The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

PUBLIC AUDIT COMMITTEE

Wednesday 25 April 2012

Session 4

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CONTENTS

PUBLIC AUDIT COMMITTEE
6th Meeting 2012, Session 4

CONVENER

*Iain Gray (East Lothian) (Lab)

DEPUTY CONVENER

*Mary Scanlon (Highlands and Islands) (Con)

COMMITTEE MEMBERS

*George Adam (Paisley) (SNP)
*Colin Beattie (Midlothian North and Musselburgh) (SNP)
*Willie Coffey (Kilmarnock and Irvine Valley) (SNP)
*Mark Griffin (Central Scotland) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Tavish Scott (Shetland Islands) (LD)
*Humza Yousaf (Glasgow) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ron Culley (Convention of Scottish Local Authorities)
Dr Allan Gunning (NHS Ayrshire and Arran)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Duncan MacKay (North Lanarkshire Council)
Ranald Mair (Scottish Care)
Michelle Miller (City of Edinburgh Council)
Ian Welsh (Long Term Conditions Alliance Scotland)
Councillor Douglas Yates (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

Committee Room 4

Scottish Parliament

Public Audit Committee

Wednesday 25 April 2012

[The Convener *opened the meeting at 09:30*]

Decision on Taking Business in Private

The Convener (Iain Gray): I welcome everyone to this meeting of the Public Audit Committee and ask all present to switch off their phones. If there are any American billionaires present, they are in the wrong place and should go now.

The first item on the agenda is a decision on taking business in private. Does the committee agree to take in private item 3, which is consideration of the evidence that we will hear this morning, and item 4, which is our work programme?

Members *indicated agreement.*

Section 23 Report

"Commissioning social care"

09:31

The Convener: Item 2 on the agenda is continuing consideration of a section 23 report, "Commissioning social care", with evidence from three panels of witnesses. I welcome to the meeting the first panel, which comprises service users and independent and voluntary sector social care providers: Ian Welsh of the Long Term Conditions Alliance Scotland; Annie Gunner Logan from the Coalition of Care and Support Providers in Scotland; and Ranald Mair, chief executive of Scottish Care.

It is customary to give our witnesses the chance to make an opening statement before we begin questioning. Does anyone want to say anything?

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): The clerk asked whether we wanted to do so, but I think that our submission is comprehensive enough.

The Convener: That is fine.

We have received submissions not only from the CCPS, as Annie Gunner Logan has mentioned, but from Scottish Care. The CCPS submission, in particular, makes a number of detailed comments on the Auditor General's report, and we will come to those in our questioning. First of all, though, I should point out that when the Auditor General brought this report to committee, he said that it was if not the most important report then one of the most important reports that he had presented to the committee in his time as Auditor General. It was one of seven that had been produced about the integration of health and social care and how that might be delivered; however, as that series of reports showed, there had been very little progress on the matter and he felt that to be particularly serious.

In view of that, I will kick off with a general question. Given that we have been trying to deliver a joint approach to health and social care for so long, what has gone wrong and why are we still saying that it is not working?

Annie Gunner Logan: That is quite a significant question. The CCPS certainly shares the Auditor General's concern in the report that there is very little evidence that anything in particular has improved. For quite a long time now, we have been seeking improvements in commissioning and have been plugging away with various parliamentary committees, particularly the Local Government and Communities Committee in the previous session and the Health and Sport

Committee, with regard to the way in which procurement is often used as a proxy for commissioning. We very much played our part in ensuring that Audit Scotland examined this area, because we felt that a number of improvements could be made.

Instead of analysing the detail in the report, I should perhaps summarise our view on where we want to go from here. As our submission makes clear, rather than simply encouraging what will be, post-integration, the health and social care partnerships to develop approaches or whatever, we think that it is time to place some requirements on those bodies with regard to how commissioning is carried out, the content of a commissioning strategy and how such a strategy might be taken forward. To that end, we have proposed that the Social Care and Social Work Inspectorate Scotland have a role in the matter. In short, there should be a bit more stick and a bit less carrot.

The Convener: I see that Ranald Mair is nodding.

Ranald Mair (Scottish Care): Yes. We absolutely share the view that the CCPS expressed in its submission. What we have largely had recently—more recently, this has been driven by budget pressures—is a crude procurement or purchasing model, as opposed to a strategic long-term commissioning model. If we are to secure a long-term model for the future, we need to adopt strategic commissioning that is based on partnership. Commissioning is something that we do with, not to, providers and it must provide them with a sustainable basis.

We also agree with the point about regulation. We had high hopes when the new Social Care and Social Work Improvement Scotland—the care inspectorate, as it is now referred to—was set up. We thought that bringing the Social Work Inspection Agency and the Scottish Commission for the Regulation of Care together would mean that care delivery and care commissioning would be looked at in the round. That has not happened.

We need clear, national standards for commissioning that place obligations on us all. They need to be backed by some powers of enforcement or requirements that drive the process forward, alongside the other initiatives that are taking place in the context of the reshaping care agenda and health and social care integration.

Ian Welsh (Long Term Conditions Alliance Scotland): In the 1980s, when I was a young elected member, the then Secretary of State for Scotland was calling for greater co-operation and integration between health and social care sectors. Successive secretaries of state and ministers have called for such an approach, and a range of efforts and policy interventions have tried to bring about change, as members know.

For whatever reason, only in the past 10 years has there been much closer involvement between the sectors. That is largely because the sectors have been separated by budget and by policy context—in the main, until now. They have also been separated by, in many cases, language and by terms and conditions and so on, and driven by separate governance arrangements. I am greatly frustrated by the lack of integration, but I understand why integration is difficult to do.

In response to your question about why integration has not happened, another point is that, in the context of commissioning social care, procurement legislation has driven local authorities, in particular, down a particular route, in which so-called best value often comes down to cost. I am not criticising local authorities for their approach in austere times, but the impact on the service user is often a reduced, low-cost service.

All that is significant. However, as one of the oldest people in the room I suggest that policy platforms are built every six or seven years and that we are in a new phase. We have the opportunity of some stability at central Government level and we will have the opportunity, post-election, for some stability at local authority level. A significant process of integration, rather than whole-system change, will colour the approach to commissioning—it is about setting the mood music. Change, and closer co-operation and working, will be driven by, for example, the need to focus on outcomes for individuals in a much more significant way.

It is also fair to say that, in all the time that I have been involved in talking about the issue, there has been scarcely an edge of policy difference between the Scottish political parties, compared with the situation in England. There is consensus about prevention, integrated working and—thankfully—the significance of the third sector, although I have to say that we are still treated with a degree of condescension across the board, in practice. There is also a consensus around service redesign. That is a good basis on which to work.

Although “Commissioning social care” was generally negative, it also highlighted some good examples of good practice in commissioning in specific local authority areas. The big challenge in public services is how to replicate good practice across disparate planning contexts.

The Convener: Before we come to the issues of prevention and the move to self-directed support, I want to drill down further into the core question of working together. Ian Welsh eloquently outlined what divides local authorities and the

national health service. The mechanism that we have tried to use over the years is joint commissioning in one form or another. However, I was struck by a sentence in the Scottish Care submission—which Ranald Mair more or less repeated in his answer—which describes the process of commissioning as

"a crude process of trying to secure minimal care delivery at the lowest possible price, disregarding choice, quality and sustainability."

Further, the CCPS submission says:

"procurement processes ... are structurally incapable of assessing either service quality or a provider's capacity to deliver it. Moreover, they offer very little scope for people with care and support needs to exert any influence".

Is the issue really about improving joint commissioning, or is that just the wrong way to try to bring together the two worlds that Ian Welsh described? It is all very well to talk about the care inspectorate using

"a bit more stick and a bit less carrot",

but are we in fact taking the wrong approach to integrating social care?

Ranald Mair: I think that we have a challenge to see whether we can move the agenda on. The change fund is one of the levers that is being used to do that at the moment. There is a requirement this year for local partnerships to come forward with their approach to joint commissioning. Importantly, the partnership is not just about the councils and health boards coming together. If anything, from a provider's perspective, that could simply mean that we would be dealing with an even more monolithic bureaucracy than we are at the moment. The important question is, how do we create genuine partnership that includes third sector and independent sector service users as well as the two principal statutory agencies?

I do not want to seem as though I am saying that that question involves a blame game in relation to the statutory agencies. There are times when we might feel that the approach has not been inclusive enough. My members might tell me off for saying this, but I believe that providers have to step up to the plate and have to want to be part of longer-term strategic commissioning, which might mean that some parts of sectors downsize while other parts grow, that we consider sustainable delivery of care over a period of time and that we accept that there are constraints on the financial and resource envelope that we are operating in. There could be a danger that people such as me make accusations about what public bodies are doing or not doing, but I think that we have to work collectively on that.

