The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 15 May 2012

Session 4

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HEALTH AND SPORT COMMITTEE

16th 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:

Professor Frank Clark (Social Care and Social Work Improvement Scotland)
David Cumming (Social Care and Social Work Improvement Scotland)
Ellen Hudson (Royal College of Nursing Scotland)
George Kappler (Mental Welfare Commission for Scotland)
Duncan Mackay (North Lanarkshire Council; Association of Directors of Social Work)
Sandra McDonald (Office of the Public Guardian Scotland)
Ruth Stark (Scottish Association of Social Work)
Adrian Ward (Law Society of Scotland)

CLERK TO THE COMMITTEE

Douglas Wands

LOCATION

Committee Room 1

Scottish Parliament

Health and Sport Committee

Tuesday 15 May 2012

[The Convener *opened the meeting at 10:00*]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the Health and Sport Committee's 16th meeting in 2012. I remind everyone present that mobile phones and BlackBerrys should be turned off, as they often interfere with the sound system.

Agenda item 1 is a decision on taking business in private. We need to decide whether to take agenda item 6, which is on our work programme, in private. If members have no good reasons to take that item in private, do we agree to take it in public?

Members *indicated agreement.*

Subordinate Legislation

Food Additives (Scotland) Amendment Regulations 2012 (SSI 2012/119)

10:01

The Convener: Agenda item 2 is consideration of a negative instrument. The Subordinate Legislation Committee raised no issues on the amendment regulations. As members have no comments, does the committee agree that we do not wish to make any recommendations on the regulations?

Members *indicated agreement.*

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

10:02

The Convener: Agenda item 3 is witness expenses in relation to the Social Care (Self-directed Support) (Scotland) Bill. Do members agree to delegate to me, as convener, the responsibility for arranging for the Scottish Parliamentary Corporate Body to pay, under rule 12.4.3, any expenses of witnesses who attend to give evidence on the bill?

Members *indicated agreement.*

The Convener: We come to agenda item 4. As members know, we went on a fact-finding visit to Glasgow yesterday to hear from carers and service users. It would be useful to put on the record some of the themes that arose and our impressions of those meetings with people at the council and from the community. It is important that those are reflected at this stage so that there is parity between those we spoke to yesterday and witnesses who come along to the committee. Do any members wish to give their reflections on the visit?

Gil Paterson (Clydebank and Milngavie) (SNP): It is always good to get out. It was a worthwhile day during which we concentrated on the issue with people from across the sector, including those who are involved in delivering care and those who receive it. It was a good day. The hospitality and the way that we were treated were also good. We should do more such visits, because the committee and our work benefit from them. I am sure that the visit will be reflected in our report.

Nanette Milne (North East Scotland) (Con): I absolutely agree with that. It was an excellent day. It was good to be face to face with users, carers and various other people who will be directly affected by the proposed legislation. Clearly, there is unanimous support for the principle of the proposals, although many of the details will have to be gone through as the bill proceeds through Parliament. I look forward to getting the report from the people who took notes yesterday.

Bob Doris (Glasgow) (SNP): It might be helpful to reflect on some of the themes that we heard. I will not give my opinion, as we are still testing a lot of the evidence.

It was interesting to hear from social workers and social work management at Glasgow City Council about what is known as the equalisation agenda—how we ensure that the resources that go to the cared-for are shared equitably across all cared-for groups. There was an acknowledgement that, historically, that may not have been the case. There are challenges in that, and it is something that we will have to return to.

The carers we met raised the issue of whether carers assessments happen and whether they are reviewed. We will need to return to that, as well.

Another issue is the need to get a balanced mix of alternative providers in the voluntary sector and the wider third sector as well as self-directed support and council provision, to give choice to those who are cared for.

General awareness of self-directed support is also an issue. Some of the people whom we met did not realise that it existed and had to find out more about it.

That is a cluster of themes that came through in the evidence. I agree with Nanette Milne that pretty much everyone to whom we spoke believed that self-directed support, if done well, can transform people’s quality of life.

That is a nice point on which to end my reflections on the visit. I thank everyone who gave us that informal evidence.

Richard Lyle (Central Scotland) (SNP): I was very impressed with the set-up that we saw in Glasgow city chambers yesterday. I was impressed with the officials who were allowed to come along and give us their views on SDS. We also had an excellent meeting with the carers in the afternoon and got a good insight into what they require from the bill. One of the main themes that I will carry on is the suggestion that, from a social work point of view, there should be more training for carers to ensure that they know their full rights, in order that the bill can be implemented correctly and that it will benefit the people who require it.

Drew Smith (Glasgow) (Lab): I agree with much of what has been said and do not want to add anything in particular, although I will slightly elaborate Richard Lyle’s point. A clear challenge is presented to professionals who have been used to working in a particular way. We might want to follow that up with representatives from social work departments. It was made clear to us by the service users, the carers and the social workers themselves that the bill will require a different way of working, which will present short-term challenges. The aspiration is that the policy should be cost neutral in the long term. However, in the short term, there will be a big impact on how the current service can be continued. Professionals will need to think about reorientating their caseloads and how they can provide information to people and support them through the choices that they will be able to make as a result of the change.

The Convener: Thanks very much for that. It was a long day and involved some hard work, but the clear message came across that there is widespread support for the principles of the bill. If I heard "The devil's in the detail" once yesterday, I heard it half a dozen times. Our job will be to explore some of that.

The committee will wish me to put on record our thanks to Glasgow City Council for all its help with the morning sessions. The panels with which we engaged in the afternoon would not have happened without the help of the independent living in Scotland project and the Princess Royal Trust for Carers, which we thank for all their help.

For item 5, we welcome our first panel of witnesses: Duncan Mackay, head of social work development at North Lanarkshire Council, who represents the Association of Directors of Social Work; Ruth Stark, social worker and manager at the Scottish Association of Social Work; and Ellen Hudson, associate director at the Royal College of Nursing Scotland. Richard Lyle will ask the first question.

Richard Lyle: Good morning. I declare that I know Duncan Mackay very well, as I previously served with him in North Lanarkshire Council. I am interested in his comments, as I note that North Lanarkshire Council has just over 30 people on SDS, whereas we heard in evidence last week that Scottish Borders Council has more than 200.

I said that one theme that emerged yesterday was training, and another theme was whether the bill is cost neutral. What are the panel's views on whether the bill is cost neutral? What do they suggest needs to be done to ensure that social workers and carers are trained better? The point was made yesterday that, when someone goes to social workers for SDS, they have to pick what they need from a computer, and that sometimes that does not suit the person involved. What do we need to do to train all your staff and carers to ensure that people get the correct care packages?

Duncan Mackay (North Lanarkshire Council; Association of Directors of Social Work): I will kick off, but I am sure that Ruth Stark will want to give her perspective. First, I will pick up on your comment about the numbers of people who are on self-directed support. The current statistics measure the numbers of people who have direct payments, which are only one way of drawing down self-directed support.

Something like 80 people in North Lanarkshire have direct payments, which is low in comparison with the rest of Scotland. However, more than 600 people in North Lanarkshire have wholly individualised budgets. The process of inviting people to exercise choice and control over those budgets—the extent to which they choose to do so is fundamental to self-directed support—is on-going.

We have 150 people who have in the past year moved on to an individual budget. One third of them have taken that in the form of a direct payment, but others have decided that that option is not for them and have asked the local authority to arrange or provide services on their behalf. That is the key difference between direct payments and self-directed support. Direct payments are one way of having self-directed support, but they will not suit everyone.

You are entirely correct to highlight the challenges that implementing self-directed support and the bill will create for local authorities and partner agencies. It is a whole-system change and not simply direct payments plus. It will require all the financial systems to be changed, because money will be distilled to each individual, regardless of whether they choose to have a direct payment. Individuals will have to be aware of the individual budget that is indicatively allocated to meet their needs in order to make a properly informed choice about whether to exercise total control over it.

The approach will require to be embedded in assessment and care management processes. In my authority, that will involve six days of additional training, reflection and follow-up, because of the scale of thinking and working differently. Self-directed support changes in a positive way the balance of the relationship between the worker, the supported person as a citizen and their representatives, and any provider that might be involved or which a person might wish to involve.

Self-directed support requires local authorities to adopt a resource allocation system. Bob Doris spoke about equalisation. It is essential that local authorities develop equitable and transparent systems for allocating resources. If they do not, there will be confusion and legitimate challenges—for example, why person A gets a budget of X pounds but person B, with apparently similar needs, gets a budget of Y pounds.

A resource allocation system will also be important to the local authority because it will need to manage within existing budgets, which are reducing. The system must therefore reflect the total available resources for current and projected need and it must balance the financial value of that need so that it can remain within budget at a time of increasing need and reducing resources.

10:15

The Convener: Does anyone else want to respond?

Ruth Stark (Scottish Association of Social Work): Yes, if I may. Richard Lyle asked about the training of social work staff. One of the complications relates to understanding the role of social work staff in the process of self-directed support. The Scottish Government published the practice governance framework, which set out social workers' rules and tasks. One of the issues for the social worker—taking that particular post out of all the others in the range of social work services—is that they have a responsibility to carry out the duty of protecting from harm vulnerable people in our communities. The relationship between a social worker and a person using the services is quite complex. On the one hand, the social worker is trying to meet need, which is what everybody wants out of self-directed support, but on the other hand the social worker has a responsibility to protect people.

The evidence that was given to the committee by HUG—the Highland users group—was particularly poignant on the support relationship between the social worker and the service user. There are complications within that relationship that are not addressed in the bill and which cause our profession concern: it is about how we meet all the responsibilities—how we are honest and independent brokers while recognising our responsibilities to protect vulnerable people.

In protecting vulnerable people, we have considerable powers in relation to assessments and professional opinions that we take to courts and tribunals, for example on people's ability to live in the community, whether they should be detained in a mental health hospital or whether they should be in public care. There is a real issue around that tension. How will the bill and the functions that it asks professional people to undertake address the laudable aspiration, to which every social worker would subscribe, that people should have more control over what goes on in their lives, given that the social worker has other duties and tasks that they must somehow weave into the process?

I do not know whether the committee has a sense of that, but it is a very complex task for us. The bill reads as quite simple and straightforward, but putting its provisions into practice will require more than one day's training because we will have to work out how we weave in our complex set of duties and responsibilities to meet need and protect people.

The Convener: We heard from social workers yesterday—and, indeed, read in some of the submissions—that the bill is an opportunity to get back to good, old-fashioned social work.

Ruth Stark: We really want to embrace the bill and work with it. However, you used the phrase "The devil is in the detail", and we do not see enough detail in it to help us with some of the tasks that other legislation places on us to protect people. That is part of the problem with which we struggle in relation to the bill.

Richard Lyle: I dealt with social work for 36 years. In those 36 years, I had to visit the social work department only about seven times. I appreciate the work that social workers do. However, yesterday, carers made the point to us that they want to be able to sit down with a social worker, go through everything that they require, feel that the social worker understands what is required and know themselves what is required. That comes down to training.

I agree with what you say to a point. There is a training budget and local authorities send staff on training at various times. Will you have sufficient time to ensure that social workers are trained to meet the needs of carers and the clients whom they serve?

Ruth Stark: I hesitate to say. Not enough training has been built in. It will be much more costly than has been indicated in the papers that I have seen so far.

Duncan Mackay: The Association of Directors of Social Work struggled—as did most councils and, perhaps, partner agencies—to provide information to inform the financial memorandum because saying how much will be required to implement the bill is, to some extent, informed guesswork. It depends heavily on the situation in any given local authority.

If an authority has already decommissioned group services, created individual budgets around the packages of support that people receive—even if, at that point, they do not necessarily have control over those budgets—and embedded the concept of self-directed support in its own assessment and care management procedures, it is more likely to be well placed to make the transition to fulfilling the new duties under the bill. The 32 local authorities are in a variety of different positions so, if none of those things applies, the task will be substantially greater and the level of investment that will be needed to make the transition will likely be greater.

It is fairly straightforward to cost the implications of some bills but, on this occasion, it was probably more difficult. That has been reflected in the responses that the committee has seen.

Ellen Hudson (Royal College of Nursing Scotland): I will respond to Richard Lyle's original question.

The bill gives people more choice and control over how social care needs are met. One of the elements about which the Royal College of Nursing has concerns is the impact of the delegation provisions in section 18. National health service bodies will be required to fulfil the duties in the bill if they have delegated authority—as happens in NHS Highland at the moment, through the integration agenda.

If that happens, we could face scope creep because, in care within an integrated system, how can we determine what is a health need and what is a social care need? If we pool our NHS and local authority moneys within an integration agenda, the edges are bound to blur and we could incrementally end up using self-directed support moneys to pay for health services. We consider that to be scope creep. There is not enough detail on that, which is why we call for further consultation and detailed discussions on the matter.

I will respond to Richard Lyle’s question on training as well. If, in their delegated roles, staff in the NHS have to assess people for self-directed support, they absolutely need training. They need to have knowledge of social care assessment and to be able to support those individuals to make an informed decision about the choices that they need to make around the four options that are available to them.

