of the question is absolutely right; we need better information on how the policy is moving forward. However, I do not know that there is a lot of rich information that we can draw on just now to provide answers. Elaine Torrance has highlighted that there is information on individual case studies. We have quite a lot of that, which is good, but I do not know that we have got particularly far with aggregating it.

Elaine Torrance: We must remember that direct payments were the default position, so we were supporting direct payments. The three pilot sites have had a significant amount of money to roll SDS forward. We have had a very small pilot in our area—50 people have come forward, three or four of whom chose an individual service fund. That is because the concept of direct payments is now well understood and people know what they are taking on. We are developing processes and procedures around individual service funds, so it will take more time for information on those to come through.

Bob Doris: Has the bill been a focus and driver for local authorities to start to get those data together?

Elaine Torrance: Yes.

Andy Martin: Absolutely. I referred to the fact that we are in the process of infrastructure building. Some of the funding that has come through in the past financial year has been used to establish posts that will drive some of the infrastructure building over the next phase. It is important to emphasise that we collect huge amounts of information across all service areas and that only a fraction of it is processed via the Information Services Division up to the level of Parliament or the committee. In terms of single outcome agreements, all local authorities and health boards carry out, below the waterline, significant activity in collecting information.

A focus on outcomes has progressed in parallel with the discussion around SDS. Many local authorities—mine included—have established processes and procedures and have trained staff, and we are now running in that direction. That has started to produce information, which we routinely harvest from reviews of care plans to inform decisions.

Bob Doris: I will ask a final question. In the round-table session, Drew Smith and I mentioned the situation in which the local authority is central in assessing care needs and desirable outcomes with the person who may qualify for self-directed support, but is also a core provider of services. How do you ensure neutrality in that process? Put simply, if an older person who is getting support in their home asks the person who is going through their assessment needs what will happen if they choose a specific option, the local authority person might respond, “I won’t come to your house any more because that service would be provided by another provider.” I am not saying that that happens, but you can see the perceived dangers. Do we need almost to detach parts of the system so that we can ensure neutrality in a process in which the local authority is a commissioner, a provider and an assessor rolled into one?

Elaine Torrance: The assessment role is about supporting the individual to get the right outcomes; it is a negotiating position. The individual budget—a sum for the person to spend however they wish—requires our looking impartially at the range of available options and having a conversation about how best to spend the money to meet the person’s needs effectively.

It is interesting that, as we are trying to price, and make clear the price, of local authority services, we find that they are sometimes more expensive than other services. It is about having a dialogue. If local authorities are offering a high-quality service, people may well opt to continue to buy that service, which is good. Alternatively, a person may prefer to have the service provided in that community rather than in this community, and so would spend their budget on something else. The assessor or care manager must remain open, rather than say, “I like that provider—on you go to that one.”

Reference has been made to advocacy: an individual can have an advocate if they feel that the process is not being carried out properly. If a provider is not achieving a person’s agreed outcomes, that must be reviewed and a solution found. There are checks and balances in the process.

13:15

Andy Martin: I echo Elaine Torrance’s comments. Individualised budgets are critical in all this; after all, if people either notionally or actually know the amount that they have to deploy against their needs, that is an important starting point.

We should also recognise that we have had an assessor-provider split and a mixed marketplace for quite a long time now. SDS is not bringing those challenges with it; they have been on-going.

Ron Culley: I agree with all that—in particular, the point that councils are already wrestling with such issues was well made. Either last week or the week before, your colleagues on the Public Audit Committee were dragging us over the coals on similar themes to do with protection of in-house services. There are challenges that have to be worked through. For example, the bill contains a proposal that will potentially ensure that people who want to go into a care home can access direct payments, but such choice could create challenges for local-authority run care homes, which, as Elaine Torrance has pointed out, tend to be more expensive. Such big challenges will have to be managed and we have been trying to wrestle with them over the last wee while.

Jim Eadie (Edinburgh Southern) (SNP): Although I am very mindful of Mr Culley’s point that self-directed support is not exclusively about direct payments and that such payments are, in fact, only one of the four available options, I want to stick with the subject and ask a couple of specific questions.

First, information that we have received from the Scottish Government suggests that 40 per cent of people who receive direct payments have a physical disability, 26 per cent have a learning disability and 3 per cent have both. As vice-convener of the cross-party group on learning disability, I wonder whether COSLA will seek to work with the Scottish Government on a breakdown of those figures by local authority to give us a more accurate picture of what is happening.

Ron Culley: We are always happy to work with the Scottish Government on whatever issue, so I am happy to take up that suggestion with it.

Jim Eadie: I am not aware that such a breakdown is available; it would certainly be useful.

Secondly, with regard to the payment itself, the bill says:

> “‘relevant amount’ means the amount that the local authority considers is a reasonable estimate of the cost of securing the provision of the support to which a direct payment relates”.