A start is being made, but if we are to deliver the right sorts of care in the volumes that are required in different parts of Scotland, we need long-term partnerships, and we have to get into that dialogue. That has not happened to date, and I share the concerns about that. However, we have started to put in place some of the building blocks of partnership around reshaping care and the change fund. We have to build on those rather than throw all the pieces up in the air and come up with yet another model or design for commissioning. The truth is that we have not done strategic commissioning yet—that is why it has not worked. We have done purchasing and procurement, but we have not done strategic commissioning—and we have certainly not done it on a partnership basis.

09:45

Annie Gunner Logan: That is the point that I wanted to make. I emphasise that, in our view, strategic commissioning and procurement are two different things. We have a strong critique to make of procurement that is taken forward without the backdrop of a commissioning strategy to inform decisions. The Audit Scotland report was clear about what a commissioning strategy ought to look like and ought to have in it—it should start with a needs analysis and go on to look at what models of care and support will meet those needs, who can deliver those models and what the various cost and quality parameters are.

If a procurement exercise is held once such thinking and analysis have been done, that can act as a guide. Otherwise, we will just have service-by-service procurement, where the imperative will be, "This is what we have now—how can we get it cheaper?" A commissioning strategy tells us why we want a service in the first place, what we are trying to achieve with that service, what outcomes it is meant to deliver and what it brings to people, which gives a procurement exercise something to go on. Our critique of procurement is that it happens without any of that prior thinking having been done.

I have a point to make about the word "commissioning". We are coming to the view that it is quite an unhelpful word, because it is often confused with procurement. People take them as meaning the same thing. In discussions that we have had in the third sector, we think that strategic commissioning is about making investment decisions. If we changed the vocabulary slightly, we might be able to separate it from the rather crude purchasing that goes on.

Ian Welsh: I absolutely agree with Annie Gunner Logan's point.

In addition, although, as I have said, the third sector often feels excluded and sometimes feels condescended to and patronised, albeit that it is actively involved in some areas, I recognise the

huge challenges that local authority staff face. Factors such as reduced local authority staffing levels and tighter fiscal constraints do not allow for a better commissioning process.

I have a plea to make about the policy platform process that I envisage, which is tied in with human rights issues and the business of empowering the individual. There needs to be a better debate at the local level about how formal commissioned support is combined with non-commissioned services that operate around the strictly commissioned services. That is all about taking a much wider view of the local landscape. It is also about looking at how the third sector at large can contribute to lower-level support and intervention options that contribute to prevention in the longer term. Too often, that debate does not happen at the local level in the broadest possible way.

I go back to my original point about the context that we are in giving us a bit of stability at central Government and local authority levels, and I make a plea that, as we go into health and social care integration consultations, we should take the opportunity to plot the policy map against the local population and to adopt a much broader and more innovative approach to building and redesigning service delivery landscapes at the local level, because that is where it is most important.

Mary Scanlon (Highlands and Islands) (Con): I find it difficult to agree when you talk about the separation that exists. I represent Highlands and Islands, where NHS Highland is now the lead agency for adult and elderly care and Highland Council is the lead agency for children, with staff moving in both directions. Things are happening out there.

My question is about cost and quality. The Coalition of Care and Support Providers in Scotland makes quite a comment in its submission. At paragraph 2 on page 5, it mentions the current public spending climate and the fact that councils have a duty of best value, and questions why councils

"sustain ... high-cost in-house services".

It goes on to state that there is "evidence" that

"shows that in-house services are generally of comparatively poorer quality relative to the voluntary sector."

That is quite an allegation against council services.

Along the same lines, Scottish Care states at paragraph 7 of its submission that

"there is no level playing field around cost".

It also states that councils are tasked with

"delivering best value to the public purse",

but that what is happening

"allows councils to adopt a protectionist approach to in-house provision, even where this delivers neither quality nor value for money."

In these difficult times, when more than £3 billion of taxpayers' money is spent on social care, those are very serious allegations. It is our duty to look at cost and quality. You are both saying that councils are adopting a protectionist, monopolistic approach and that there is higher cost and poorer quality. I am asking you both—Ian Welsh may want to pitch in—to clarify those serious allegations.

Annie Gunner Logan: I am not sure that it is an allegation as such—

Mary Scanlon: It is a statement.

Annie Gunner Logan: We reference in our submission the then care commission's report on its 2011 quality of care review, which presents tables that show the proportion of services by sector that achieved ratings of 1 and 6. To explain that to the committee, the care commission's gradings went from 1 to 6, with 1 being unsatisfactory, and—progressing upwards—5 being very good and 6 being excellent.

The care commission looked at a number of adult care and support services and at the proportion of 5s and 6s in the sectors of care at home, housing support and care home provision for older people and adults. The voluntary sector had a higher proportion of very goods and excellents across the board, so that is where that assertion comes from.

When we spoke to your colleagues on the Local Government and Communities Committee a couple of years ago about care at home, the care commission put on record some further statistics specifically on care at home services. I would be able to dig those up for you. From memory, third sector care and support services had upwards of 90 per cent of services in the quality of care and support category rated as either good, very good or excellent. For in-house public sector services and private sector services, that figure was upwards of 70 per cent, so there was a 20-point difference.

We are not saying that every single in-house council service costs a bunch and is not very good, but that was the evidence that the care commission presented across the piece. The Local Government and Communities Committee quizzed the then chief executive of the care commission about why she thought that that was the case, and we had some interesting debates, because we could not quite put our finger on why the voluntary sector was consistently better. We all have our theories about that, but we have never

really got to the bottom of why that should be so. That is where that assertion comes from.

Audit Scotland and a number of other bodies have produced reports that show that in-house services tend to cost significantly more than those purchased from the third sector or the private sector. We are looking at the results of a freedom of information request to every council in Scotland on the rates that they paid for care. In our submission at footnote 6, I give the example of a particular council that capped its rates for purchased care at home at £10.43 an hour. However, the council disclosed to us that the equivalent cost for its in-house care at home service was £21 an hour. That kind of difference was consistent across the piece. I am not sure that there is any argument about that, in the sense of its being controversial. It is controversial that it exists, but I do not think that many people would say that it does not happen.

I accept that that is a generalisation for all services in Scotland. However, the general trend or pattern tends to be that in-house services cost more and do not achieve across the piece the kind of quality that the third sector achieves.

On protectionism, I do not think that we used that term, but I accept that it is perhaps implicit in the evidence.

Mary Scanlon: Scottish Care used the term.

Annie Gunner Logan: It is an issue because it is very unusual for in-house services to be included in procurement exercises in which private and third sector services are in effect put back on the market for the bidding process in order to drive down costs. In-house services are usually taken completely out of the equation and are not tendered out in the same way as existing purchased services. That is where the concept of protectionism comes from.

Ranald Mair: I echo Annie Gunner Logan's point about where the comparators come from for cost and quality. We know that councils' spend on in-house provision is greater, but there are parts of the country for which we have to say that that is justified. There are remote and rural areas of Scotland where the council is the default provider and probably neither the third sector nor the independent sector could take on those tasks. We are not attacking councils; we are saying that if councils in certain areas outsourced, they would probably spend less than they spend on in-house provision, or be able to purchase more care for the same amount that they spend on in-house provision.

From my perspective, the points that we were trying to make were about moving the agenda forward. I repeat that we are not attacking councils; we are saying that if we are trying to develop a strategic commissioning model, strategic commissioning must apply to in-house provision as much as it applies to externally purchased provision. We are saying that we must look at it in the round and create a level playing field. If councils can deliver certain services more effectively, at a higher quality or at a more competitive cost, that is fine. However, we should not have one system that deals with purchased care from the third sector and the independent sector, and a separate system that possibly offers a degree of protection to in-house provision.

Councils do not encourage the independent and third sectors to develop in certain areas, such as reablement care at home. Such services are seen at the moment as the preserve of local authority home care. We must take a partnership approach to commissioning that asks what volumes and what kinds of care will be required locally and how they are to be commissioned—whether in-house or externally, but on the same terms. That is what we are arguing for.

We are not using the issue as a stick to hit councils or anybody else with; we are simply saying that if we are going to make progress on commissioning, that must be done on a level playing field—various aspects must not be separated off. The current situation creates endless dilemmas for councils, because they are purchaser/commissioner, as it were, on the one hand, and provider/competitor on the other.

10:00

Mary Scanlon: I have one question that is similar to the one that I asked earlier to which Annie Gunner Logan responded. Last year, I, too, submitted an FOI request to all the councils and found that, although some councils pay the same for a placement in a council home as they pay for one in the independent sector, others pay 80 per cent more to place someone in a council home. Highland Council is one of those councils. Can the independent sector provide the same quality for 80 per cent less funding?