We are concerned that the budget for training goes on only to 2013-14. As the integration agenda of local authorities and the NHS moves forward, the need for training will increase. We need to ensure that the workforce that will be supporting people who are facing those options has the knowledge and skills to fast-track the process and ensure that those people get the packages that they deserve.

Nanette Milne: The principle of the bill is to improve the outcomes for service users. Do you think that bringing health and social care together will deliver a more holistic care service for people?

Ellen Hudson: We have developed a principles paper on the integration agenda. One of the key points that we raised in it was that the success of any integration must be measured by how well the agencies work together towards the core, common aim of what they are trying to establish. They are trying to avoid duplication of effort, ensure that we work smarter and enable people to access services far more quickly. It is important to involve people. There is a duty to involve, inform and collaborate. The necessary infrastructure has to be there in order to deliver that. At the moment, the bill does not have the necessary level of detail to enable us to take an informed position on that issue.

We fundamentally support the founding principles of the bill. It has to be about promoting service users to be independent and to participate more fully.

On the impact of outcomes, it is not clear from the bill what the outcomes will look like. How will they be measured? How will the success of an SDS package be determined? The bill contains no details around the frequency of review. The local authority and the individual who is receiving an SDS option can call for a review at any point. However, if something changes in that package, what is the structure whereby the service user can get a rapid review of the package to ensure that it is still the right one for them? People’s health needs can change quickly and they need to have responsive services.

Duncan Mackay: The committee is exploring an interesting area here. On the finance implications, there is already a gap between assessed need and available resources. Because of the projected local government and NHS settlements and so on, that gap will grow over the next few years, regardless of whether self-directed support is in place.

The bill is short on detail, as others have said. We recognise that there will be statutory guidance and regulations that will, presumably, address some of the detail that is required. There is a nervousness on the part of the ADSW and others that things could be more far-reaching than the bill intends them to be.

The bill is silent on eligibility. It is not possible for a local authority to meet everyone’s needs. Whether there is a self-directed support system or a more traditional system in place, the local authority has to make judgments, within available resources, about what needs are prioritised. The bill is silent on duties for the NHS other than, as Ellen Hudson said, in relation to delegated authority, such as is being facilitated in NHS Highland. Our view is that that approach is quite incoherent in policy terms given that parallel legislation is being introduced and there is consultation on arrangements that seek to dissolve the identity of health and social work budgets.

10:30

Although this is not a direct parallel, there is quite a body of experience in England, where more than half of the primary care trusts offer individual budgets. An evaluation report will be produced in October 2012, and some of the initial findings are very encouraging.

My direct experience is that things are more likely to work the other way round—the social work funding is likely to meet a health need. Let me give an example.

We have an extraordinary young man in North Lanarkshire, who had a tragic accident that left him paralysed. He has two young pre-school children, and he moved, through the process of planning to meet his needs, to an adapted house. He then chose to take his support in the form of an individual budget and identified a provider to meet his needs. Due to the extent of his injuries and condition, he has health needs. He requires an enema in the morning to facilitate a bowel evacuation, which takes two hours to work. The earliest that the nursing staff could arrive to do that was 8 o'clock in the morning. Consequently, although his children had already been up for several hours, he could not get up and dress until he had had the bowel evacuation, which, on average, was around 10 o'clock in the morning.

Our local NHS colleagues worked very hard to work out a solution whereby the treatment might have been administered much earlier to allow him to get up at the same time as his children. In the end, the agreed solution was that he would use the individual budget allocated through the local authority to buy the service from an agency, and NHS staff provided training to ensure that that happened.

For me, that is a good illustration of a situation of someone who has health and social care needs in relation to whom both agencies need to collaborate. If the bill continues as it stands and does not permit the use of NHS resources to meet needs, that will impair, not facilitate, integration.

Ellen Hudson asked how we will know whether a self-directed support package is successful. In my experience, the answer is that it is necessary, at the point of assessment, to identify the intended mutually agreed outcomes that any resource, whether in the form of a direct payment or a direct service, needs to achieve. If that is not done, what is there to review in three or six months' time? The extent to which the outcomes for an individual have been realised—all of us will have different needs and different outcomes—must be reviewed, otherwise the wrong thing tends to be counted, such as the number of hours that a person needs. The question should actually be whether the resource or the service provided has met the identified intended outcomes, and whether it should continue or needs to be adjusted.

Nanette Milne: The example of the young man is interesting. We heard several examples from service users whom we met yesterday who are in absolutely no doubt that the outcome for them has been that their lives are much better. That has to be the aim of the legislation, if it is to work. SDS is a tool to give people the better life that they seek.

Yesterday, we also picked up that there must be a considerable cultural change in going along the lines that are proposed, which will not be easy. Is there professional resistance to the change? I have heard that there are difficulties between health and social work professionals. Would you say that that is a fact?

Ruth Stark: The proposed change fits with our codes of ethics and with the principles by which we want to work. I do not detect resistance to it, but I detect that people are concerned about how we do it, which is what is causing debate in the profession. How will we achieve the aim? There is no problem at all with the principle.

Ellen Hudson: I agree with Ruth Stark that the concerns are about how we do it. Some individuals who have given evidence to the committee have claimed that some professionals, especially nurses, are risk averse in their approach to the concept. I will paint the picture: risk assessment is the norm for many community nurses day in, day out because they work in a non-clinical environment, in responding to health needs. They try to create a safe environment for patients in their homes, and they try to apply all the necessary care, attention and technological advances and inputs. They do that virtually—not in a hospital setting, but in the patient's home. Day in and day out, community nurses have to make hard judgment calls that involve risk assessing patients and considering the responsibilities for care and bringing in the appropriate people. Those nurses cannot do their job without collaborating with their general practitioner and other primary care colleagues, social work colleagues and wider healthcare teams.

The Convener: In written evidence, the RCN and social workers have highlighted the importance of the integration of social care. I think that you agree on that point. The ADSW submission states:

> "these other areas of support in the legislation would be more consistent with the agenda around the integration of health and social care and would better reflect policy priorities around best use of resources."

I believe that there is agreement among the professional organisations on the general principle. If that is not the case, please comment.

Duncan Mackay: I think that there is agreement. The point is that the bill does not reflect that; it imposes duties only on local authorities and not on the NHS, and it refers only to local authority budgets. I take pride in the fact that the concept of self-directed support was initially developed in North Lanarkshire. However, the bill dilutes the concept. It was never intended that there would be only a local authority budget; indeed, it was never intended that there would be only local authority and health budgets, but that it would be possible to draw on education moneys where appropriate, or on the benefits that people are awarded, for example, for needs that are associated directly with their disability. The concept has been reduced from the original aspiration. It would be a great shame if that were to remain the case throughout scrutiny of the bill.

Ellen Hudson: We are concerned that as the integration agenda proceeds, more and more individuals could seek SDS and direct payments, but there will be a finite budget for that. If many people go for that option, what will be left for those who do not apply for those packages and who are reliant on core services? The funding could have run out.

The Convener: Does that get back to the written evidence from the Association of Directors of Social Work, which suggests that

> "'Social Care' has no place in a Bill that aims to shift power and control from organisations to individuals"?

Is that part of the narrowing of the agenda that you are arguing about?

Duncan Mackay: The term "social care" almost implies that people are always dependent and passive recipients of care, whereas in fact the principle of self-directed support is that it builds on people's gifts, strengths, capacity and knowledge, and on networks in their communities. Of course, people sometimes have significant needs that have to be met, often through high levels of allocated resources.

However, historically, the pattern of services has tended to be that we did things to people. The self-directed support journey is characterised by doing things with the person in the hope that, wherever possible, he or she will do things themselves. Parallel developments in areas such as re-ablement and home support have demonstrated spectacularly how that is possible.

Ellen Hudson is right to say that there is a finite pot of resources available to meet a greater level of need, which is why it is necessary to have criteria for determining who can access individual budgets. That does not mean that the local authority and its partners do not have an obligation to signpost the ways—preventive or involving early identification—in which other needs can be met.

In my view and that of ADSW, the answer to Ellen Hudson's question is that we need a resource allocation system. The bill makes no reference to the fact that we need such a system, but if we do not have one, we cannot manage within a budget. The budget is difficult to gauge, because we have to predict the unanticipated need that will come through the door and that is likely to be met.

It is true that in any system there will be a gap between assessed need and available resources. Partnerships are working within that context and will continue to do so; the bill just places a different framework on them.

Ruth Stark: I thoroughly endorse what has been said about removing "Social Care" from the bill's title. Self-directed support is much more about people being in charge of their own lives, and the social care aspect masks the involvement of education and health budgets in helping to support people in their journeys through life.

Ellen Hudson: The bill's wording does not stress the responsibility that comes with the choices that people must make around self-directed support. That goes back to the point that Duncan Mackay and Ruth Stark made about the bill empowering people to take control of their own packages.

We have heard words such as "co-production" and "reciprocity", but self-directed support is about involvement. People must make informed decisions and be responsible for the care that they receive—there is an obligation on them, too, in that regard.

The Convener: Fiona McLeod has indicated that her questions have been responded to, but she will have an opportunity to come back in, if she wishes to do so.

Bob Doris: One or two things do not quite stack up for me. Perhaps that is due to my lack of understanding, but I will ask about them. First, I should say that I have taken on board the point—which was well made—about training needs in social work and the NHS where there is an interface and there is integration. I am sure that we will return to that.

On whether there is cultural resistance, when we asked how outcomes were measured Mr Mackay said—it might just have been a slip of the tongue—that we need to know whether we are counting the right thing or the wrong thing. I suspect that the committee's understanding is that the outcomes are not about counting things, but about the quality of the care experience for the individual, so I will put the question back to Mr Mackay. Will the bill make what we are counting less clear? Is that part of its principles?

Duncan Mackay: That is a very fair point. The danger is that, when the bill has been enacted and there is a natural desire to know how effective it has been, it will be easier to count sums of money, numbers of people or hours of support, so those things will get counted, whereas it should be, as you quite rightly say, about outcomes for people. The challenge in measuring outcomes is that everyone's outcomes and the ways in which people's needs are met are unique to them. In our own lives we sometimes choose to meet our needs with a formal service, but very often we will use not a formal service but our own networks, knowledge and so on.

Outcomes measurement is still relatively unsophisticated. There has been a lot of policy work to develop it but we often still get stuck on issues such as whether a person is healthy and safe. Obviously, that is important, but you could be healthy and safe and be a person with a learning disability, living in a long-stay hospital all your life. Being healthy and safe does not get to the nub of what is really important for that person's life. That is a challenge and people can usually tell us that. However, we are not always very good at capturing that and directly relating what we do to assisting people to achieve those outcomes in their lives.

10:45

Bob Doris: That is helpful. I hope that you do not think that I am concentrating my questions on everything that you said, Mr Mackay, but I would appreciate a response to a second comment.

You spoke about the scope of the bill, and I think Ms Stark mentioned that the initial vision of self-directed support drew not just on social work but on education and health. You said that you hoped that we could expand on that in our scrutiny of the bill. As someone who has to scrutinise legislation it struck me that we have to be able to implement that legislation. Given the existing challenges of the scope of the bill, would it be realistic to extend its scope at this stage?

We heard in great detail yesterday about the back-office challenges of auditing and tracking the process just within social work. I wonder whether our ambition should be to get this right and move to the next stage. Are you saying that we should add things to the bill? From my perspective, that would be too much of a challenge. The bill as it stands is a challenge that we could deliver on, but to expand it further would be unrealistic.

Ellen Hudson: That was entirely our point as well. The bill is set up to look at social care and social care needs. The scope creep that we mentioned in relation to the delegation provisions in section 18 could start to track out towards health. The RCN thinks that it is important to get the bill right first, then later to have further consultation on possible impacts on other organisations and agencies.

Bob Doris: My final question will be on scope creep. However, Mr Mackay may want to respond to my previous comment.

Duncan Mackay: From the perspective of ADSW, there is no reason why the bill should not incorporate access to health budgets. In the context of the parallel legislation, I do not see how it can operate without doing so because of the aspiration to lose the original identity of the budget, whether it is a social work or health budget.

It is not a mad social experiment to use health budgets to meet individual need; the practice has been established elsewhere for some time, although it needs to be joined together. Overall, there is a strong body of evidence that outcomes improve for people if they not only have greater control over the support that they require but have the choice to exercise control over the resources that are allocated to providing their support.

I understand why the view of Scottish Government officials, through the bill steering group—of which I am a member—has been that it is perhaps not achievable or desirable at this stage to increase the scope of the bill to include budgets, but in the context of integration it seems to me that it is impossible to avoid that.

Ruth Stark: On the ground, the practitioners who are struggling to get their heads round the integrated health and social care agenda and the bill would like to see some joining together of the vision of where we are going. We therefore urge the committee to think about extending the scope of the bill beyond the social care budget.

Bob Doris: That is interesting.