Do you expect the statutory guidance that will be issued following the bill’s becoming law to set out the level of payments or should that continue to be at the discretion of local authorities?

Ron Culley: The level of payments will have to remain at the discretion of local authorities, simply because of the judgments that will have to be made on available resources, service options, local marketplaces and costs, local policies, eligibility thresholds and so on. I do not know whether it would be possible to set a national framework for that that would benefit individuals.

As a result, I think that this is an area where we need to delegate power to the local authority and allow its professionals to establish an overall framework. I do not see the advantage of taking such decisions above local authority level.

Jim Eadie: We have examples from across Scotland of inconsistency in charging for care for people with learning disabilities and I can already hear the same argument being replayed with regard to direct payments. Are you concerned about that? What reassurance can you offer people who have such anxieties?

Ron Culley: We have worked hard to engage on charging over the past few years. Two competing ideals lie behind it: first, the importance of local democratic decision making in respect of charges that are levied on the local population; and, secondly, ensuring that provision for the local population is consistent relative to provision for others in Scotland. Management of that tension has proved to be challenging at times.

We have tried to engage on charging through national dialogue with the Scottish Government and voluntary sector partners in order to establish a set of guidelines. We may consider that type of arrangement in respect of the new obligations that will come in under SDS. However, it is a difficult balancing act that should be left to the discretion of local authorities.

Jim Eadie: Thank you.

Andy Martin: To supplement what Ron Culley said, every local authority in Scotland is wrestling with how to construct a resource allocation framework to meet the demands of the bill, which can only be done with quite detailed scrutiny and distillation of current spend. For example, the spend in East Dunbartonshire across older people, people with learning disabilities, adult mental health, children’s services and so on is—for good and proper reasons—profoundly different to the spend in West Dunbartonshire.

It is entirely appropriate for the bill and the associated guidance to set the parameters for an acceptable resource allocation framework, and the experience that has been illustrated in the pilots is extremely helpful. However, at the end of the day, constructing a resource allocation framework is a task that needs to be delivered locally.

The Convener: On capacity, other services need to be available—provided by the third and independent sectors and by carers themselves—so that people can choose to opt out of the current services. COSLA’s submission raises some issues around that with regard to carers, in particular, and assessment.

Ron Culley: On capacity, the role of the local authority will change slightly over time and will move towards stimulation of local markets and facilitation of different types of service provision. We are already seeing that.

On the carers issue, we are slightly nervous about some elements of the bill. We recognise the inherent value of the carer community, as most people do. However, we are concerned—especially about calls for duties to be placed on local authorities to provide more direct support to carers. That is troubling in two respects: first, it could leave us with a bill that has not been properly costed, which would be quite significant, and secondly, there is the philosophical issue about the role that we want carers to play in our society and whether remuneration should come with that. It raises a whole set of issues that require, at the very least, further discussion. We would be strongly against the inclusion of any prescription in respect of the powers that have been given to local authorities on the carers agenda.

The Convener: Is COSLA concerned that local authorities may have to pay for care that carers currently provide free?

Ron Culley: We support the position around the powers that the legislation might introduce, but we would resist powers’ being put forward as duties, because that is where the costs would begin to impact significantly and where the professional judgment of individual social workers would be compromised.

As it stands, there is not an awful lot in the bill that we would object to in respect of the carers agenda, but we are concerned about its evolving into something more prescriptive.

Andy Martin: I echo what Ron Culley said about the distinction between powers and duties. In my earlier answer I indicated that we are comfortable with the idea that there are circumstances in which it is appropriate to support a family member financially to care for a person who needs care. However, a duty on local authorities to consider or to actively support the relationship of parent to child, spouse to spouse, or child to parent would be unsustainable.

It is important to remember that behind the issue is the very challenging task of disaggregating resource from existing services to the future services that all local authorities are developing. That will mean our doing some of what David Williams referred to—transfers of undertakings and distilling what is in jobs into cash that can be disbursed to fund the future shape of services. That is a big, big challenge.

Elaine Torrance: I fundamentally believe that we need to support carers to the best of our ability. I said quite a lot about that at the outset.

In building community capacity, it is important that we work closely with providers and have a good dialogue under way. Providers feel that it is an uncertain world, so they need to be reassured that if they provide flexible services, people will want them.

Like other local authorities, we are working closely with community planning partnerships to develop capacity in small communities. In the Borders, we are working to provide the right support in terms of early intervention, as well as providing care for people. It is a two-way process—which is very much reflected in the Christie commission report—that we are trying to build on locally.

The Convener: I offer witnesses the same opportunity that I have given to other panels: if the bill has any implications that this meeting has not brought out, but that you feel are important to put on the table, please do so before we close.

As there are no further comments, I thank the panel members for their attendance and the evidence that they have provided.

Meeting closed at 13:27.

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