Ranald Mair: Again, the issue is slightly more complex than that. We have two different systems. The declared cost of council in-house care home provision is on average about half as much again as our national contract rate, which is the rate at which councils purchase care home places, so there is an additional cost factor. However, care homes have two income streams. They have an income stream from purchased care at the public rate and another income stream from self-funders, which might be at a higher rate that is in some instances closer to the costs of council care. The models do not quite add up in a way that allows us to make simple comparisons.

However—this is a point that we make in our annual discussions with councils—we feel that the sector is at present dangerously starved of the resource that it requires to deliver quality care in a sustainable way in future. In the past year, there has been instability in the sector for a variety of reasons. We want to secure a situation in which providers are adequately resourced to deliver the right quality in a sustainable way over time. The issue is not just the headline rate that is paid; it is also about the flow of placements. Providers need security and need to know that there will be demand for their services.

To echo Annie Gunner Logan's point about investment, at present providers in the third and voluntary sector and in the private sector want to invest in developing new provision and in improving the quality of the physical environment and service components, but they are holding back because there is not a clear long-term sense locally of how much care the local authority and health board will want to have and of what sort. Providers are wondering whether to open a new wing with specialist dementia provision or to invest in outreach provision or respite care. We need a strategic commissioning model that gives providers the basis on which to do their business planning and which encourages their investment in the on-going development of quality provision. The danger is that we constrain the purchased care sector and take it away from care homes, which is the example that the member used. The levels at which some councils seek to purchase care at home are below a sustainable level of funding.

Mary Scanlon: I know that my colleagues want to come in, but I want to ask one final question. I do not want to take up too much time, as we have three panels of witnesses today.

Ranald Mair said that, if a council pays a certain rate, that might not affect quality. I know that it does not, because I have seen the ratings for the independent sector. Mr Mair also mentioned self-funders. I am aware that, in Highland, which is the area that I know best, the council can pay £473 a week, while a self-funding person can pay more than £1,000 a week for the same care. Is that fair?

Ranald Mair: I do not know whether it is fair. We are saying that we have two different systems at work.

Mary Scanlon: Yes, I understand that.

Ranald Mair: In a sense, providers are balancing the overall income that they need to deliver the care by saying, "I've got X number of council-funded residents at that amount and I need to balance that through higher costs for self-funders." I would be interested to know whether there really are examples that are quite as extreme as the one that you have used. Nonetheless, your point is that we have two different systems. We could create an integrated system. In other countries, all care is purchased at the same rate. The discussions about the future funding of care must look at both our expectations of self-funders and the expectations of publicly purchased care.

Annie Gunner Logan: I offer a brief input on the balance to be struck between cost and quality. Most CCPS members are involved in non-residential care, so that is where I will focus my comments. It is clear that we can throw money at something and not make it better. The fact that something is expensive does not mean that it is going to be good—we have endless amounts of evidence about that. Our concern is that there will probably come a point at which that will make something worse.

People are worried about criticising local authorities, but my colleagues in the public gallery know that I am slightly less squeamish about that. The other day, I was talking to a provider who was involved in a discussion with a commissioning authority. They were talking about the hourly rate, which is the currency of care at home and housing support. The provider said, "We need X amount to put in place proper management and supervision, proper workforce development and training, and decent pay and conditions to avoid too much turnover." The response was, "Never mind all that. Can you come in at X pounds an hour?" It is that kind of attitude that we are trying to tackle. For non-residential support in the third sector, anything up to 85 per cent of the costs are workforce costs. If downward pressure is applied to the costs of care, that means paying people less, stretching their hours and cutting their training and development. If our agenda is excellence in care, where is that agenda going if that is the kind of procurement behaviour that we are seeing?

Willie Coffey (Kilmarnock and Irvine Valley) (SNP): Good morning and welcome to you all. I am fascinated by the views that are being expressed and the suggestion that we have been focusing on procuring rather than commissioning, lacking a focus on outcomes. Ian Welsh has talked about best value not being fit for purpose in this particular sector in this day and age, and it has been suggested that we are at a point in the cycle when we are thinking about new models. How long have providers in your sector felt that way? Are we suddenly coming to that conclusion? Having listened to you, I doubt it. How long have you felt that, and has anybody listened to your concerns up to this point?

Ian Welsh: It is good to see another Kilmarnock supporter here, Willie, and it is good to be here in Edinburgh after a recent victory—I just wanted to get that off the table.

I guess that I should expose myself—

Tavish Scott (Shetland Islands) (LD): You just have.

Ian Welsh: —as a progressive municipal socialist, which is how I have been described. I do not easily criticise local authorities because that is where I learned my trade and I know of the fantastic work that is being done. However, seasons change and the problem is that everybody is straitjacketed by historical structures. That is certainly true in the health service, it will be true in the Parliament until it is changed and it is true in local authorities and schools. There is that feeling abroad. That is why I am keen to say that there is an opportunity for a new platform here.

Our organisation does not provide services so, unlike Ranald Mair, we do not talk the language of level playing fields and competitive prices. However, for the past decade, I ran a large family of United Kingdom third sector organisations that provided services, so I know that context. I say to Mary Scanlon that there is no doubt that an imbalance exists, partly because local authorities have 1,000 things that they need to reshape. However, there is an opportunity now that the evidence exists.

On Willie Coffey's point, the third sector has been recognised in all the rhetoric at a strategic level for a long time. There will not be an MSP who would not say that the third sector is a significant part of what we do, and there will not be a senior civil servant who would not quote back to us the statistics that we produce about our financial contribution to the Scottish economy. No civil servant or politician would disagree with the agenda. There has been huge buy-in, especially over the past 10 years.

However, that rhetoric is not matched by new patterns of resource distribution or new approaches to commissioning, joint investment partnerships and working with local sectors. The most recent example of that comes from the change fund process. As members know, that process is designed to shift the balance of care in older people's services. I would be the first to say that loads of fantastic work is going on across the board, but third sector involvement has in many cases been reduced to signing off the change plan—the third sector does not have active and proactive involvement.

The evidence so far is that significant investment is not being made in new third sector-focused approaches. The work is largely about plugging service gaps. I do not criticise that, because that relates to the fiscal reality that people face.

The larger third sector representative organisations have the continual challenge of building the strategic relationship, with which everybody agrees, against the reality that third sector organisations—even large providers, such as many of Annie Gunner Logan's members and some of mine—are subject to unfair downward cost pressures that other services do not have. At that level are organisations with a turnover of £40 million. At the lower level, investment has been withdrawn from loads of local third sector organisations—members will all know them—that contribute significantly to health and social outcomes in the national framework and all that stuff.

There is tension. The condescension that I talked about is genuinely felt. I, too, used to be condescending to third sector organisations. I would sit on a local grants committee in South Ayrshire, scrutinise a £40,000-turnover organisation and accuse it of building up reserves that were beyond its requirements. I failed to recognise the business model that was needed. Cutting a grant throws a whole set of services into difficulty. That problem is still with us.

I have digressed a wee bit.

Willie Coffey: I will give Annie Gunner Logan a chance to respond. As the Scottish Government is beginning to integrate health and social care and is setting up the strategic commissioning steering group and so on, the next big question is what your role in that process is. Do you feel that you have a role in that process? How should that role develop?

10:15

Annie Gunner Logan: I will take all your questions together. The voluntary sector has a long and proud history of telling people exactly where the unfairnesses are in how it operates. The difference now is that we are moving from things being unfair to things being quite risky. Our interest in all this became much sharper after the Public Contracts (Scotland) Regulations 2006 were introduced and competitive tendering took off big time in Scotland in about 2007-08. It was no longer a question of what was fair; it was about what would impact on quality and outcomes.

There is a paradox, because there is strong support in the Government for the strategic involvement of the third sector in planning but, at the same time, there is a severe cost pressure at service delivery level. Those two things are going on. We need to encourage the first and fix the second.

Ian Welsh mentioned the reshaping care agenda and the change fund. We and a number of other third sector organisations now have funding to run a project to increase the engagement of the

third sector in, initially, reshaping care and, thereafter, the integration agenda.

The Cabinet Secretary for Health, Wellbeing and Cities Strategy has said that the voluntary sector will be round the table in health and social care partnerships, which is great—that is why I talk about strong support for such approaches—and we will all play a part in that. However, I am worried that that will not necessarily solve the severe cost pressure at service delivery level, which is what we need to sort out.

For my money, we should see off the crude way in which tendering is done and start to consider more creative alternatives. As Ranald Mair said, we should focus strongly on the impact on quality and outcomes across the board. Whoever the provider is—in-house services, the private sector or the third sector—we need to focus on what the services are trying to achieve, focus on what quality we want and then adjust the cost accordingly.