Ms Hudson spoke about the challenges of ensuring that budgets are used appropriately. I am sure that your point was that health budgets should not be used for social care needs. You are worried about scope creep. How will things be different after the bill is passed? After all, even if the bill had not been introduced, an NHS or social work lead would, under the current joint working and pooled resources approach, still be able to decide the most appropriate package for the individual being cared for. Given that with self-directed support the only difference is greater choice for the cared-for person, I am not sure where scope creep comes in. What is so different with the bill's aim of extending individual choice?

Ellen Hudson: If, as in the Highlands, the local authority were to delegate to the health board responsibility for providing social care for older people and adults, the board would, under the legislation, have to assume all the duties. In that respect, the NHS is akin to the local authority in assessing needs and so on.

However, the bill is specifically about social care needs; it is not about developing self-directed packages to support health needs. As we have said, the bill simply does not contain enough detail, and there needs to be further consultation of a wider range of agencies and organisations to find out what its practical impacts might be. We work with local authorities day in and day out in defining care packages; the difference is that, at the moment, the NHS is already providing individuals with core health services without having to be caught up in the packages that will be provided under the bill options. At this stage, we simply do not have enough information to be assured that the bill addresses such matters, which is why we are calling for further discussion and debate with people who are involved in healthcare.

Bob Doris: I thank committee members for their patience. I seek a little more clarity about what will change with the introduction of self-directed support. If, without the bill, an NHS-based lead individual can, under current good practice and collaborative working, already be delegated to access pooled budgets or whatever, I simply do not understand what will be so different about giving individuals on the ground more choice. At the moment, the lead person, who might be in the NHS, can turn round and say, "All you can have from the local authority is A, B or C"; however, with the bill, they could say, "You can have A, B or C but do you think option D"—in other words, self-directed support—"would be more appropriate?" Where does the scope creep come in? The only change I see with the bill is that it will give more freedom to the individual on the ground. I am not trying to create disagreement. I just genuinely do not see where you are coming from.

Ellen Hudson: The bill will give more freedom but does not indicate where the budget for supporting the SDS package will come from. With such packages, the health board will be responsible for providing the social care that the local authority used to provide, but if it turns out that a lot of people are using up that budget and that further health needs must be met, health resources will have to come into play. Integration is a brand new policy—it came in only on 1 April—and organisations are working together to find out how it is working. Besides giving the ability to fudge budgets, the approach will lead to scope creep because health moneys will be used to pay to meet identified social care needs alone. The pooling of resources leads to the blurring of boundaries.

I am sorry if I am not making myself clear.

Bob Doris: There might be genuine and honest disagreement here, because I think that what you are saying goes completely against the integration agenda. The RCN regularly says that we should use social care resources for preventative health spend.

I will read the evidence, and I thank you for your comments.

Duncan Mackay: Integration might be a new policy in the context of proposed legislation, but we can all remember the joint future agenda in the 1990s. Many of us were working on how to produce a suite of integrated services and approaches. The phrase "scope creep" is perhaps a bit unfortunate, because it sounds quite negative. When people have health and social care needs, it seems entirely coherent that there should be access to budgets from both areas.

Gil Paterson: I am looking for clarification from Mr Mackay. When you were talking about the work that you already do, it seemed to me that your approach is wider than is envisaged in the bill. Are you suggesting that the bill will prevent you from taking such an approach, or did I pick you up wrongly?

Duncan Mackay: I was trying to convey the sense that it was never the intention that an individual budget would be drawn solely from a local authority social work service or from the local authority itself, and that if we are to realise the potential that self-directed support offers people in exercising choice and control in their lives—especially people who have complex health and social care needs—to the full benefit of the individual, the only feasible way of doing that is by giving people access to funding from both parties.

Gil Paterson: You are not suggesting that what you currently do will be restricted.

Duncan Mackay: No. Self-directed support is one element of a wider approach to personalisation. There will be many people who do not have needs that meet the eligibility criteria that a partnership applies, but who require access to highly personalised approaches to meet their needs. Their support might not necessarily be in the form of an individual budget.

Gil Paterson: Thank you for shedding a wee bit of light on the situation.

Jim Eadie (Edinburgh Southern) (SNP): Does not self-directed support offer an opportunity to save NHS resources? People in Glasgow yesterday and a good written submission from Glasgow City Council gave examples of people who receive social care. One individual faced spending the rest of his life in hospital unless significant additional social care resources could be found to commission support in the community.

If we get things right in the community, we might prevent people from being admitted to hospital and becoming a drain—if that is the right term—on NHS resources. Have you considered the issue from that end of the telescope? Have you thought about the opportunities for, rather than the risk to, the NHS from self-directed support, which is ultimately about ensuring that the right care package is provided for the individual?

Ellen Hudson: That is absolutely what it is about. However, the bill gives no clarity on what constitutes a "relevant amount", that is,

> "the amount that the local authority considers is a reasonable estimate of the cost"

of securing the support. We do not know how much money will go into an SDS option or package. The recipient of the package will need clarity on that, as will the people who provide the service.

We would hate the bill to be used by local authorities that are struggling with their budgets to cut costs. In its written evidence to the committee on the draft budget, Unison Scotland said that Glasgow City Council had introduced SDS for people with learning disabilities and mental health issues

> "in the belief that this will achieve a 20% saving over the two years 2011-13."

We are concerned about that. We also think that there is a risk that core services will be lost as more people opt out and take the SDS route.

It is about getting the balance right. There absolutely should be a suite of options for people—choice is really important—but, as Duncan Mackay said, there is a finite pot of money and the bill should not be used to get round that problem.

11:00

Jim Eadie: That is a helpful clarification. Notwithstanding your concern about cost cutting, does the RCN accept that, at the moment, people are being offered services almost—if not quite—on a take-it-or-leave-it basis? Mr Mackay suggested that, by purchasing services for an individual, we are able to ensure that they receive genuinely personalised services instead of being told that they can receive a service only at a certain time of the day. That is, ultimately, where we should be going with this. At the moment, a lot of the core services—as you describe them—that would be threatened by SDS if we removed personal budgets from the money that is available for them spend a lot of that resource on overheads rather than on providing a service to people. Before a service is provided to a person, money must be spent on transport or the upkeep of a building if it is a day service that is being provided. Do you understand that point?

Ellen Hudson: The NHS is already providing core health services. Within that, there will be various complex health packages for people with palliative care needs and things like that, which will take an incredible amount of input from a number of different agencies. That is the best way of working. We want to assure whoever is in receipt of any service, be it a social care service or a health service, that they are getting a good-quality service from the resources that are available and that the people who are delivering the service are skilled and know exactly what they are doing.

More closely integrated working is obviously a very good thing because it reduces duplication of effort and makes a service much better for the individuals concerned, but that is where there are jointly assessed needs. The bill is looking primarily at assessing for social care services, and that is the distinction that we are trying to make.

The Convener: This has been an interesting discussion. There is a contradiction in what we are trying achieve through the integration of health and social care. I think that Mr Mackay described a situation in which the social work budget was purchasing health services.

Duncan Mackay: Yes.

The Convener: I thought that that was a great, succinct example. We had discussions yesterday with service users who support self-directed support in principle. They were concerned that health service or clinical involvement was separate, but your example was a good one. That local authority's social care budget is being used to provide health services, but there is something not right about that—you would think that it is important how the budgets are shared.

Duncan Mackay: There is something not right about that only if the converse cannot apply and the bill's provisions do not impose the same duty on both partners.

Local authorities face cuts in the region of 15 per cent or more over the next three years, having already applied cuts of between 5 and 10 per cent over the past two years. Let us think about how a local authority budget is constructed. One large-spend area is education, in which the budget is spent mostly on teaching and there is very limited scope to make savings through differences in class sizes and so on. Where the authority is a major housing provider, as my local authority is, the budget is almost overwhelmingly the housing revenue account, which is drawn from rent. Those two areas are largely immune from the savings that must be made. Social work services are, far and away, the next biggest area of spend, and in the region of 75 per cent of the budget is spent on community care services.

It is important to separate out the aspirations. The bill can be flagship legislation, support integration and place Scotland foremost among western nations in the way in which it supports its most vulnerable people.

In the situation that we face, there will have to be some budget reductions because resources in future will not be at the level that they are at now. There is a risk that self-directed support gets slightly discredited because it is being introduced at a time when cuts are having to be made. The message to the public has to be that the cuts must be made regardless of whether self-directed support exists and that, in fact, self-directed support offers a way to navigate through some of the funding problems that face statutory agencies, because our experience is that people will choose to use the resources on what are not necessarily formal services but are perhaps more economic and more directly related to outcomes.

There is anxiety across the board that traditional services, if you want to call them that, might be adversely affected. That is part of the case that Ellen Hudson has made. Our experience is that, when traditional services are highly flexible, outcome focused and delivered at times and in ways such that people can have their needs met and have an active choice about who supports them and about where, how and when they are supported, people often choose the traditional services and do not necessarily seek a direct payment to have the support provided in a different way. That is why measuring direct payments is not in itself a measurement of very much.

Ruth Stark: I fully support what has been said, but there is also an issue with the overall health budget. Many people who will access SDS have to deal with chronic health conditions and other issues while living in the community. One issue for the health service is how to shift some resources from acute services into supporting people with chronic health conditions in the community. I believe that the health service has to provide its fair share of funding for that. That does not detract from the fact that, as I think all three witnesses are saying, there must be transparent resource allocation and it must be clear where the resource comes from. The burden of it needs to be spread between the major suppliers of education, health and social care services.

The Convener: Finally, I do not know whether we have had an announcement this morning, but we have had an insight that the proposed legislation on the integration of health and social care might have been kicked into the long grass and may not be necessary because partnership working can achieve that, so we do not need legislation. Would it not be good news if we could avoid that legislation and integration could happen naturally?

Duncan Mackay: That is a big question and another committee might be considering that. However, it is a legitimate question because, if we are outcome focused, which is the focus of this bill, it is perhaps questionable whether legislation on integration would drive those outcomes or have the perverse consequence of diminishing the likelihood of them being realised. That is perhaps a matter for another discussion.

Ruth Stark: This is about culture change as much as it is about legislative change; it is about how the public service providers work together. I suggest that you need to put as much investment into culture change as you put into the legislative agenda.

Drew Smith: I will come on to questions for all the panel members about workforce issues that might arise from the changes but, first, I want to ask a question of principle about the suggestion that there should be an appeals procedure in relation to the needs assessment that is made and the allocation of resources. Among the things that have been said to us is that having such an appeals procedure would involve a huge cost. When Mr Mackay answers this question, I ask him to take off his hat as a director of a social work department. From the point of view of directors of social work and social work professionals, do you believe that, in principle, we should consider having an appeals procedure?

As you rightly say, there is an issue with cuts that are going on. There has been controversy, particularly in Glasgow, about how decisions are made, given the funding situation. Leaving aside where the money would come from to administer an appeals process, from a social work point of view do you think that people should, in principle, have the right to appeal? I understand that, if agreement is reached at the start of the process, having a review of things might negate that, but in the current circumstances, in which there is controversy, does it make you uneasy that there is no appeals mechanism?

Duncan Mackay: There is an appeals mechanism—social work has to have a statutory complaints procedure. The Association of Directors of Social Work would strongly suggest that that procedure should be used, rather than creating a separate appeals mechanism. As Ruth Stark said, the issue is one of culture change. If we are serious, we want to embed self-directed support as normal, everyday practice. It would not be especially helpful to create a separate appeals process when there is already a statutory process.

A key aspect of self-directed support is that the person should know the indicative budget that is likely to be made available to meet their needs before the support planning is done, because the support planning must test whether their needs and the intended outcomes can be met from that budget. If they cannot, it is beholden on the local authority to review the level of budget allocation. If it remains a point of dispute, that is when the complaints procedure should apply.

Drew Smith: I think that there is a difference between a complaints procedure and an appeals procedure, but that was a very clear answer.

I want to ask about the wider workforce. As representatives of professionals in the system, do you have a view on whether other parts of the workforce will need to be regulated as a result of the bill? I am thinking, in particular, of personal assistants and the choices that people might make about whom to employ. Do we need to think more about how we regulate some of those people? As we move to having more and more providers, which involves a competitive element, costs will be driven down, and it seems to me that that presents a danger. To what extent is that a concern for you, as representatives of professionals in the system, with regard to both the parts of the workforce that you represent and other parts of the workforce?

Ruth Stark: It is absolutely the case that we need to have some checks and balances on who the personal assistants might be. Some of the worst situations that I have had to deal with as a social worker have been cases in which there has been abuse in a very intimate care setting, whether by parents, carers or support assistants. We must have proper checks and balances in our system because, in some cases, we work with extremely vulnerable people.

Duncan Mackay: It is a complex question, which challenges what we intend to achieve through the bill.

Self-directed support does not mitigate the need for local authorities and their partners to risk assess and risk manage, nor does it mitigate their public protection duties. There are many circumstances in which such an arrangement would not be appropriate, just as it would not be appropriate to make a direct payment for someone who needs emergency heart surgery to get it from the NHS. Only a relatively small proportion of people will choose to take the individual budget in the form of a direct payment, because that brings its own responsibilities, and an even smaller proportion will choose to employ personal assistants. That has been the experience when self-directed support has been rolled out on a large scale.