Ranald Mair: I will comment a little bit on the part that the private sector plays. Scottish Care is not an exclusively private sector organisation—we also have voluntary sector members who provide care homes and other services—but the private end is a significant part of the independent sector, so I will comment on that. It is positive that the private sector is increasingly considered to be an important strategic partner. Seventy-five per cent of care home provision is in the private sector, as is a growing part of the care-at-home sector, so we must be a strategic partner. I have spent most of my working life in social care in the public sector and the voluntary sector, so it has been interesting to spend the past five years in Scottish Care. At times, part of my work there has been to say that the independent sector needs to be included as a strategic partner.

The national care home contract is probably not a strategic commissioning model, but it is a strategic procurement model. It has tried to do some strategic things, and there is dialogue with the Convention of Scottish Local Authorities at the moment about how we make it into more of a commissioning model in future.

Another part of my task has been to say to private sector organisations that deliver care that, if the sector is to have a seat at the table and be included as a strategic partner, it needs to be a responsible partner in the process. Private sector providers cannot expect to have a seat at the table unless they sign up to a public service ethos, which must govern what they do and govern the delivery of improved outcomes for the people who use services.

There is a dialogue; it is certainly not a one-way process, from my perspective. It is not simply about us being let in to the process; it is also about the provider side demonstrating its commitment to working in partnership to deliver public service. A culture shift is happening in both directions. Some parts of the statutory sector accept a mixed economy of care that includes the third sector and the private sector as well as the public sector, but it is also about the sector itself coming up to the mark on that.

At present, the testing ground is within some of the change fund partnerships—that is where some of that dialogue is happening. The Government has said that they have to be four-way partnerships, and that is requiring people to say, "Well, what sort of partnership is it? What does it look like? How do we make decisions? What are the different accountabilities in the partnership?" Some of that is happening, and we have to see how it can be built on.

Colin Beattie (Midlothian North and Musselburgh) (SNP): In my questions, I will approach the costs from a slightly different angle. I am looking at two documents—one is the Audit Scotland report and the other is the CCPS submission. Paragraph 12 of the Audit Scotland report states that

"Councils' social care spending increased by 46 per cent (in real terms) over ... eight years"

and it mentions that the increase for adults with learning disabilities was 68 per cent. Those figures are in real terms, after inflation. Paragraph 23 states:

"Public sector budgets are expected to be reduced by 12.3 per cent in real terms between 2010/11 and 2014/15."

That does not directly correlate with commissioning, which we are talking about, but there must be some impact on that because of the squeeze on councils.

Page 3 of the CCPS submission states:

"councils have forced contract prices ... downwards".

It adds:

"Providers tell us that their capacity to support services in this way is being rapidly exhausted."

That seems to limit the future possible savings. I think that councils are focusing as much on savings as on anything else.

Mr Mair talked about being dangerously starved of resources. Mr Welsh talked about resource redistribution, which is a significant issue in the context of the exponential increase in demand for services—if it is going to continue into the future. I do not know what evidence there is on that because, as an audit committee, we look backwards rather than forwards, but it must be an issue for service providers.

In addition, we have inflation. I am not sure how it is performing at the moment, but it seems to be edging upwards again.

All those things come together to create a situation in which it must be tremendously difficult for providers to project what they are going to provide in the future. We are talking about new commissioning models, new strategies and all the rest of it but, at the end of the day, those are—

The Convener: Are you coming to a question, Mr Beattie?

Colin Beattie: I was grinding my way there.

We are talking about the change in strategies and so forth. How can we cope with the exponential increase—that is what it is—in demand for services? How do we cope with the cost of the services in the context of budget cuts? How can the providers cope with that?

The Convener: That was an easy question.

Ian Welsh: I was just going to say that.

Facts are chiels that winna ding. We will have a major demographic issue over the next 30 years, or even over the next 10 years. There is no doubt that the problem will not go away. There is a yawning gap—the figures are in the report—between what will be required to meet need and what is delivered at present. We can make reasonable projections of that. Unless there is a huge increase in economic growth in Scotland in the next 30 years from wind farm development and so on—sorry; I was too political there—there will have to be a fundamental look at how we design services.

At a basic level, we could argue about the prevention agenda and the money that the Scottish Government has allocated for it this year, which I welcome. It has done well to sculpt a bit of money in that direction. The requirement is for all of us, in tandem, or in partnership, to look at how we build new, low-cost, low-support interventions that reduce the requirement for longer-term, highly cost-intensive services. That is an aspiration, but there is no route map towards it. To paraphrase Chairman Mao, this is only the first step. We have to take that step and we must then calibrate year on year the impact on budgets.

Annie Gunner Logan: A number of things are already happening. In Ayrshire, Alzheimer Scotland is looking at a very interesting model of care that is trying to delay the point at which a care home place is required, or even to remove the need for a care home place, by using money creatively through self-directed support. Some of the findings from that pilot are very interesting. It is pretty small scale, but the evidence is already quite positive. We could do more of that kind of thing.

Colleagues have talked about reablement, which is about getting people back on their feet rather than saying, “You cannot do this now, so we will come and do it for you.” In mental health, it is about recovery rather than keeping people in services. The big challenge for providers in taking demand out of the system is how they make it a reasonable business proposition to get people to the point at which they need less of the provider. Everything that the voluntary sector has been told for the last 20 years has been about making itself more like a business: sell more, go for growth, put in more hours of care and make the organisation bigger. That is the model that we have been told to follow, but I think that it is the wrong one. We need to support people to the point at which we can start to withdraw, because they do not need us any more.

That approach will not work in some areas, such as palliative care, and end-of-life care, but, with a lot of people, such as younger disabled adults, children in need and people recovering from strokes, it is no longer about putting care in to do things for people in perpetuity; it is about getting people to the point at which they do not need you any more. It is a challenge for commissioners to make it a reasonable business proposition for providers that they do less rather than more. We would like that issue to be considered.

It will be difficult to take money out of acute care and put it into more preventive approaches—keeping people well and keeping people independent—without bridging funding. There is the whole issue of commissioners discriminating between a service that is achieving something for them and one that is not. What tends to happen in the voluntary sector is that a local authority says, “There is a 5 per cent cut for all of you this year,” whether the voluntary sector organisations are good, bad or indifferent and whether or not they are already efficient. The irony of making a 5 per cent cut across the board is that that puts the most efficient organisations at a bigger risk of collapse than the least efficient ones, because the most efficient ones have no fat left to trim. A more discriminatory approach is required. The approach should be for commissioners to ask what is working for them and giving them what they want, and to protect that and cut something else.

My colleagues in COSLA might well bring this issue up later. There comes a point at which we are trying to apply management solutions to something that is, in effect, a political problem. There is the question of how much is in the pot for health and social care, and decisions should be made about that. Political decisions are made everywhere about how much money goes into a particular area. I worry that, in the name of efficiency, we have been trying to manage something that is much bigger than that.

10:30

Ranald Mair: I will add a couple of points. I agree with a lot of what has been said. We have to put an emphasis on prevention and upstreaming support, consider lower-cost options and shift the balance of care away from the high-cost acute sector, although there is currently no model that shifts the resource. When we keep Mrs Smith out of hospital, no money comes with her to provide the additional care in the community, or at least it does not work at that level.

I echo Annie Gunner Logan's last point. We need to make best use of the resource pot but, as a society, we will have to spend more money on the care of older people, and we should do so. However, Governments do not want to have a conversation about that. There is a desire to believe that, if we do all the fancy footwork, the problem will solve itself and there will be a management solution, as opposed to grasping the political reality that, over the next 20 years, we will have to spend more to meet the demographic demand and provide quality of life for older people in Scotland. Whether individuals will have to contribute more for their own care, whether we will all have to pay more in our taxes, whether we will have to reduce the scope of universal provision of free personal nursing care or whatever else we have to do, a political debate needs to take place about how care will be funded. We need to expect that there will be a gap in care funding that will have to be met.

Colin Beattie: Would you say that, in the end, no matter what strategic changes are made or what changes are made to improve efficiency in commissioning and procurement, for example, if the proportion of the pot to pay for care does not increase, they will not work?

Annie Gunner Logan: There is a risk of that.

Ranald Mair: Yes, I think that there is.

Ian Welsh: There is, but we have a significant opportunity to build a platform for change in the current context and to reach agreement on policy and the direction of travel. The health and social care integration process will be an interesting testing ground to see whether we can do that.

I go back to a point that I made earlier about local authorities having the time and inclination to map the landscape and to try to plot service redesign. That happens in some areas. I was very impressed by the City of Edinburgh Council's officer paper on a fresh way of looking at things contextually. All local authorities need to take a fresh look at things and break out of the straitjacket of structures that prevents fresh and new ways of doing things. If that process bears fruit in five years, that is fine and we will know that we are going in the right direction but, to be honest, I do not think that we can look further than the next five to 10 years to see whether we can build that platform.

Humza Yousaf (Glasgow) (SNP): Good morning to the panel—except Mr Welsh after his football allegiance exposure. I am kidding.

Most of my points have been covered, so I will be brief. Every carer to whom I speak and many of your service users say that self-directed support is a good thing in practice, but there are incredible difficulties with it and some fears about it. I refer to case study 11 on page 37 of the "Commissioning social care" report. Glasgow City Council is laudably looking to save money in these difficult times, but the report says that many of the service users involved

"perceived the council's motive as primarily ... that of saving money rather than improving services."

Uptake has therefore been quite low.

The idea of involving service users in the process a little bit more has been talked about, but I have a feeling that that is not just about involving them at the beginning when the policy is being created. Once people take up support and direct payments, is there enough follow-through, consultation and engagement, or is it simply thought, "Well, they're not our responsibility any more"? Does that make people more reluctant to make that choice?

Ranald Mair: As we said in our submission to the consultation on self-directed support, providers generally welcome the move. However, self-directed payments form only one part of self-directed support. Although I am not so sure that all older people have the appetite to become employers or commissioners of their own care, that does not, of course, negate the principles of self-directed support, which are to provide a personalised care package of which the individual has ownership and to give them choices about how the public money that has been allocated to their care is spent.

We have to move forward with self-directed support, examine how it will impact on the commissioning landscape and ensure, in particular, that people are not simply given the money and told to get on with it. That would certainly not be in keeping with the aim of the policy, which is to empower people and enhance their control over their care. That might include their having to manage the budget themselves, but it might not. In any case, is that what all older people, who might be in their 80s or 90s when they need care home provision, really want?

As I have said, self-directed payments are only one part of self-directed support, but the principles of personalisation and empowerment that lie

behind the policy apply whether or not direct payments are the vehicle.

Ian Welsh: I am a carer; my 28-year-old son is disabled. As I am not a lawyer by profession, I am not bounding with glee towards the notion of self-directed support; there is, after all, a comfort in knowing that your services are being supplied directly. That said, for a huge phalanx of disabled people, the move will be an empowering experience. It is not a black-and-white situation.

We should bear it in mind that dismantling local authority structures, building new cultures and supporting the cadre of people who take self-directed support will not be cost free. Moreover, the move will not be cost free for providers. As Annie Gunner Logan has pointed out, for many years now they have been encouraged to adopt a particular business model based on volume and so on, and now they need to take a view on how customised support will fit into the scheme of things. It is a very challenging but potentially very empowering agenda.

In response to Humza Yousaf's question, I would not want local authorities ever to lose their duty of care.

Humza Yousaf: Is there a danger that they might be pushed in that direction?

Ian Welsh: This is all about human rights and acknowledging the empowerment that comes with an individual's being able to manage not necessarily their budget but their provision. Nevertheless, I think that local authorities should still be vested with a duty of care.

All kinds of projects out there are taking first steps in the direction that we are discussing. For example, in South Ayrshire, where I live, my son Stuart and his peers can plan their respite provision in a different way and with a third sector provider. That is an important step; instead of being told, "Here's where you're going for your respite," he gets asked, "Will we go somewhere else?" The process is neither unchallenging nor cost free for all parties, but it has a strong human rights dimension and, as I have already suggested, it is also part of the new policy agenda that we all have to acknowledge as we move forward.

Annie Gunner Logan: The CCPS feels strongly that self-directed support is a policy and a principle, not a cost-cutting system. Although there is evidence that, when empowered to choose and design their own support, some people design something that costs less than that which might otherwise have been arranged for them, we cannot and should not assume from the outset that that will happen in every case. With certain personalisation and SDS systems that have been introduced in Scotland and England, the assumption right off the bat has been that they will save money, but that is absolutely not what this is all about.

There is good evidence on how this route can achieve better outcomes for people and enhance their health and wellbeing, but not necessarily on how much less their services cost. The Social Care (Self-directed Support) (Scotland) Bill, which has just been introduced, puts its principles up front and clearly states that the intention is for people to have as much involvement as they wish in designing their care. For some people, that will mean taking a direct payment; for some, it will mean asking a local authority to make certain arrangements; and for others, it will mean saying, "You know what? Just arrange something for me."

The important thing for providers to remember is that even those who ask for arrangements to be made for them and who do not want to control resources are still entitled to have as much involvement as they wish in the way in which the service is delivered. That bit is often forgotten, and there is a real risk that self-directed support will be seen as the answer to getting out of financial difficulty. That is certainly not our understanding of it. It might—or might not—help to reduce the need for more intensive support further down the line, but it has the potential to deliver much better outcomes for people for the money that is being spent. We feel strongly about that.

Humza Yousaf: I can see that. You have all made very good points.

We keep talking about the demographic time bomb. The report contains some scary statistics—it suggests, for example, that the number of people who are over 85 will increase by 150 per cent over the next 25 years. Although there can always be more engagement, some sections of our society are already well represented by strong lobbying organisations. Are our older people as well represented? Are they being consulted, engaged with or—as Ranald Mair suggested—empowered enough both at a local authority level and in relation to the SDS bill? My feeling is probably not.

I am reminded of the saying, "That which is about us without us is not for us." People—particularly, in this case, the elderly people who will probably be the biggest beneficiaries of the bill that is being pushed forward—will simply become disillusioned if they are not engaged with right from the start.

Ranald Mair: You ignore older people at your peril. After all, we are talking about the post-war baby boomers, who are more consumerist and are bringing a degree of personal resource to the table. We must ensure that they get the

engagement that allows their views to be channelled.

In his review of free personal and nursing care, Stewart Sutherland said that we need to look at the private as well as the public asset base and engage people in working out solutions. Older people are already becoming more consumerist and demanding about the services that they receive—and rightly so. The grey vote will be an important part of political life over the next 20 years, and it will be the generation that moves towards the peak of the demographic somewhere around 2031, when I have my 80th birthday—

Ian Welsh: Is that not tomorrow? [*Laughter*.]

Ranald Mair: It is not a question of allowing that generation of people to be heard; they will insist on being heard. We have to harness their energy and personal asset base, by which I mean not only their finances but what they can bring to the agenda.

Ian Welsh: I think—

10:45

The Convener: Just a second. I remind colleagues of the saying tempus fugit, because time is short now. Three members still want to pursue questions with the panel and we are well over our time, so let us keep things sharp.

Ian Welsh: Healthy and active ageing is a real issue. We have a conference on that in Parliament on Friday and I will be happy to distribute the conference report in due course. Healthy and active ageing is an issue for all those people who do not need commissioned services. There is good evidence that activity on healthy and active ageing is a sound preventative measure for most conditions.

Colin Keir (Edinburgh Western) (SNP): First, I declare that I am an elected member of the City of Edinburgh Council—for the next few days, at least.

My question is on the redesign of services, which Mr Welsh mentioned. Up to now, the main change in supply has been a movement from local authorities to the third sector or independent sector. Commissioning and supply are on-going, although we are looking at that strategically for the future. How up to speed are your organisations—in general—for the next series of redesigns that will come in? How mobile can your organisations be in the way in which they work so that they do not end up in the local authorities' current position of having to pass over services?

Ian Welsh: That is a question for Annie Gunner Logan. We are not a service-providing organisation, although some of our members are.

Colin Keir: It was a general question.

Ian Welsh: It is about how ready organisations are to change.

Colin Keir: Yes.

Annie Gunner Logan: It is about being responsive. What is interesting is whether the change that people are looking for is enabled by their commissioning and procurement processes. We hear too much of people saying, "We'll have the same thing that we've always had, please, but we'll have it for X per cent less." The issue is whether the organisation's commissioning strategy and procurement process look at innovation and redesign or whether the organisation simply wants the same thing that it has always had. That is our big critique of commissioning.

Recently, two local authorities that had centre-based provision quite rightly said, "We don't want this any more. We want something that is much more community based, in which individuals can direct their own support." The authorities went back to the provider and it said, "You know what? This is what we do, and you can take it or leave it." Given those circumstances, the local authorities quite rightly went out to the market and said, "We want something different. We want to encourage providers to come forward with their new and innovative ideas." They did that with a tender, which is a bit of a crude mechanism, but that is how they took it forward.

In such circumstances, we would not have a problem with a tendering process. Too often, however, we simply find the statement, "We'll have the same thing that we've always had." In the case of care at home—I am sure that Ranald Mair will tell you this, too—we seem to be absolutely obsessed by the cost-and-volume model, broken down into 15 minutes of care interventions. Surely we must be able to do something more creative. We can use self-directed support around that.

Colin Keir: I am not disputing that. I know that you spoke about quite a lot of that earlier. I am thinking about when there is duplication of a service and both service providers are from the third sector. How adaptable are such organisations to change? We are looking at the here and now and to the medium term, but I am thinking about how we can change things in the future if we see that there are problems.

Ian Welsh: To answer your question about how adaptable organisations are, I would say that some are, some are not and some will not be. In the new world, those that are not will not survive.