As you say, personal assistants are not subject to regulation, so the question, which you posed, is whether they should be. If I were seeking to employ a personal assistant for a family member or if I were a person with full capacity and a disability, I would probably say that I was perfectly able to decide for myself who would provide support. From a local authority perspective, we would respect that, unless there were capacity or protection issues, in which case we would intervene as appropriate. That might mean taking statutory measures through the adults with incapacity legislation, for example. The position is not black and white. Decisions should be based on good, sound risk assessment, risk management, the person’s capacity, and the circumstances that prevail around each and every individual.

11:15

Ellen Hudson: Obviously, regulation exists to protect the public, and it is very important for any individuals who are in the position to employ personal assistants that there is proper scrutiny. We need to ensure that they can be assured of the qualifications, training and competence of those individuals to deliver the package of care and that they have had a protection of vulnerable groups check. We did not see anything in the bill that drew our attention to that, so we wondered whether it would be possible for either the national health service or local authorities to insist on PVG records and undertake regulatory work. If they are employing anybody, they could ensure that those checks and balances are in place. Scrutiny is important.

Duncan Mackay: I would like to add a point that I omitted to make in answering the question. My understanding is that, under the protection of vulnerable groups legislation, an individual cannot access a check on a would-be employee. What that means in practice for the implementation of self-directed support is that, in my area, for example, we would link the person to the Scottish Personal Assistant Employers Network—SPAEN—which is one of the bodies that are empowered to undertake an advanced disclosure check, and strongly recommend that that be done.

Ellen Hudson: I suppose that that has the potential to be a loophole that could be exploited, and we certainly do not want that for somebody who is employing a personal assistant. They might not have access to that.

Drew Smith: I want to ask a general question; perhaps the answer to it will be no, so it will be brief. I refer to what was said earlier, particularly from the social work side, about the bill’s scope and the desire to see people in education, the health service and housing to some extent involved. We have had a bit of a discussion about that. Leaving aside the budgets from which the money will come, do you think that the four elements of self-directed support are sufficient?

Duncan Mackay: Yes, provided that the bill makes it explicit that the identification of an individual budget applies, whether or not the person ultimately chooses to draw down a direct payment. That is part of the consideration of how people exercise meaningful choice and control if they do not know what the budget is. If I were cynical, I could say, “Well, there are so many thousands of people living in care homes. Every one of them can get a letter that says that the value of their care home placement is £20,000 and something and asks whether they want to take that in the form of a direct payment.” Thousands of people would then be offered an individual budget. It is clear that that is not the intention of the bill. The view of the Association of Directors of Social Work is that the bill would be strengthened if it clarified the point that an indicative individual budget exists and should be required to be shared with the person, regardless of how they ultimately choose to draw it down and even if they ultimately choose to exercise no direct control over it.

Fiona McLeod (Strathkelvin and Bearsden) (SNP): I want to move on to advocacy on behalf of those who apply for self-directed support and helping them to make their choice. Drew Smith asked about an appeals mechanism. We may want advocacy for the person at that time. I noticed that both the ADSW and the RCN referred to the need for people to be supported in the self-directed support process, but that is not explicit in the bill. Do you think that it is important or necessary that the bill should explicitly say that there should be a role for advocacy in that situation? Would you appreciate that?

Ellen Hudson: We would welcome any forms of support that helped with the decision-making process for individuals who apply for SDS options.

Duncan Mackay: It is fair to say that the ADSW would be content with a statement that people should have access to advocacy, because some people will need that. There is a risk that the people who most lack capacity will be the least likely to access individual budgets, because they will be determined to be unable to exercise meaningful control over a budget, so other legislation will apply. That could compromise the principle of minimum intervention that we apply generally under legislation on adults with incapacity or on mental health. However, it is clear and appropriate that some people will need access to advocacy, which should be part of the overall provision.

Fiona McLeod: Is the bill clear enough about advocacy? It talks about “reasonable steps” to provide support and so on. Do we need to be more explicit?

Ruth Stark: Flexibility probably means recognising that people have different levels of competence in their approach. I think that that covers the issue.

Duncan Mackay: Perhaps the bill could refer to “reasonable steps such as access to advocacy” or something of that nature.

The Convener: I will raise an issue that is in the ADSW’s submission and which is worth airing—we aired it a bit yesterday. The ADSW calls for a debate on state provision as against family provision. What would be the nature of that debate? Should it take place alongside the bill’s progress?

Duncan Mackay: The association recognises that most support is provided by unpaid carers. In many ways, sustaining people at home rests heavily on that. Carers should obviously have access to support, including support under the bill, when appropriate. Currently, there are exemptions on making payments, such as an exemption when a carer lives in the same household as the person who receives care. Local authorities have a limited discretion to exercise.

When a carer should be paid directly and when it should be a reasonable expectation that a carer provides care as a loving family member is a live debate in the context of the financial situation that we have discussed. That also raises a question about the kind of society that we want. Do we want a society in which people are paid to support family members or a society in which they are supported to support family members? That has wide implications for how we live and how vulnerable people in our communities are supported.

The ADSW supports the exemptions as they stand. Some discretionary elements are usually exercised in relation to rurality or ethnicity, when it makes sense for a person to employ a family member and that is the best way to meet a need. The bill’s steering group debated at some length whether there should be exemptions. As you know, the bill does not include any exemptions. For example, there is no exemption in relation to the choice whether to buy residential care with a direct payment, which is currently not lawful. The ADSW’s view is that, although residential care should be as personalised as possible, it is not self-directed support. You cannot choose who supports you, when you are supported or whether you are supported in the kind of meaningful way that self-directed support aims to achieve. However, the issue has been left to one side, presumably to be considered as part of statutory guidance and regulations, which in itself suggests that it requires careful consideration.

The Convener: Did the steering group discuss the eligibility issue that you highlighted earlier and—to take the most positive view—the tremendous expectations that have been excited in people about the potential of this approach?

Duncan Mackay: As the only person on the steering group giving evidence this morning, I should point out that the ADSW repeatedly expressed the view that, if the bill did not recognise eligibility in some way, it might be interpreted that anyone could access an individual budget. Clearly, resources would not permit that and, given the low level of need in many cases, that would not be the most appropriate way of meeting those needs. Of course, that pertains to children as well as to adults, which is why the association's submission mentions section 22 of the Children (Scotland) Act 1995 and its reference to the

> "Promotion of welfare of children in need."

Many people supported through that section's provisions will not, in most local authorities, be eligible to access an individual budget—if anything, section 23 of the 1995 act, which relates to "Children affected by disability", is more likely to apply in this case—but the fact is that regardless of whether we are talking about children or adults the capacity to meet people's needs through either the individual budget or traditional services is not infinite. Indeed, we sought to make that very point in the bill steering group. Nevertheless, it has been suggested that it might be dealt with through statutory guidance and regulation.

The Convener: Do calculations of that kind bring us back to those questions of state versus family provision, eligibility and income?

Duncan Mackay: A great advantage—and indeed a challenge—that we have not discussed and which, I think, was raised in the RCN submission relates to the chargeable nature of social care services, the non-chargeable nature of healthcare services and how all of that applies in the world of integrated budgets. One of the beauties of self-directed support is that the budget can be calculated on a basis that does not require a charge to be drawn down, which means that, if you calculate your resource allocation system in a certain way, you can remove all the bureaucracy of charging and enforcing charges. Alternatively, you could set a higher individual budget, but you would have to reclaim that money through a charging policy. If the self-directed support budget were to be used for residential or nursing care, nearly all of it would have to be reclaimed because of the financial regulations that local authorities operate under.

Fiona McLeod: With regard to family carers, I have to say that Mr Mackay's response has puzzled me. At this point, I should declare that, until last December, I was primary caregiver to a family member.

In response to the eighth question in the committee's consultation, the ADSW says,

> "When an individual chooses to employ their own support, they should be able to do so without interference",

but then states:

> "The current restrictions on the employment of close family members are important to preserve with existing discretion appropriate in exceptional circumstances."

How do those two statements balance each other out? Should an individual not be able to use self-directed support to employ a personal assistant who is also a family member?

Duncan Mackay: You make a fair point. Those statements appear contradictory, but I refer you to my oral answer to the previous question. The exemptions are there for good reason but, given the context and challenges that we face, it is reasonable and appropriate to allow some discretion in navigating around them in certain circumstances.

Fiona McLeod: What are the good reasons for the exemptions?

Duncan Mackay: If carers were paid, the social work budget would be obliterated overnight.

Fiona McLeod: I am not talking about carers being paid. I am talking about the right of the individual under self-directed support to employ a personal assistant who happens to be a family member.

11:30

Duncan Mackay: That has the same effect of the local authority budget being used to pay for a family carer.

Fiona McLeod: You are saying that, under self-directed support, the local authority will exercise control over the employment of personal assistants.

Duncan Mackay: I am saying that the employment of personal assistants has some exemptions relating to carers that are there for good reason and that if, as a society, we moved to a position whereby a significantly higher proportion of carers were paid to carry out their caring responsibilities, then that would require a debate beyond the scope of the bill about the role of carers and how they are supported and about the role of the state in the provision of care and support.

Ruth Stark: Perhaps a parallel discussion has already taken place with regard to children being looked after by kinship carers and perhaps some of the lessons to be learned from that experience could inform this debate.

Nanette Milne: I have a question for the Association of Directors of Social Work. How ready are providers, particularly in the voluntary and private sectors, to deliver services in the flexible way that might be demanded if individuals seek those services?

Duncan Mackay: Just as local authorities will be in 32 different states of readiness, so providers will be in different states of readiness. Our experience of working with 18 providers over the course of implementing self-directed support has been that some have changed their financial systems, tackled their cultural issues and become flexible and dynamic in their practice; whereas others have struggled to make the transition and are perhaps wedded to existing ways of doing things and will ultimately find it more difficult to meet the expectations that people will have through the allocation of individual budgets.

There is one particular advantage to the bill's proposals. At the moment there are severe constraints, through European Union regulations and so on, on how local authorities can commission services—the Public Audit Committee recently took evidence on that. Where people choose to exercise their right, an army of many commissioners will be created; once the budget is with them, they can choose where to place the business. Just like local authorities and others, providers who are slow to adapt the design of how they provide support will struggle to have a sustainable business, whereas those who adapt will be well placed to be cutting-edge providers in the new world.

Nanette Milne: So, as you said in your previous answer, the bill will lead to more efficiencies and economies in the provision sector.

Duncan Mackay: One of the great weapons in social work's armoury is that there are many ways in which to meet a need. If we always resort to expensive formal services or the default ways of meeting the need, we will always incur costs that will mean that we will restrict access to fewer and fewer people. Self-directed support offers an opportunity for people to be much more engaged in how their needs can be met and to apply their own, often very imaginative solutions to that. At the same time it will release resources that can be used for reinvestment or, indeed, to contribute to the savings agenda.

Ruth Stark: People do not have to take services that they do not need. There is sometimes inflexibility in the current system in that regard.

Bob Doris: Mr Mackay referred to 18 providers in his local authority area. When assessment has been done and outcomes have been agreed, the main provider may be the local authority and one of its employees may determine or give advice on what provider may deliver the best outcome. Professionally, they would hope to be completely neutral, but is there a possibility for conflict of interest? If so, how could it be negated?

Duncan Mackay: The bill addresses any risk that people might be corralled and sent down one course of action or another by setting out the options that must be presented to the person, and facilitating access to expert support that is independent of the local authority. The most significant determinant of what people choose is the point at which the discussions take place. If they take place when people are in crisis, the opportunity to explore an individual budget is likely to be much less attractive to the individual. If good preventative work is done and intervention takes place at the appropriate stages, discussion becomes meaningful and there is no bias about how their needs can be met.

Bob Doris: If the bill succeeds, would it be worth doing post-implementation scrutiny across local authorities to see what the mix of provision becomes? Some local authorities are doing more valid and real working and being more proactive with third-sector and voluntary sector organisations to get a mix of potential products out there. We are more likely to see a cascading of services for carers going to those organisations. Would it be worth following the audit trail on that to see how one local authority compares to others?

Duncan Mackay: It would be worth doing that, but it is important to remember that the majority percentage of services is externally commissioned now, particularly in community care, although perhaps less so in children's services. It would be interesting to monitor the implementation.

Bob Doris: We heard mention of the term individual accountable budget—I forget the precise term you used.

Duncan Mackay: Indicative.

Bob Doris: One of the traditional forms of care provision is the day centre for older people or for people who have learning difficulties. It might be an old building and staffed by people who are—I would hope—on reasonable pay and conditions. The building might be difficult to heat and, as a business model, that set up would be inefficient, so the indicative cost of sending someone there might be quite high. However, what would have to be applied through an individual indicative budget to disaggregate that service would, I imagine, have to be proportionally less than what it would cost to send someone there, so that an amount of core provision could remain with the service provider and we would not get to a tipping point. How do we weave our way through those kinds of issues?