Over the past five years, the larger providers—I will not name any of them—have all been involved in significant downsizing, redundancy programmes and renegotiation of terms and contracts. The more progressive ones have also done some research and development on how to reshape

themselves for a new service future. The situation is no different from the situation with local authorities, some of which are progressive and at the cutting edge of service provision, while others take a more desultory approach to things.

Ranald Mair: I was talking to Douglas Yates of COSLA before the meeting and it was mentioned that, in one local authority's discussions with its care providers about a five-year plan, it said that, during that period, it would need less of this and more of that, and it asked the care providers to come with it on that journey. That is where the strategic commissioning partnership has to come into play.

We know that we will need the workforce. We do not want to shed jobs from care at this point in time or to lose people with experience. The demand for care will continue to exist, but care might need to be packaged in different ways. For example, we might want more care to be provided in people's homes, more extra care housing or more community supports.

At the heart of the issue is local partnerships doing their capacity planning right, which is about doing the sums and working out how much of the various sorts of care they will require in order to meet the needs of their population over the next period of time. It is about moving away from month-to-month or even year-on-year purchasing and getting into a dialogue about what is needed. It is possible to adapt.

There is a lead-in time when an organisation downsizes in one area and expands into another. If an organisation sticks with providing the care that it has always provided, it might get caught out by that process, but if we go on a joint journey to meet needs in new ways, it seems to me that there will be opportunities for the majority of existing organisations.

Mark Griffin (Central Scotland) (Lab): Mr Mair said that the biggest risk to the service is that it has been dangerously starved of resources. In its submission, COSLA says that the failure of Southern Cross was the result of a 7 per cent drop in occupancy and in the income from that, which it says was caused not just by a poor business model but by

"the virtual absence of a commissioning agenda in respect of the care home sector."

Do you agree? How big a risk is that to your members? Can you see more Southern Cross-type situations arising because of the absence of a commissioning agenda?

Ranald Mair: I do not want to spend too much time addressing the Southern Cross scenario, because in my book it is probably atypical. The private sector in Scotland is largely made up of individual owner-run care homes rather than large corporate entities.

However, it is clear that a stop-start approach to purchasing—turning the tap on and off—can create instability. In some parts of the country, there is excess capacity in the care home system, whereas in others there is a lack of adequate provision or things are finely balanced. Part of the strategic commissioning discussion that we are beginning to have with COSLA is about saying that we need strategic commissioning at a local level, but we will also need a national plan.

Should we license care home development? Should it be possible to open a care home in any part of the country, or should we be asking where the resources are needed most and what sorts of resources are needed, thereby getting into a slightly more strategic discussion about capacity planning? That might mean some disinvestment in some parts of the country or some parts of the sector, and new investment to grow capacity in other geographical areas and other sorts of care provision.

We need to do that strategic thinking. What we need is certainly not for councils to respond to short-term budget pressures with a stop-start approach to the purchase of care, because that would simply create instability in the sector. We must get into longer-term, sustainable contractual arrangements within a strategic commissioning framework.

Tavish Scott: At the start of the meeting, in answer to a question from the convener, the panel suggested that strategic commissioning simply has not worked. The standard public policy response to such issues is to have national standards and centralisation. I want to test that. Why would national standards work here?

Ranald Mair: I suppose that I should answer the question, as I have advocated that to both this committee and the Health and Sport Committee.

We have to put requirements on people, although we can also exhort them. There is strong motivation at present as people are realising that, if they do not change, a crisis will loom. That is a strong driver. However, we need to set out what strategic commissioning means. It means a partnership approach to the planning of care that requires the local authority and health board to consider the capacity that they need in the care sector and to engage with partners on how that will be provided. It is not about ratcheting up regulation; it is simply about saying to people, "Do it."

Tavish Scott: Who will say that?

Ranald Mair: In part, the Government has a role in saying what it expects. There is some

leverage through the change fund because, if bodies do not engage in partnership working, they will not have access to that chunk of money. However, we have to go a bit further. We have drawn a distinction between procurement and commissioning, or investment planning, as Annie Gunner Logan suggested. We have to say how that must be done. In the make-up of the proposed health and social care partnerships at local level, some prescription must be built in to that process.

Tavish Scott: Should that prescription be from Government?

Ranald Mair: Yes. On whether that requires active regulatory activity or inspection on the ground, I suggest that, post Crerar, we should not ratchet up scrutiny of public bodies. However, it seems to providers that it is an anomaly that the care that they deliver to Mrs Smith is heavily regulated, scrutinised and inspected, but the process by which Mrs Smith's care was commissioned in the first place is not looked at. The output end is examined, but the commissioning end is not. There has to be an element of even-handedness.

Tavish Scott: Would standards be set on a national basis, so that they were the same in Dumfries and in Edinburgh?

Ranald Mair: From my perspective, the approach would not necessarily have to be the same everywhere. The same principles must apply, but there has to be an element of local decision-making on the balance of care and care arrangements.

Tavish Scott: So, in your opinion, it is the Government's job to set the national standards.

Ranald Mair: That should be done with partners. The Government should not do things in isolation and without dialogue with the professions that inhabit these territories and that would want to be well advised. However, the Government should take a lead.

Annie Gunner Logan: I will offer a slightly different view. Once we start talking about national standards, we will have to set up another initiative through which the standards are drafted and so on. Exhibit 7 on page 18 of Audit Scotland's report sets out the kinds of initiatives that have already been set up to support commissioning. We have a self-evaluation guide for authorities on commissioning—

Tavish Scott: The report says that they are not working.

Annie Gunner Logan: We have all this stuff, but nobody requires anybody to do it. I do not see a standards project as an entirely separate thing because, in effect, we already have the standards. Audit Scotland's report is crystal clear on what a commissioning strategy should look like and what should be in it. Our view is that somebody needs to go and make that happen.

Tavish Scott: Who is that somebody?

Annie Gunner Logan: We have suggested that the care inspectorate is the somebody.

Tavish Scott: The care inspectorate is a regulator; it is not the Government.

11:00

Annie Gunner Logan: The care inspectorate is a regulator of services, not of the commissioning function—it is an inspector of the commissioning function. Its predecessor body, the Social Work Inspection Agency, carried out performance inspections of every single authority and produced a report that said that none of them was very good at it, with honourable exceptions. However, that is where the process stopped. There is an idea that public reporting on commissioning and other such functions is sufficient to promote improvement, but the Audit Scotland document that is before us says that it is not.

I would shy away from regulating commissioning, because I am not sure that it is regulatable—if that is even a word. However, a set of requirements could certainly be put in place. We spoke to your colleagues on the Health and Sport Committee about the Scottish Government enhancing the powers of the care inspectorate to give it a little more oomph and a little more than simply the power of public reporting. The nature of those powers is up for discussion.

I suspect that there will be resistance to that from our colleagues in local government, which the committee might hear later. However, the Government and the care inspectorate must provide a much higher level of scrutiny and much clearer monitoring of whether people are up to snuff on the issue.

Ian Welsh: The committee will be pleased to know that a group is considering strategic commissioning. I will not comment on it other than to say that Allan Gunning, who co-chairs the group, is here and will give evidence to the committee later, and I am sure that he will have something to say about it. The group will certainly involve discussions on standards and guidelines or helpful hints.

The Convener: I am sure that we will get to that, but we will not if we do not move on through our panels. I thank Ian Welsh, Annie Gunner Logan and Ranald Mair very much for their evidence during what has been a long session.

Ian Welsh: Convener, can I make one final point? I just want to say that all three of us are part

of a large consortium that commissioned work from Dr Jim McCormick called "Living well with long-term conditions—Twelve propositions for social care". We embarked on dialogue on that last year and we hope to have a round-table discussion soon with Ron Culley and Angiolina Foster, the top health officials.

The Convener: That might be something that you could usefully submit as written evidence.

Ian Welsh: We will do so.

The Convener: Thank you.

11:02

Meeting suspended.

11:04

On resuming—

The Convener: Okay, let us get started again. I remind colleagues who were checking their BlackBerrys to switch them off again. I welcome our second panel. I apologise for keeping you waiting and for the rather later start than we had intended. I welcome Duncan MacKay, head of social work development at North Lanarkshire Council; Michelle Miller, chief social work officer at the City of Edinburgh Council; Councillor Douglas Yates, health and wellbeing spokesperson for COSLA; and Ron Culley, team leader in health and social care for COSLA. I offer you the opportunity to make an opening statement, if you wish.

Councillor Douglas Yates (Convention of Scottish Local Authorities): I thank the convener and the other members of the committee for the opportunity to speak on behalf of local government about this important agenda. I was surprised and saddened to hear the evidence that has been led so far, which seemed to be particularly negative about local government.

As you will be aware, COSLA has submitted written evidence describing some of the activity that we are involved in, which addresses issues raised by the report. Our time is limited, so I will not repeat those points. COSLA broadly welcomes the report's recommendations, as they reflect some of the key actions that are already under way or planned for the immediate future, which will be important in ensuring that we have the right building blocks in place at both the national and the local level. Although we recognise that there is scope for significant improvement in strategic commissioning, there are good reasons to be optimistic as we go forward.

Health and social care integration has the potential to bring renewed impetus to this joint commissioning, unlocking the resources of secondary care and helping to ensure that services are commissioned around the outcomes. Just as important, COSLA is working with the Scottish Government and other key partners to put community planning on a far more secure footing. That will be vital for developing whole-system approaches and ensuring that there is sufficient focus on prevention and early intervention. I will be happy to expand on that theme during our discussion, as will my colleague Ron Culley.

The report indicates that councils are tightening eligibility criteria for early intervention and prevention and that they are increasing charges at the expense of investment upstream. Our written evidence outlines COSLA activity on charging and the use of eligibility criteria, and I do not intend to repeat that. Those trends are connected to broader questions around finances and demographic change. In truth, even if we had the best commissioning process in the world, we would still face an enormous funding gap for our health and care systems. As you will all be well aware, the gap is set to reach £3.5 billion by 2031, and no amount of improvement in commissioning will overcome that.

In addition to driving forward strategic commissioning over the next few years, we need a more mature debate about how our health and care system is funded and to determine what balance needs to be struck between the responsibilities of the citizen and those of the state. I ask the Scottish Parliament to engage on that strategic issue as we go forward.

Duncan MacKay (North Lanarkshire Council): North Lanarkshire Council welcomes the opportunity to provide evidence to the committee on this important matter. The joint commissioning strategy in North Lanarkshire is cited in the report as an exemplar and has been the subject of positive comment by both Scottish Care and the Coalition of Care and Support Providers in Scotland. I am sure that we will not be the only ones to be cited in that respect, but that may have been a little difficult to detect from the evidence that you have heard thus far.

Commissioning is much less of an exact science than we sometimes like to pretend. Social work is not like some parts of the public sector, in which a need may often be met in a specific and more or less universal way, such as filling a pothole, cutting the grass or even carrying out some health interventions. Social work need is a relative concept. All of us who are sitting around the table have needs, which we sometimes choose to address through a formal service but which we often choose to address through our own capacity and the support that we derive from our own networks and communities. Because there are many ways of meeting a need, it is eminently

possible, though challenging, for social work, in partnership with partner agencies, people who use services, carers and so on, to navigate ways of supporting people by using quite sophisticated strategies that require a wide range of approaches to be deployed.

One aspect of the discussion that has concerned me so far is that commissioning has been treated as if it exists in isolation—as if it were a single process. In fact, commissioning needs to be intrinsically connected to assessment and care management, resource management, community capacity building, learning and organisational development, and other key levers of change. If those elements are not closely integrated within a service or partnership—for example, if practice thresholds are such that many more children and young people are looked after and accommodated or many more older people are admitted to care homes than is appropriate or necessary—commissioning itself will not address the problem. Equally, without expert commissioning of alternatives to institutional forms of care, it is not possible to maintain proportionately low numbers of people in those settings. Balances of care—the proportion of people who are supported at home—are therefore a good measure of both effective assessment and care management and commissioning.

It follows that skilled commissioning must not only ensure the availability of intensive alternatives to institutional care; it must facilitate access to a wide range of preventive approaches that prevent or delay people's needs from escalating to points at or near crisis. That is why, if local authorities and their partners meet only people who are adjudged to be in critical need, they are likely to achieve poorer outcomes for the person concerned and at greater cost.

Preventive approaches almost certainly do not always have to be formal services. Given more time, I would love to illustrate what I mean by that in relation to partnerships that I am familiar with, for example with taxi drivers, football clubs and arts organisations.

As we have heard, the commissioning of formal services often involves major spend, the thresholds for which require their acquisition to fall under European Union regulations that were designed for the provision of furniture and stationery, not personalised care and support. That is an awkward fit, to say the least.

Self-directed support offers a way around some of those problems by changing the nature of the commissioning task and the nature of the relationship between the citizen and/or their representative, the local authority and, where relevant, the provider. In the context of parallel legislation on integration, it is puzzling that the proposed legislation imposes duties on local authorities, but none on the NHS. In general, commissioning in the NHS means something very different, so there is a major challenge for partnerships to embrace in that context. Effective commissioning is key to managing the growing gap between assessed need and available resources.

Michelle Miller (City of Edinburgh Council): I will be brief, as I agree with what my colleagues have said.

Fundamentally, I agree with and support the recommendations in the report, but there is a huge amount of negativity in it—as there was in evidence that colleagues led previously—that we could spend a lot of time arguing over and challenging. That time could be better spent in thinking more creatively and productively about how we face a seismic change in how we need to think about service delivery, design and funding, which is a critical issue. I hope to be able to say a little bit more later about some of the real challenges of that.

I disagree with a comment that was made about this being about the short to medium term. We need to take a careful look at a much longer-term change in how society operates, considers the vulnerability of its citizens and prioritises how we fund services. There is an opportunity to do that now. If all we do is implement the recommendations in the report as they currently stand, all that we will do is fix, in inverted commas, the current issues and perhaps create something that, although it is fit for the short to medium term, will not be enough to deal with the long-term changes that we face.

The Convener: Thank you very much.

I will kick off with a question that is really for COSLA, as it is not about a specific council. We do not, of course, hold specific councils to account here; they have their own democratic structures. COSLA's submission says:

"we would contest any general view that progress has been limited over the last decade."

That is included in a paragraph that looks at commissioning strategies for services. However, the Audit Scotland report shows that 21 out of 32 local authorities have no commissioning strategy at all. Those two things seem quite incompatible. Given that only 11 out of 32 local authorities have a strategy, can COSLA explain why it believes that progress has not been limited?

11:15

Ron Culley (Convention of Scottish Local Authorities): I can answer that question. It depends on the perspective. From the perspective

of the individual—for all that we have spent two hours discussing the issues, there has not been a great deal of discussion about the person—one could reasonably paint a different picture. We have a general sense that outcomes are improving—

The Convener: I am sorry to interrupt, but surely a local authority either has a strategy that it can demonstrate or it does not.

Ron Culley: I am questioning what we are collectively trying to achieve. If we are interested in what councils produce by way of output in their commissioning strategy, then of course—as we said in our submission—we welcome many of the report's findings and we want to engage with them. We want to ensure that councils and partners are in a position to deliver good and effective commissioning frameworks.

I was trying to contest the general picture of failure, which I think is straightforwardly wrong. Outcomes have been improving, and the Audit Scotland report shows that satisfaction levels among service users are extremely high. Key indicators across the piece show how partnerships have evolved; delayed discharge is a good example of terrific progress. I accept that we still have further to go, but it is incorrect to portray the past 10 years as a dismal failure. That does not give credit to the good work that has often been done.

The danger is that we approach the issue at a level of generality that is not helpful. One of the challenges that we face in commissioning is variation. We have some examples of good, effective, strong commissioning practice, and examples of practice that has not been as good. We need to build on the good practice and ensure that we take a more robust approach in future.

It therefore depends on how you want to answer the question. I prefer to answer it in terms of the experience of individuals, but I recognise that there are other ways to answer it.

The Convener: Do you think that it does not matter whether a local authority has a commissioning strategy?

Ron Culley: Of course it matters, but it is about where one places that in the general order of things. Our first priority should always be the people who access services and are supported by local authorities and partners. Of course we should work harder on the commissioning agenda—we have said as much, as the Audit Scotland report points out—and you will not get any disagreement from us on that. All that we are saying is that we must put that in the context of the experiences of the people who have used the services in the past decade.

The Convener: The purpose of the commissioning strategies has always been to pull together the partnership between local authorities and the NHS. If a local authority does not have a commissioning strategy, how, where and when will the contribution from the local authority and the NHS come together?

Ron Culley: I agree that we need commissioning strategies across all partnerships. We do not contest that: in fact, we have been working with colleagues in the Scottish Government and beyond to ensure that we progress the integration agenda so that every partnership can produce a good and effective joint strategic commissioning plan that focuses not only on social care practice and primary care, but on secondary care too. What has been missing over the piece is a joined-up attempt to plan services—

The Convener: It has been missing in 21 out of 32 local authorities. That is the lack of progress that the committee is concerned about.

Michelle Miller: I am not here to speak for all local authorities, but there is a point to be made about terminology.

It may well be true that local authorities do not have commissioning plans, but for years they have had community care plans and they have been required to produce children's services plans. Those plans, by their very nature, have elements of commissioning within them—the community care legislation required local authorities to assess need, including unmet need, and to consider ways in which that need should be met.