Duncan Mackay: Earlier I made the point about traditional services needing to redesign themselves, if they have not done so already, so that they are flexible enough to meet need in ways that improve a person's outcomes. From direct experience of that, I know that it is sometimes necessary to allow some short-term, intensive services, such as those that have an assessment or re-ablement function, to operate outwith the framework of individual budgets. That can be used as a way of determining future levels of need that might then, because of that intervention, reduce the level of need, so that people do not need a lot of support thereafter, or determine the correct level of need that can be met in the individual budget. All those factors have to be taken into account in calculating resource allocation.

The Convener: We got some feedback about that yesterday. Earlier you mentioned the transfer of costs to individual budgets, and people have told us about the 25 per cent cuts in their budgets. They were aware of the global budget that was previously applied to an individual's family and care, but when they took the self-directed support option in the pilot, they saw a deduction of 25 per cent in their budget. In those cases, that perception has poisoned the process from there on in. Those people do not see self-directed support as empowering or an opportunity; they see it in the context of a financial cut.

Duncan Mackay: I do not wish to dominate the evidence session, although I suppose that I have the advantage over some witnesses in that I have direct experience of operating self-directed support. In North Lanarkshire, we chose to do it in a very different way from the approach in Glasgow. I mentioned the first 150 people who now have fully implemented individual budgets. They were all new presentations of need, so they did not have an existing set of arrangements that we then had to reduce or potentially reduce.

Glasgow's approach was to start with the existing population of service users and the existing resources and need. That approach is more challenging, because it is more likely to result in a reduction in resources. In North Lanarkshire, we have moved into the process of applying individual budgets to people who are already in services. That often involves people in long-stay institutional care or long-stay hospitals, such as people with learning disabilities, in which very little effort has been made to maximise their capacity. For example, some people who moved into their own house would wait at the door for somebody to open it, because that was what happened in the long-stay hospital environment.

Where the focus has not been on trying to restore or maximise capacity, the level of need and of individual budget is likely to be higher. However, after the move to an individual budget, the amount might be less than the amount that they received previously. There is a reduction, but people are likely to have much more flexibility in how they deploy the resource.

Richard Lyle: Every Government brings in a new policy or bill. To return to comments that Fiona McLeod and Ruth Stark made, we all know how the 32 councils have 32 ways of dealing with kinship care. Some have implemented it and some have not—I have fought with Duncan Mackay on the issue. How can we ensure that we do not have a postcode lottery under the bill, that everyone is treated equally and that the 32 councils implement the bill?

Ruth Stark: We need open and transparent scrutiny of the resource allocation to ensure that people throughout the country receive similar services. We must take into account the difficulties of providing services in, say, the Western Isles compared to the difficulties in the Borders or Glasgow, which will all have different cost implications. Therefore, we will need a complex system to ensure that we have an equitable service. Such a service might cost different amounts in different parts of the country.

Duncan Mackay: I am tempted to say that policy eventually catches up with best practice, but I will not. I am sure that that question will helpfully be directed at the care inspectorate—Social Care and Social Work Improvement Scotland—when it gives evidence in the next panel. It is a reasonable aspiration of Government—people can legitimately expect the same standards, support and service in all local authority areas. Some of the discussions on the bill steering group have examined whether there should be a national resource allocation system. The reason why that is not possible is that authority A might choose to allocate much more to social work than authority B, so the amount in the pot that can be distributed through individual budgets might be different.

The funding in Glasgow and Fife is different from that in North Lanarkshire or South Lanarkshire. The care inspectorate has done detailed work on that, and it will say that the situation does not necessarily mean that there is a difference in outcomes. There is not necessarily a direct relationship between spend and outcomes. Ultimately, the issue is about how we measure outcomes across the 32 areas. That is a challenge in itself, but ultimately that will be the acid test of whether policy is being implemented with equal vigour and success.

The Convener: As there are no more questions, I express the committee's thanks to the witnesses for giving us their time and for their evidence. Thank you very much indeed.

11:45

Meeting suspended.

11:50

On resuming—

The Convener: I welcome our second panel of witnesses. From Social Care and Social Work Improvement Scotland—the care inspectorate—we have David Cumming, the director of operations, programming, co-operation and registration, and Professor Frank Clark, chair of the board of the care inspectorate. Sandra McDonald is the public guardian. George Kappler is deputy chief executive of the Mental Welfare Commission for Scotland. Adrian Ward is convener of the mental health and disability committee of the Law Society of Scotland.

Gil Paterson: My opening question is a general one, although we will come on to discuss capacity, which I know is of particular interest to the panel. Do you welcome the bill? Is it taking us in the right direction?

Professor Frank Clark (Social Care and Social Work Improvement Scotland): Thank you for giving us the opportunity to present evidence. The care inspectorate is supportive of the bill and the principles in it, but we do not see it in splendid isolation. We regard the bill very much as a logical step on the way to the integration of health and social care.

Adrian Ward (Law Society of Scotland): I welcome the basic principle of empowerment. We expressed a range of concerns about the draft bill and we are impressed by the extent to which our concerns were taken on board before the bill was introduced. We still have some concerns, which is why I am here, but much of what we and others said has been listened to and acted on, which we welcome.

Sandra McDonald (Office of the Public Guardian Scotland): The public guardian's office feels likewise. We welcome the general tenor of the bill. We had specific concerns about people with incapacity, which have largely been listened to.

George Kappler (Mental Welfare Commission for Scotland): The commission is of the same mind. We certainly welcome the bill's objectives and support the principles, but we have concerns about how capacity will be dealt with.

Gil Paterson: The Mental Welfare Commission's submission set out issues to do with capacity. Please feel free to talk about your concerns.

George Kappler: A major concern is to do with the point at which assisting someone in making choices and in having their care delivered moves into making substitute decisions on their behalf. There can be a fine line in that regard. Capacity is not an easy thing to establish—we cannot take a blood level of it—but it can be enhanced. All of us, in isolation, would not be able to make certain decisions, especially complex financial decisions, that we could make if we had the appropriate help and support.

Assistance with choosing options and enhancing someone's capacity is therefore an essential part of the bill, which we welcome. However, what is confusing is that the policy memorandum sometimes talks about the possibility of substitute decision making, particularly in the context of the use of section 13ZA of the Social Work (Scotland) Act 1968 to gain authorisation to take action on behalf of someone who cannot make informed choices. Someone who can be assisted to choose an option but cannot be an active participant in organising the care that will be delivered to them probably still has the capacity to choose to appoint a welfare attorney or financial attorney to act on their behalf.

Our concern, especially based on the explanatory notes, is that the bill might allow for the use of substitute decision making, and we do not think that there are appropriate safeguards in the bill to allow that. It might not take advantage of some of the protections that are in the Adults with Incapacity (Scotland) Act 2000.

Gil Paterson: Does anyone else want to say anything? I would be happy to hear any solutions that people might propose.

Sandra McDonald: Our concern related to the confusions that might be created by the use of the term "assisted decision making" alongside language that is very much the kind of language that is used in relation to adults with incapacity. We do not know whether practitioners might feel that they can assist those who truly lack capacity to make a decision, which would go beyond assisted decision making and towards substitute decision making. The policy memorandum makes it clear that that is not intended to be the case, but it is not clear in the bill.

David Cumming (Social Care and Social Work Improvement Scotland): You will appreciate that the formation of the care inspectorate last April brought together various previous workstreams. In our previous experience of carrying out social work inspections across the 32 councils, we have realised—primarily through the reading of files and records and trying to form a view about how sensitively they reflect the work of the frontline practitioners—that discussions of capacity issues and sensitive areas by practitioners is of key importance. We have seen some good practice, but we have also seen some examples of a perfunctory approach being taken. If frontline staff tend to be anxious to get to the end point of an assessment, it can be difficult to convey to the service user that there is time to make a considered decision and that there is some understanding of their position, including how much capacity they have to understand the choices that are available to them.

Adrian Ward: I used the word, “empowerment”. A balance to empowerment is protection.

We can think of three categories of people. There are those who are capable of making their own decisions and do not need help—that is easy. There are those who are capable of making their own decisions but need some help to get there, which is where empowerment comes in and where, potentially, some protection is needed to determine whether we are hearing what they want with assistance, or what the assister wants us to hear. Finally, there are those who are not capable of making decisions. If someone is not capable of a decision, you cannot assist them to make it. The draft bill was unclear in that regard. I agree with George Kappler and Sandra McDonald that there are still concerns about that, including concerns to do with the language in the section. Why are we referring to

“mental disorder or difficulties in communicating”?

That is the sort of language that is used in the Adults with Incapacity (Scotland) Act 2000 when it talks about people who need help. If you need help, you need to define why you need help—you need to say, “I feel I need someone to help me.”

If someone is still capable, but is in need of help, why should the local authority appoint someone to help? If I need help, surely I would know who I wanted to help me. That should, perhaps, be my choice.

If there is no capacity, or the person is so vulnerable that the person who helps them is in danger of substituting their views for those of the service user, we need protections to be in place—we cannot get away from that. Of course, capacity can not only be at different levels in terms of the person’s ability to make certain decisions and their lack of ability to implement them, it can also change over the course of time. Someone who needed help at one point might have lost capacity to manage matters at a later point. We need to pick up those issues as well.

I was impressed with what Ruth Stark said during the earlier session about her concerns about the many issues that weave into self-directed support. Another one is this: if the local authority chooses the person to assist, what will its responsibilities be, both in terms of the choice and in terms of monitoring what goes on afterwards?

12:00

Professor Clark: I will make a more general point in response to Gil Paterson, who asked, “So what can we do about this?” You have heard about some of the technical issues, but we need to set the issue in a broader context.

Sandra McDonald mentioned confusion. The area is undoubtedly complex and, as a precursor to the legislation, we need effective communication with the public at large about what self-directed support means, what people can expect from it and so on. We also need those things to be communicated simultaneously to professional staff. I am talking not about training, but about providing information to people. We also have to engage service providers in the process of understanding self-directed support.

In particular—David Cumming touched on this—the engagement with individuals who might avail themselves of self-directed support needs to be handled consistently and in a manner that effectively markets it and adequately communicates its potential to people.

The Convener: In cases where capacity is under question, we heard yesterday that, under the full guardianship arrangements, people are having to use the legal process and present before a sheriff. Would you concede that the process does not need to be as formal as that? Should there be something less formal to enable people to access self-directed support?

Sandra McDonald: At present, only the two extremes exist. If the person has lost capacity or lacks capacity and they have not previously granted a power of attorney to somebody so that they can make the decisions, then, if they require self-directed support, the guardianship process is the solution. That would involve both financial and welfare guardianship, because both limbs would be required—one to administer the money and one to commission the services.

There is a proposal before the justice side of the Government, which is thinking about whether an interim measure could address the issue, but that will be some way down the line, even if the Government agrees that it would be a solution to that and other issues that we face in the area.

The Convener: Is there general agreement that something should be done? In some cases, things are not planned. Perhaps someone has a stroke or someone goes into hospital. People are anxious to push this on—not just social workers or local government employees, but family members. People who are closest to those who need support are anxious to make appropriate arrangements as soon as possible. What is the solution? If there is a general acceptance that an interim measure can be sorted out and there is willingness to work towards meeting people's needs, why is it taking so long?

Adrian Ward: For a person to have someone else managing their support probably puts that person in a dominant position in most areas of their life. It is not a minor matter. It is not like managing one bank account. It is a pretty major role with all sorts of consequences and it determines the quality of the person's life. The question could then be whether the procedures and protections that the Parliament put in place at its outset for people with incapacity should be available to people who will potentially have somebody else exercising such a major role in their lives?

The Convener: You pose a scenario that the appropriate person would be someone other than the person who was appointed guardian through a legal process. In the vast majority of cases, it would be the same person, would it not? The appropriate person would be the spouse, partner, son or daughter.

Adrian Ward: Yes, but if you have a guardian with appropriate powers, your problem is solved. To pick up George Kappler's point, if somebody has limited or deteriorating capacity, they can follow the much simpler procedure of appointing an attorney competently. You can be capable of appointing an attorney—you know what you want them to do but you are not capable of doing all the detailed things that that attorney is going to have to do. Those two routes are available.

Sandra McDonald has alluded to a debate that she deserves the credit for initiating, which is whether we can get in place some grades of—we will call it guardianship—that are less than full-blown guardianship. That raises a raft of issues. I doubt whether it is really a matter for this discussion. There will be many views on that and there are many issues relating to that.

The guidance suggests that we add to those two possibilities—guardianship as it now is, and power of attorney—section 13ZA of the Social Work (Scotland) Act 1968. I think that Sandra McDonald's submission pointed out that section 13ZA is to do with welfare matters, not matters of financial management. It seems to me that to point people in that direction is rather circular, because that empowers the local authority to do what is necessary. For example, I have opted for self-directed support but I am shunted to an amended section 13ZA that includes all the financial and contractual matters. However, the local authority will do it, so am I not back to the local authority doing it in the first place?

George Kappler: We have considerable sympathy with families who feel that they have to take out guardianship just for self-directed support. What is harder to tease out are the gradations. How many of those people would have been able to appoint a power of attorney?

The other side of that is that if someone lacks capacity to such a degree that they cannot make decisions on a lot of aspects of their lives, it is hard to think why we would need only that one power and not other powers to make decisions and take actions on behalf of the individual.

We support the discussion that needs to be taken forward about the possibility of graded forms of guardianship. Arguably, a family that has been caring closely for someone for their whole life should not be treated in the same way as someone who is kicking over the traces, such as a 25-year-old with severely challenging behaviour who is alienated from his family or does not have a family. At present the law treats them in the same way. It should be possible to have something that is more proportionate to individual circumstances but still provides the necessary safeguards.

Section 13ZA came about because people were stuck in hospital waiting for welfare guardianship applications to go through. Three local authorities in particular—West Lothian, Perthshire and Fife—caused problems because the legal advice that they were getting meant that people who did not need to be in hospital were clogging up hospital beds. Section 13ZA was a way of clarifying what the Government felt was the authority of social work to take action when no one was in opposition to it.

The problem that we have is that no one has had any kind of oversight as to how that is working and whether it has been used properly. We get no indication that local authorities are on top of it, so it is hard to do any kind of central monitoring of how it is working.

Gil Paterson: I have a short question for the Law Society, although anyone is free to answer.

In order that the Government achieves what it has set out to achieve, there is a call for the issue of capacity to be included in the bill. Is that necessary, or is it adequate for the Government to show its intention to cover that issue in guidance?

Adrian Ward: Because of the confusion that Sandra McDonald and I referred to, the language of incapacity is leading us towards assistance. The first divide should be an assessment of capacity. Does the particular service user have the capacity to decide for themselves, either with or without assistance, or do they not have the capacity to make some or all of the decisions? It would be very helpful if that was in the bill, because at the moment what is in the bill creates doubt and confusion.

We are not talking about whether we will get the right outcome if we are all judging, or if the public guardian and a senior member of the Mental Welfare Commission are judging; we are talking about folk out there just picking up and working with the legislation. If there is scope for confusion in the legislation, confusion will occur and things will go wrong. That could be avoided if the drafting of the legislation was clearer on that point.

Sandra McDonald: There has to be some reference to capacity in the bill. To pick up a point that was made by one of our colleagues, assisted decision making is perfectly legitimate, but there is no reference to when assisted decision making may stop if the person then loses capacity. In such a case, the person who is assisting would become the substitute decision maker unless there was a clear differentiation between the capacity levels.

Fiona McLeod: Sections 5(3) and 5(4)(a) and (b) talk about the local authority taking "reasonable steps" to provide assistance. Would it help us in this situation if it was explicit that advocacy services had to be available to support people?

Before the panel answers that, I have a little statement to make. Professor Clark talked about doing a selling job on SDS, and I would like to do a selling job for the Office of the Public Guardian. One of our biggest tasks is to convince people to take out powers of attorney when they have the capacity to do so, so that we are not in a bad position later.

The Mental Welfare Commission talked about article 12 of the UN convention on the rights of persons with disabilities, which is about access to support. The care inspectorate talked about the use of advocates and advocacy. I know that this is not the complete answer to the problems that we are discussing, but would it be a step towards helping in such a situation?

George Kappler: There is no doubt that advocacy has a role to play. I am not sure whether it is necessary to put it in the bill—I am open to debating that—but advocates definitely have a role. The problem is that advocacy is a bit overstretched in many areas. Some attention would have to be paid to the funding of advocacy services if they are to be formally extended. There is a danger in not formally extending those services, because they are underresourced at the moment. Some attention would have to be paid to ensuring that the resources are there to make the provision of the service realistic.

Professor Clark: I am thoughtful about the whole issue of advocacy for a variety of reasons. It must be proportionate to the assessed needs of the individual and it is always difficult to get that fit. We must not lose sight of the fact that we are talking about independent advocacy as opposed to the advocacy that every doctor, nurse and social care practitioner should, as of right, provide on behalf of their patient, client or whatever. Independent advocacy should be provided as well as, and not instead of, that advocacy that must be in place.

We must be careful about the circumstances in which advocacy is engaged, the costs associated with it, and how much of the pot could be spent simply on advocacy but not on the front-line services that the individual might need. That is not to deny them the support of advocacy but, as was graphically demonstrated in the earlier evidence session, the pot is finite and only of a given size. If we use a significant amount of it on advocacy, by definition, the balance will be correspondingly less. We must be careful about that. There is no one-size-fits-all solution, and the issue is complex. I am being repetitive, but we must keep it in mind that independent advocacy is provided in addition to that which is provided by health and social care professionals.

12:15

David Cumming: A key factor in all this is the interaction between the social care professional and the person who is seeking and using the service. At the heart of that, there must be a strong element of trust and confidence that the eventual decisions are properly person centred and not foisted on the individual. I use the word "foisted" just to accentuate that point.

The decisions must be taken carefully. I read some of the evidence from last week's meeting, which took me back to my earlier career as a social worker. We would expect to spend some considerable time with the service user. At that time we used the term "casework", but it involved considerable engagement with the service user. The pressure on front-line services nowadays sometimes reduces that kind of contact and, correspondingly, the element of trust. I am not saying that it is absent, but it must be built up further.

Adrian Ward: May I respond, too, on advocacy? First, I declare an interest, in that I was responsible for establishing an advocacy service. I am totally in favour of such services.

The most difficult contested guardianship case that I ever had was eventually resolved when I said, "Let's get everybody together and, among other things, make sure that the adult at the centre of it is represented by an advocate." That gave us the key to resolving that case, so I am very much in favour of an advocacy service. However, there is more need than there is availability.

I read through all the committee's proceedings of a week ago—people do do these things—

because I was interested to see what could be gleaned from the pilots about how issues were dealt with. I did not find very much, but I found this quotation from Dr Ridley:

> "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."—[*Official Report, Health and Sport Committee*, 8 May 2012; c 2182.]

I thought that that was quite a telling piece of evidence, which sets the scene for the discussion that we are having just now.

The Adults with Incapacity (Scotland) Bill was amended by the Parliament to include specific reference to independent advocates in the court processes—basically, sheriffs must listen to independent advocates. I do not know whether that would help us in this discussion, but it would do no harm. There has been the precedent of specific reference to advocacy being made in the Adults with Incapacity (Scotland) Act 2000, so perhaps it would be appropriate to discuss it in this context. I am neutral on that, but I can see that it could be valuable.

Fiona McLeod: The care inspectorate referred to the professionalism of social workers, healthcare workers and everybody who supports a person. I understand that. However, we heard at last week's meeting that, particularly for social work departments, there will be a balancing act; they will support users and commission care for them, and they will also be providers of care. That is another reason why there should be an independent voice to speak for the user who cannot make their opinions understood.

Professor Clark: I would agree with what you said, with that last qualification for the individual who has been demonstrated as needing such a service and who can benefit from it. However, historically, we have seen local authorities acting in the capacity of the provider of services and having a multiplicity of roles in that regard, and doing that quite satisfactorily. They do it, for example, with care homes, so there should be no reason why they should not be able to translate that into responding to this particular area.

Fiona McLeod: On personal assistants and the regulation thereof, it was interesting that the care inspectorate talked about the regulation of care assistants when they are employed by agencies. However, increasingly we will see that individuals may employ their personal assistants directly. Should we consider moving personal assistants who are not employed through an agency into the framework that you are currently using? There is a date by which all personal assistants have to be trained or qualified to a certain level—I cannot remember when it is.

How would you inspect personal assistants, if they came within your remit? In the interim, would it be a sufficient safeguard to insist that personal assistants who are not employed through an agency must go through PVG disclosure?

Professor Clark: The issue goes almost to the heart of the bill and the detail in that regard. Personal assistants could represent a significant call on SDS and will not always be independent; in future, people could well employ family members.

The care inspectorate's job—if you will indulge me for a moment—is to look at the totality of social work services in Scotland's local authorities. As part of that, we will consider the extent to which local authorities are giving effect to SDS in their day-to-day work. We will consider whether authorities have systems and procedures in place and whether they actively promote SDS for individuals who might benefit from the approach, as we expect them to do. We will do case-record reading, to ascertain whether there is evidence of the approach being carried through, and we will sample or validate—call it what you will—the self-evaluation material, to determine whether anticipated outcomes for individuals are achieved. That is one way in which we can ascertain whether the presence of a personal assistant is achieving the benefit that was intended when the individual engaged them. That is our intention.

Let me put on another hat. I am a member of the board of the Scottish Social Services Council. Members know that we have been moving progressively towards regulation of the social care workforce. There is no doubt that to have a largely unregulated group of individuals offering services to the most vulnerable people in society would leave an anomaly. Effective care management and care co-ordination in local authorities should take account of that.

David Cumming: When the care inspectorate examines the arrangements that local authorities put in place, we will expect there to be an early reviewing mechanism. That is important. I am not saying that we expect a situation to get worse before it can be improved, but local authorities have an on-going duty of care. The care inspectorate expects there to be an active mechanism for review if someone says, "This isn't really working for me. The outcomes aren't being achieved and I want to have another think about it." We will want to see evidence of how local authorities put into practice their reviewing arrangements.

It is about working alongside the person who is receiving the service and trying to advise them, while not undermining their autonomy, if there is an issue that is prejudicial to their good care and independence.

George Kappler: Because of the nature of the work that the Mental Welfare Commission is involved in, we end up seeing perhaps the 1 per cent of people who will take advantage of a situation and exploit someone for their own purposes, so it is reassuring to hear about the care inspectorate's intentions in relation to external scrutiny.

Internal governance is particularly important, and we are concerned that that is getting more difficult for local authorities, given their stretched management systems. We have had a few investigations that indicated that local authorities do not always take advantage of the mechanisms that exist in the legislation on the protection of vulnerable individuals, which are an essential part of the system.

I said that capacity can be enhanced; we must also remember that undue external influence on a person who is on the cusp can diminish their capacity to act freely and in their own interest. We must always be mindful of that.

Sandra McDonald: Our experience has shown that an on-going assessment or review of the person is more important in the first instance than a PVG check, which can be only a snapshot of a moment in time.

In the guardianship process, a nominated guardian appears before the sheriff. They are assessed as potentially suitable by that sheriff in a fairly onerous process, and are deemed to be suitable. However, some way down the line, under the current supervision arrangements, we find that the person is not actually suitable. It may be that they were perfectly suitable at the outset, but circumstances have changed. Stresses and pressures have arisen in their life, and they have succumbed to them and unfortunately abused the person for whom they legitimately and genuinely set out to care.

The PVG check may be perfectly fine in the first instance, but unless there is on-going supervision—I am thinking in particular of directly employed people—one would not notice that circumstances have changed. I would certainly support something taking place further down the care inspectorate route, rather than just a one-off initial PVG assessment.

Professor Clark: Regulation or registration of individuals by themselves will not prevent abuse occurring. We know that: we see it day and daily. However, with our input, such regulation could reduce the risk of that abuse happening.

The Convener: We have been discussing pretty reactive stuff to do with what happens when things go wrong—or are expected to go wrong—or where there is a lack of trust in the system. However, we have received written evidence from the Scottish Human Rights Commission, which advocates a more human rights-based element in the legislation and refers to a report on independent living by the UK Joint Committee on Human Rights.

The SHRC's submission states:

> "The Commission believes that this Bill represents an opportunity for Scotland to enshrine the right to independent living in this core piece of social care legislation."

Would that address some of the problems? Would it shift the balance, so that we move from the right for people to live as independent a life as they possibly can and put the onus on others? Would it take us beyond the language of choice, partnership and participation, which we anticipate from our experience of previous legislation may not lead to the best outcomes?

David Cumming: How many hours will we spend debating that question? It is a good question, but it is very complicated.

One of the big challenges that we face is trying to enable people with significant difficulties to live lives that are as normal as possible. That intention is inherent in the bill, but we are struggling with how we take that forward.

We must consider what we have achieved since the National Health Service and Community Care Act 1990, which included directions in choice. We have moved forward quite considerably in that regard, as was alluded to in the previous evidence session. One obvious example that was mentioned was the fact that in the not-too-distant past, large numbers of adults with learning disabilities were living day and daily in hospitals. There has been a major transformation in that regard.

That is not to say that all is now as we would wish it to be, but the bill gives us an opportunity. On the question whether it is an opportunity or a threat, I think that it is very much the former. We must move forward in that spirit by enabling the individual to exercise control, and enabling the professionals—if that is the word—to work in full partnership, using terms such as collaboration. We need to include all those arrangements for working together.

That stands in distinct contrast to the service-driven approach that obtained prior to the 1990 act, after which there was a move towards a needs assessment approach. The bill represents another quite significant change with its move towards empowering people to take a view on how they wish to remain independent and to exercise that independence in their own lives.

12:30

The Convener: But many of the same good intentions sat behind the direct payments legislation, guidance and everything else and the proof of the pudding in that respect has been very slow take-up, resistance to the move and—some might say—the appearance of vested interests.

David Cumming: Earlier, Duncan Mackay acknowledged that in his authority the level of direct payments was very low, but he regarded it as one indicator of how people could be supported. He also set out some very impressive numbers on the people receiving individual budgets and I note that, in its inspections, the care inspectorate's predecessor body examined how that particular local authority had enabled service redesign over an eight to 10-year period. An important principle is that some of these transformational changes will not happen over one or two years; it must be understood that they will take place over a longer term. That might require not only patience but some vision and confidence that this is the right direction, and I certainly think that some of the empirical evidence that Duncan Mackay cited earlier is correct in that respect.

The Convener: The basic issue is whether the bill is sufficient to shift the balance towards those who are in receipt or need of care. Earlier, we were discussing the question whether, if I become incapacitated, I can be confident that people are being compelled to do their best for me. Does the bill do what it says on the tin?

Adrian Ward: As a lawyer, I point out that our aspiration for the law is that it create the optimum framework for getting things right. In other words, the law itself does not get things right; people have to operate and work within it.

The fact is that we have come a long way. Prior to the Adults with Incapacity (Scotland) Act 2000, we had very fixed provision. Basically, a diagnosis put an individual in a certain box and, as a result, they got certain provision. The philosophy behind and legal framework set out in the 2000 act were based on assessing need, having a range of flexible possibilities and putting in place provision to suit the individual. Under this bill, the same will apply to the care and services that individuals receive. Instead of their being put into this or that fixed box, they will have a range of possibilities to meet their needs. Passing this bill will take things in the right direction but it will not simply make things happen. It is a bit like being in a traffic jam: there is a huge difference between being stuck in a jam and going nowhere and being stuck in a jam but moving in the right direction—if not as quickly as you would like to be. I am afraid that that is the reality of the world that we live in.

Professor Clark: I concur with Adrian Ward. Although legislation does not make things happen in and of itself, it provides the best opportunity for them to happen. However, a number of things have to take place alongside it. This is all about cultural and operational differences and how health and social care professionals interact and work with individuals to put them at the centre and to support them in making informed choices about what is right for them. That might shake some of the foundations of traditional thinking, because people will come up with imaginative and innovative ideas and we must ensure that we do not get in their way.

Richard Lyle: I have listened to those comments with great interest. Indeed, I have been through the situation myself and know that it is very complex.

I apologise if I seem to be moving in an entirely different direction, but the witnesses might have heard my earlier question about the possibility of a postcode lottery with 32 councils doing different things and the need to ensure that everyone is working towards providing people with the same service. Why do you believe that local authorities are performing at different levels with regard to SDS?

David Cumming: The starting point is different. Variation across the country is informed by local decisions. The point that was made during the earlier evidence session also recognises that the amount of resource that is committed by each local authority will vary on a per capita basis and in the real terms of the resources that are assigned to those services.

If we look at the issue very narrowly, it might be seen as a focus on one part of the public sector budget when, in fact, it is a much wider area. That point was raised earlier so I will not rehearse it again, but it is important. If people are to be independent and have fulfilling lives, they will want to access a range of services within the public and private sectors and they will have to be reflected in local circumstances.

Certain approaches will have to be taken that are fundamental to that situation, and I cannot see any change to how one will go about assessing jointly with an individual service user what they want in order to achieve their outcomes. That has to be a necessary starter.

The flipside is that we should not just take a one-dimensional approach. Other people within the individual's household—I am talking about carers or extended family members—are vital, too. Sometimes the development of services for one individual might also have to take fully into account the consequences for another. When we are talking about the redesign of services for adults who have a learning disability, for example, sometimes the pace at which that redesign takes place is significant. Sometimes the pace is too hasty and neither considered nor measured, and sometimes the consequences for those who had full-time care responsibilities are not given enough weight.

We might come on to discuss carer strategy and carer assessment later, but there has been a variability in those across the country for reasons that we can go into. We cannot easily state that the country has a uniform approach to such provision, and nor should we because of the contrast between island and remote and rural authorities and certain urban areas. They require quite different resources and provide different access to services.

Professor Clark: May I add to that? Richard Lyle has asked a very good question. I would not expect provision to be exactly the same across the country, for the reason that David Cumming has described; I would expect some variation.

I would like the care inspectorate, as a regulatory and scrutiny body, to be aware of and share a set of credible characteristics of good self-directed support that form a shade card that is known to and accepted by individuals so that, when we do our inspections, we can hold up the self-same shade card that the local authority is holding up and ask whether its self-directed support is characterised by the same elements, some of which are expressed in the principles in the bill. I am not advocating any kind of national prescription, because that would not work. It would also get in the way of innovation. However, we need some common characteristics so that what is expected is explicitly understood and so that, when the care inspectorate looks at the situation Scotland-wide and reports on it, we can highlight good practice and commend it to individuals, as well as identifying those areas that might be falling short of the mark and examining with them why that should be the case.

Nanette Milne: When the care inspectorate inspected social work services and their variability, did you detect any resistance to culture change, which would obviously have to happen if the bill goes ahead?

David Cumming: I suppose that resistance to change is always present in any circumstances. We should point to the achievements that have been made over a period of time. We are talking about reshaping care for older people or shifting the balance of care, and that is about transformational change. That is not to say that we have reached the end of the process; we are still on the proverbial journey.

There is a lot of evidence that front-line staff, especially when they are working with colleagues in localities, are more likely to know one another and have confidence in one another's abilities. We have talked about pooled budgets and shared activities. A very good point was made in the earlier evidence session about the local authority funding what might otherwise be deemed as a health response.

Some of the barriers can be broken down when there is confidence that the outcomes that are being sought in conjunction with the person using the services are the right ones. Again, we are in a precursor stage for where we might be in a few years, so it is important that we have a joint vision and that staff from different disciplines, whether that be education, health or social work, have the same understanding. That is part of the cultural shift that we have talked about. We need to be alert, too, to the public awareness issue that Frank Clark talked about. A risk-aversion position can obtain, but we can also see opportunities for promoting a good service.

Professor Clark: A relevant point is that unless we can get staff to behave in the manner in which we need them to behave, the change will not happen. The situation is a bit like what happened with the integration of health and social care, in that there is no point in getting the structure right unless practitioners on the ground behave differently.

To answer Nanette Milne's question directly, the people to whom I have talked are not resistant to change but they are uncertain about it. As the process unfolds, we need to give clarity and there must be strong leadership and support for individuals. Some find the process a bit threatening because they tend to convert it back into, "My budget and your budget are coming together, so what does that mean for me?" However, such reactions are natural and need to be managed.

I would not therefore say that there is resistance to change. I think that most people can see the benefits down the line and are not resistant, but they are probably a bit uncertain about what it might mean for them.

Nanette Milne: I am encouraged by your responses. My latter days as a councillor were when direct payments were first coming in, and I detected significant resistance to them at that point. Clearly, things are moving forward in that regard, although they have not gone the whole way.

The Convener: In our earlier session, Mr Mackay referred to work that the care inspectorate had carried out across local authorities. Is that available to the committee?

David Cumming: Each of the predecessor bodies—the care commission and the Social Work Inspection Agency—published end of session reports, so to speak, in 2010, which are very informative about examples of good practice. There are areas of good practice across the regulatory services and services that local authorities provide or commission. Each of the two reports highlighted key gaps that needed to be worked on. Indeed, as a scrutiny body, we continue to work jointly with local authorities and with the regulatory care providers on how the services can be improved. That is at the heart of our grading and engagement approach.

The Convener: We look forward to your accessing those reports for us. A recurring issue over the past couple of days has been postcode lotteries—Richard Lyle referred to that. We heard yesterday of good examples of practice, but the personalisation agenda is affected by what part of the country people live in and the different packages that may be available to them. We look forward to seeing information about that.

This will be made public anyway and I do not want to go on too much about it, but we feel from our engagement with service users that there are some issues about how assessments are carried out—the users have strong views about that—and whether there is continuity with regard to the social worker. Our work on those issues may be informative for you and the work that you carry out.

David Cumming: We will be able to give you some evidence from the work that I referred to about responses from various service-user groups and carers. For each of the 32 councils, we undertook considerable surveying and had direct meetings with carers and service users.

12:45

The Convener: Is the care inspectorate's ambition to inspect this and other areas all budgeted for and subject to a planned programme? The committee is aware of its work in care homes but is the inspectorate getting out to a wider group of people who are not being put up by the local authority or social work and whose problems are unlikely to be presented on the day of the inspection?

Professor Clark: You asked two or three questions there and the answer to your first is yes, we are resourced to do the work. The cabinet secretary intervened to protect our budget—

The Convener: Is this work covered by your budget or is it additional?

Professor Clark: As I said earlier, given that we see self-directed support as an integral part of looking at local authority social work departments, we will examine it when we inspect other matters and will not treat it as something separate and independent. It is not a case of our saying that we are not resourced to do it.

Although our new organisation had a bit of a late start-up—the board did not come together until March last year—we have made very significant changes over the year; indeed, this year, we will start for the first time groundbreaking work on an integrated approach to the scrutiny of children's services and hope that by the tail-end of the year we will be able to roll that out on a pilot basis to adult services. Instead of having a multiplicity of inputs, we will have a truly multiagency input and hope that, over time, such an approach will reduce the scrutiny footprint in these areas.

The Convener: So this is simply a continuation of the inspection of direct payments that you carried out in the past.

Professor Clark: Absolutely. However—and you would expect me to say this—I cannot at this stage dot the i's or cross the t's because there is nothing to dot or cross yet. We are as confident as we can be that we can accommodate all this within our future scrutiny plans.

The Convener: You can write to the committee with the planned programme for inspections.

Professor Clark: I am happy to share that with members.

Drew Smith: I apologise if I have assumed incorrectly but I believe that you were all present for the evidence from the previous panel, whom I asked about appeals with regard to the assessment of need. Do any of you wish to comment on that? For example, do you agree with ADSW's statement that the complaints procedure was robust enough?

George Kappler: I was just about to raise that very issue. In order to fully avail themselves of the opportunities presented by the bill, people will need ease of access to a review, appeal or complaints procedure. Mindful of Duncan Mackay's comments on the potential resource implications of having a separate appeals process and of the fact that the adversarial nature of complaints procedures means that parties often exhaust themselves without securing a happy outcome, I think that we should move from some kind of adversarial procedure to a system in which assistance is provided for, say, mediation.

Sandra McDonald: I certainly advocate the kind of separation of appeals and complaints that I think Mr Smith is alluding to. There is an appeals mechanism at every stage of the process for incapable adults, with whom I am concerned, and I think that for the sake of equity the same mechanism should be available for capable adults who are being assisted. However, I appreciate that such a move would have resource implications.

David Cumming: I do not wish to say much more about appeals, because we do not have a strong locus in that respect. Our responsibilities include following up complaints against regulatory services—and, indeed, our own practices—but we would regard that as part of our on-going work.

Professor Clark: We need to look at the issue from the point of view of the individual who feels unhappy, aggrieved or whatever. What matters is their perception of the fairness of the process. Whether it is defined as a complaint or an appeal, the individual should feel that it is fair. The object of the exercise is to give power to people. Part of the exercise of that power must be to bring them to a point at which they are perhaps not happy, but they understand why the point has been reached and they have a mechanism for dealing with it.

Adrian Ward: There is a huge difference between a complaints procedure and an appeals procedure. In practice, people often come to me because they have been through complaints procedures and they are still unhappy. They bring great big long letters attacking what has happened in the past and expressing their unhappiness with individuals. They might have started off with one or two complaints, but they will probably have many more. Just yesterday, I read a letter that had got up to about 14 complaints—the person was thinking, “What else can we throw in?”

Complaints are all about looking backwards and being critical. When people come to me and I have read all that, I ask them what they are trying to achieve and where they want to get to in future. Sometimes, the answer is, “Oh ... um ... er.” An appeals procedure is about saying that we think that something has not gone right and asking where we want to get to and what we want to put in place. Complaints procedures tend to be backwards looking and about criticising individuals.

As a practising lawyer, one of the first things that I ask people when they get into any sort of dispute is whether the person whom they are in dispute with is somebody they will fight out the dispute with and never deal with again, or somebody they will have to work with in future. Those are two different situations.

I am not sure that a clear appeals procedure is more demanding of resources than a complaints procedure. I have already alluded to the reason for that. In a complaints procedure, people will drum up everything that they can possibly find to attack and they might go on for a long time. After exhausting one procedure, they will go on to another. They will write to their MSP, their MP and the Prime Minister. Such cases come to me. I see people who are so hung up on hammering their complaint that they are almost disappointed if I find a way of resolving it, because it has become a way of life. That must have huge resource implications for the people who are on the other end, whereas, with a clear and focused appeals procedure that considers what people want and where they want to get to, we will get through the procedure. The person might get a loaf or half a loaf, or they might get nothing, but the issue will have been addressed.

Drew Smith: It is useful to have that on the record, particularly Mr Ward’s comments. I tend to agree that we should not overlook the resource implications of a protracted complaints procedure. I presume that Mr Ward’s point on the budgetary implications is a general view among the panel. Bearing in mind that the main argument against going down an appeals route, or having something that is different from a complaints system and closer to an appeals route, is to do with cost, are you involved with or aware of any systems that might present an opportunity to find a compromise?

Professor Clark: I would not want to give the impression that cost is the only driver. Again, we must consider the issue from the point of view of the individual. A complaints procedure can be a long, drawn-out and tortuous process. In most circumstances in which an appeal is considered necessary, that is because there is an immediacy about the individual’s needs, so they cannot wait to go through a lengthy process. There must be a mechanism for fast tracking so that the issue can be resolved for the individual one way or t’other, and with no guarantee of the outcome. There must be continuity of care. The care cannot be put on hold while the person works through a complaints process in which statements are taken, witnesses are called and so on, which would militate against continuity of care.

Gil Paterson: If we had an appeals procedure, would that do away with the need for a complaints procedure? I see that everybody is saying no.

Adrian Ward: For your record, I point out that everyone is shaking their head.

Gil Paterson: Okay, thanks very much for that.

The Convener: There is an issue about whether or not the process is described as an appeal. Yesterday, we heard about a number of examples that we would not condone. Someone was asked at 9 o’clock in the evening whether they could complete the assessment form over the phone, and not face to face, because the person was under pressure. Someone discovered that if he played down his carer’s role, that could affect his package by up to 40 per cent. That might go back to Fiona McLeod's point about the issue being about information and advocacy.

More importantly, it is necessary to understand the assessment procedure, the criteria that are applied and the points system that is used, which may vary from one local authority area to another and, indeed, from one social worker to another—we heard examples of that on our visit yesterday. Disproportionately more weight should not be given to the carer than to the person who receives care.

Yesterday, I heard about people being asked, "Do you take your own medicine?" and answering yes, even though it was taken out of the box for them and put in their hand, or, in response to the question, "How do you go outside?", saying, "Through that door," and despite the fact that they needed constant help with that, the view that was included in the assessment form was that they could do those tasks. That is perhaps the point at which some of these issues need to be resolved. I do not know whether you have done any work on that. Are there any standards that could or should be applied throughout Scotland?

Professor Clark: You could say that defining the characteristics of good assessment is not difficult. There is probably a lot of commonality in that, in any event.

I worry about any artificial separation of health and social care, because a health condition can drive a social need and vice versa. I do not think that we should be artificially constrained by a need to separate out whose budget it is. That issue came up earlier. The assessment process must transcend the health and social care spectrum so that the right solutions are arrived at for the individual. The whole purpose of the integration of health and social care is to move away from the tribal or territorial separation of functions, and I think that that is true of SDS as well.

David Cumming: In working with our colleagues in Healthcare Improvement Scotland, we have recognised that when someone who is involved on a full-time basis in the care of a member of the family presents to a general practitioner, it is expected from a good practice perspective that that would allow for an understanding to be gained by the GP and the local authority of what the routes to better assessment or reassessment should be. It is not just that the quality of information on the service user and/or the carer needs to be improved; there is also a need for information to be updated, because sometimes information that might have been very good becomes obsolete, and it really needs to be current.

The Convener: That concludes the session. On behalf of the committee, I express our appreciation and thanks to you for giving us your time this morning. The session has been very interesting. Thank you very much indeed.

Work Programme

12:58

The Convener: We move on to agenda item 6. We have in front of us a paper that reminds us that, at our meeting on 24 January 2012, we agreed that, in principle, we would like to visit Glasgow to see the Commonwealth games venues prior to the summer recess. The provisional date that the clerks identified was Tuesday 12 June 2012.

However—such things sometimes happen—we are compelled to consider and agree our NHS boards budget scrutiny report. As the committee will need to devote a full meeting to that in June, that puts our intended visit to Glasgow into question, because the only date that is available is the provisional date for our visit. The fact that we are required to consider and agree our stage 1 report on the Social Care (Self-directed Support) (Scotland) Bill prior to the summer recess accounts for the other meetings, which is why we have a clash that impacts on our proposed visit.

If we are still keen to conduct a visit before summer, we could identify a Monday or Friday that suits the majority of members—that option is available. Alternatively, a visit could be combined with a business planning day in August—that is another option. If we go for the August option, we will need to agree to hold a business planning day in Glasgow.

I suggest that we take that part of the paper before we move on. I presume that we agree that, given the pressure of work and our responsibilities as a committee, the 12 June option is no longer viable.

Members *indicated agreement.*

13:00

Richard Lyle: Convener, I note that we are pressed for time and cannot do 12 June, and I note that 5 June is the public holiday for the Queen's diamond jubilee, but I am keen to see the Commonwealth games structures that have been erected in Glasgow. Can I suggest that rather than leave it to the latter end of the year we look at Monday 4 June? I also have comments about sport—

The Convener: We will come on to that part of the paper. Thank you, that was useful. I ask members to note that 4 June is also a public holiday. I am sure that you are not hung up on the date and that you are suggesting that, if it can be managed and the majority of members can come, a day could be arranged before the summer.

Richard Lyle: Yes.

Gil Paterson: People whom we need to see might be on holiday if we turn up on 4 June. That is a practical problem.

The Convener: That is a practical consideration. Leaving aside the date, which is unconfirmed, do we agree to ask the clerks to attempt to get a suitable date, which is not a holiday, and to attempt to facilitate a visit before the summer break?

Richard Lyle: Yes.

The Convener: Is that the majority view?

Members *indicated agreement.*

The Convener: Under the heading "Inquiry work" in the paper, there is an opportunity for the committee to hold up to four oral evidence sessions during September 2012. The reason we are discussing that now is that we need to put arrangements in place before the summer recess and contact people who might participate.

As we have said before, we have spent a lot of time on health and social care and on legislation, and members have reminded us that the committee has a sport remit. Some members have a strong interest in conducting a sport-related inquiry.

There are a couple of options on the table for members to consider. One is an inquiry into support for community sport—I will not read out everything in the paper, but it talks about community facilities, access, sports hubs, private finance initiative facilities and so on. Another is an inquiry into preparations for the Commonwealth games—facilities, governance and whatever.

Bob Doris: Of course we should take the temperature of progress on the Commonwealth games at some point, but I do not think that we need to have an inquiry. We could have a focused, one-off session with the individual who is responsible for delivering the games, to get matters on the public record. I would nudge to one side the idea of doing an inquiry on that.

I am keen to see a fairly meaty inquiry into how sport is used to give positive health outcomes at all levels of society. The convener knows that I have already been to see the work of the football fans in training programme and how that interacts with positive health outcomes. We should see how sport—whether football, basketball, athletics, in local sporting clubs or at the level of the national governing bodies—is being used and often publicly funded to get public health benefits. We need to find out what good work is being done, how it is monitored, and how it can be promoted and potentially funded. I am keen to see such a piece of work being done over a number of weeks.

Drew Smith: I agree with Bob Doris that there is no need for an explicit inquiry into Commonwealth games preparations at the moment, because there is already quite a lot of information about that in the public domain. We might want to come back to it later. However, we probably should get into discussing the health legacy of the games at some point, and that might combine quite well with the other suggestion of an inquiry into support for community sport and, as a second part of that, Bob Doris's point about the health benefits from public funding of sport. I would be quite interested in following up the issues around community sports facilities, what is out there, and what is happening, particularly in the current economic environment, so I would certainly prefer an inquiry into that to a report on the Commonwealth games.

Nanette Milne: I agree with that. I have been a bit involved with the sporting side of things recently and there are concerns, particularly about issues such as opening up the school estate for communities to use. There are a number of questions about such issues that need to be answered. It would be useful for the committee to hold an inquiry into that.

Richard Lyle: I totally agree with all the comments that have been made. We have to look at some of the community sports and the sports hubs. We had a report some months ago about the success of some sports hubs and bringing them into other areas. Some councils could learn from what has been done in other areas and I am comfortable with the suggestion that we should look at community sports.

Some might say that we should have an investigation into the Scottish Football Association, but I do not think that I will even go there.

The Convener: You have just done so.

Richard Lyle: We have to look at all sports—football, volleyball and all the various things—and at how coaching is done across the Scotland brand and supported, especially by the lottery fund.

The Convener: Okay, thank you. There seems to be a strong consensus for doing some such work in September, and support for sport seems to be the preferred option. We have agreed to that in principle.

We have about four days, I think, in which we have the opportunity to spend some time on such an inquiry, but that might also give us a bit of time to address the issue of access to newly licensed medicines.

Jim Eadie: I endorse the views of the keen sportspeople on the committee, whose comments were well made. On access to medicines, I think that all members are probably experiencing through their postbag and e-mail inboxes a degree of public concern. I know that to be the case in my constituency, where there is concern about the operation and implementation of the individual patient treatment request process. I know that mine is not an isolated experience so I would welcome a one-off session on that process.

As for the suggested witnesses in the private paper that the clerk has prepared, there would be limited value—although there would be value—in having only the Scottish Medicines Consortium and representatives of area drug and therapeutics committees before us, because the guidance is issued by the chief medical officer for Scotland. The chief medical officer and the chief pharmaceutical officer conducted the recent review. If we have a one-off inquiry, we should bring the CMO and the CPO before us, so that we can ask them about and hold them to account for the system's operation. If we had a short-term inquiry without hearing from the CMO and the CPO, it would be of limited value.

An additional question is how the views of area drug and therapeutics committees would be heard, given that the SMC is a consortium of those committees. I am curious about who the suggested witnesses would be in addition to the SMC.

Bob Doris: I agree with a significant part of what Jim Eadie said. Consideration of the issue represents on-going work, because we have looked at individual patient treatment requests in dealing with petitions. I would not use the term "inquiry"; we would be getting information on the record and asking key questions.

I would urge caution; we must ensure that we look at processes rather than individual drugs. I pay tribute to Nanette Milne, who has hosted a couple of events in the Parliament recently in relation to the depoliticisation of the Scottish Medicines Consortium, which has a unique position. The aim would be to get more information about timescales, processes and how different things come together.

I would be cautious about allocating more than one day to the subject initially. If we are not holding an inquiry, we do not have to have a run of evidence sessions week after week. We should not squeeze out sport and the links between preventative spend, physical activity and health benefits. The question is how we would slot the evidence into September. I would probably steer us towards allocating one day to the subject.

Jim Eadie: I made it clear that I was looking for a one-off session. When I referred to an inquiry, I meant a short-term inquiry that would take one day.

The Convener: The issue is squeezing other people into that inquiry. I support Bob Doris's view that the purpose of our session on newly licensed medicines should be more to draw out information. The subject will be part of on-going work, because we will deal with the petitions at a future date. We could broaden the witness panels in any subsequent session.

If we had three days for sport, that could allow us to be a bit innovative in taking evidence. Perhaps that should not all be taken here—we could use one committee day to get out there. As Gil Paterson said, it is good to get out.

Gil Paterson: What about Lake Tahoe?

The Convener: Perhaps we could use our imagination in how we use the two or three days that are allocated to sport.

If we have consensus, all that remains is for us to agree to devote our meeting on 12 June to consideration of our draft report on NHS boards budget scrutiny; to confirm, following our discussion, the decision that we will use three of our days in September to look at the sport issues that have been described and that we will use one day in September to discuss access to new medicines; and to agree to hold a business planning day in late August, when we will discuss our general approach to inquiries and scrutiny. Is that agreed?

Members *indicated agreement.*

Richard Lyle: Do I take it that we will select a Monday or another day in June to see Commonwealth games sites?

The Convener: My apologies, Richard. Yes. That is an additional decision. We can ask the clerks to see how we can best make that happen and get a suitable date for the majority of committee members.

13:15

Drew Smith: In our previous discussions about the work plan, I think that I mentioned health and safety, which I am keen for us to come to at some point. We have probably filled up a good part of this year, so we might be talking about next year. I simply want to flag up for the clerks' information that health and safety remains an issue that I would like us to look at in the future. I think that the Scottish Affairs Committee will report on it during the summer. That could be the start of the process. We could take a look at that report and think about whether there is an opportunity next year.

In a previous discussion about the work programme, we discussed how to fit in evidence on unannounced inspections, particularly in care. Perhaps we should consider that next time we look at the work programme.

The Convener: Yes.

Richard Lyle: Yes.

Bob Doris: That is helpful. I agree with both of those things.

On a housekeeping matter, if we are going to see the Commonwealth games venues this side of the recess, and although, as a Glasgow MSP, I am always delighted about the committee going to Glasgow, which is clearly the best city in Scotland, perhaps it would be an idea to find an alternative venue for the away day. We have talked about reaching out to other parts of the country.

The Convener: Yes.

I take Drew Smith's view. We have previously discussed how we would develop our work programme, and I hope that we can consider that as well as specific subjects and how we can engage more successfully with people in the community who wish to engage with us and give them opportunities to influence our work programme and our inquiry work, at least in a conversation with us, if nothing else. I hope that we can deal with those issues in August and make progress on them as well.

Nanette Milne: I suggest Aberdeen as an alternative venue to Glasgow. We have a fantastic new sports village, which involves the whole community and has been really highly spoken of. I recommend that the committee visit it.

The Convener: Glasgow and Aberdeen have been commended. I expect no less from MSPs who represent those areas.

I thank members for their participation and patience.

Richard Lyle: And thanks to the convener.

The Convener: That concludes the meeting.

Meeting closed at 13:17.

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