Equally, there is absolutely no disagreement that not just local authorities but any commissioners of services need to have those plans in place. That is not least because of the critical point that Annie Gunner Logan made earlier: this is not about how to just continue to do the same thing while passing on a cut of five per cent, or whatever it is. This is about saying, "What do we want? What do the people who need and use the services that we provide want? What do they aspire to? What is the quality of service that we need to provide? What shape might those services be?"

We need some vision around that future planning if we are to start to encourage providers of services to change, whether they are internal to the council or in the voluntary or the private sector. We might say, "We have been buying 1,000 residential care places from you for over a year, or a week, or the past 10 years. We do not want to do that any more. We want you to do something completely different." That might be around the development of support services in relation to brokerage or personal assistance. In terms of people's business planning, they need those

commissioning strategies in order to support that change.

The point is, though, that it is not just the responsibility of the local authorities and therefore a lack on their part. We all have to take responsibility—the voluntary sector, private providers, the NHS, the Scottish Government, the local authorities—and we have to work together, as a partnership. We need to look at what we need, what people expect the world to look like and how to start to support that change.

Mary Scanlon: I have just two questions—one that you heard previously on cost and quality and then a brief question on preventative services, which was one of the major points in the report.

I know that you listened to the previous evidence session. In brief, the community care providers stated that the then care commission research concluded that the independent and voluntary sector had a higher proportion of gradings 5 and 6—in other words, the highest quality of care—and that in-house care was more expensive. To quote from the submission from the Coalition of Care and Support Providers,

"in-house service costs £21 per hour"

and the

"hourly rate for purchased care at home is ... £10.43".

In these difficult times, keeping the in-house service means that half the number of people can be cared for. On the other hand, twice as many people can be cared for on the same budget in the higher quality, lower cost voluntary and private sectors.

Could you respond to that point, along with Ranald Mair's point about a protectionist policy—that, regardless of the higher cost and, generally speaking, the lower quality, councils keep the service in-house. That is quite a serious point, given the tight budgets that we face.

Michelle Miller: There are a number of different issues there and a number of different things are being compared.

Mary Scanlon: Generally speaking, what do you think?

Michelle Miller: First, as regards the comparison between external provision and council provision, I do not think that Annie Gunner Logan made a distinction between voluntary providers and independent or private providers. You will perhaps find that the assumption—or the care commission's comparison—did not include the private sector.

Secondly—this is a critical point with a lot of evidence around it—I question whether the current model of scrutiny, as provided previously by the care commission and currently by the care inspectorate, is an effective way to evaluate quality. There is a lot of evidence that shows that the model does not evaluate quality very well. If you asked the care inspectorate about that it would probably say the same thing, because it is looking at a complete review of how it assesses quality. There is a real issue about just using the number 4, 5 or 6 to mean that the service is good.

Mary Scanlon: You are saying that the commission got it wrong. You are saying that there has been a misunderstanding and that, in fact, the grading that has resulted in the high number of 5s and 6s that is evident in research over the piece is wrong, because the higher cost council services have been unfairly graded at a lower grade. Is that right?

Michelle Miller: No, I am not saying that. I am saying that the method of inspection is not giving us a true picture of the quality of the experience that a person has in a care service. That applies equally to the lower grades and the higher grades.

Mary Scanlon: Whoever provides the service, the method of inspection is the same and the care inspectors are the same people. I am sorry, but I do not understand what you are saying.

Michelle Miller: I am saying that there is a lot of evidence to support my belief that the current method of scrutiny that leads to the grades is not an accurate reflector of the quality of that care. I am not being critical of another organisation, because this issue is about the responsibility that all public servants have for the quality of care.

The method that is used might mean that a local authority care home or a private care home receives a grade 5, even though that is not a true reflector of quality. I am not suggesting that there is a differential between those two forms of care; I am saying that the methodology is not the best way to determine quality. In some of the inquiries into significant failures in care, the facilities had received high grades from the care inspectorate. There is a mismatch there. Again, I am not being critical or negative. I am saying that, if we are to have a proper assessment of the quality of care, we need to have a different methodology so that our assessment is accurate.

Duncan MacKay: We should be quite clear that there are high-quality and poor-quality services in all sectors, and all the levels of quality in between. There is not necessarily a direct relationship between cost and quality. In the context of what the committee is considering, what is important is that the commissioning strategy sets out the justification and the rationale for why it might be appropriate for some services to be directly provided in certain circumstances and for others to be externally commissioned in other

circumstances. There is a wide range of factors that influence the decision.

In some significant tranches of activity, some councils—mine included—are no longer direct providers. Local authorities do not provide nursing care and never have done so. Further, as Ranald Mair said, 75 per cent of all care home provision lies within the independent sector.

It might make sense for a service to be provided in-house for reasons of integration. In North Lanarkshire, the reablement home support service is provided in-house, but it links directly to other services that maximise people's capacity, such as intermediate care and integrated day services, which are provided jointly by the council and NHS Lanarkshire.

In certain circumstances, it is highly appropriate that services are directly provided and, in others, it is not. What is critical, in terms of commissioning, is that that is articulated and understood, and that providers have a clear understanding of the thinking and have been engaged in the debate that has led to those decisions.

Ron Culley: I will make only two brief points, as Duncan MacKay has picked up on some of the points that I was going to make.

I refer committee members to the care commission report. I am not contesting what Annie Gunner Logan said earlier about the voluntary sector, which has quite a good record in terms of the quality of its care, as do the local authorities. The comparison that should be made is not between the voluntary sector and local authorities, which are basically on a par with each other, but between those sectors and the private sector, notwithstanding the point that Duncan MacKay made earlier, which I agree with.

11:30

It was somewhat ironic that colleagues on the first panel were, on the one hand, endorsing a strategic commissioning approach that requires partnerships to look forensically at what to deliver across what sectors in terms of the types of care that they want to fund and support, but on the other they were holding an almost a priori position that cast judgment on the validity of providing in-house services. The positions seem to me to be completely at odds with each other: it is a contradiction to endorse strategic commissioning on the one hand, and to argue against the provision of in-house services on the other.

Mary Scanlon: To be fair, Ranald Mair was asking for a level playing field, and that point is made in his submission. To be honest, I do not see the report as negative; rather, it is highly constructive.

Since 1999, most of my time has been spent as a member of the health committees. I can honestly say that the sixth Audit Scotland report into the same problems is raising the same issues that we heard in the Health and Community Care Committee in May 1999 when we took evidence on community care. I do not think that I am going to get much further on the issue, but rather than blaming the care inspectorate, will you respond to Ranald Mair's point about councils'

"protectionist approach to in-house provision, even where this delivers neither quality nor value for money"?

Councillor Yates: That was an interesting comment, but one that I would contest. Where is the level playing field when local authority workers are given better terms and conditions? We are trying to introduce a living wage, but there is no level playing field unless we have level terms and conditions and salaries for all care home sector workers. The issue is a difficult one.

I very much contest the point about a protectionist approach. The idea that quality must be sacrificed to achieve cost reductions is not at all correct. My experience relates to my council, where I am the convener of the community health and care partnership. In East Renfrewshire, about 70 per cent of the care-at-home services are provided in-house, and the remaining 30 per cent are provided by other sectors. We get huge resistance from the clients if we try to change that proportion and transfer some of the in-house provision to voluntary sector provision. The clients tell us that the in-house service provides the best quality and, whether that is the perception or the reality, the clients do not want to change.

The Convener: If a local authority has a concern about the living wage and the disparity in terms and conditions between in-service and external provision, or, in other words, that the voluntary or independent sectors are paying much lower wages in order to provide the services at the price that is being paid, could the local authority not stipulate a living wage in the commissioning and procurement process? If councils do not do that, does that indicate that they are hoping that the service might be provided more cheaply because such organisations will pay a lower wage?

Councillor Yates: No. I would hope that we make that proviso when commissioning services. If the council says that it expects to pay a living wage to its workers, it would be disingenuous to tell a service provider that we would use its services, but that we are not too interested in what it pays its workers. You make a very good point, and I agree with it.

The Convener: Audit Scotland found that the way in which services were commissioned caused

voluntary sector providers in particular to squeeze their terms and conditions. What you just described as undesirable is exactly what is happening in the commissioning process.

Councillor Yates: That is one of the unintended consequences, which we must look at.

Mary Scanlon: Many providers in the voluntary and independent sectors could pay at least the living wage if they were funded at the same level as council placements—up to 80 per cent more. I am sure that Annie Gunner Logan would agree that if those sectors got an hourly rate of £21 for home care instead of £10.43, all their staff could get the living wage.

Preventative care is one of the report's main areas. The number of people receiving home care for less than four hours a week has decreased over the past 10 years by 41 per cent. The report seems to conclude that what is being provided is crisis management care, rather than preventative care. The exception is Angus—I acknowledge that nobody from Angus Council is here—where, on average, 3.8 hours of home care are provided weekly per person, compared with 21.1 hours in Fife. Furthermore, 50 per cent of people receiving home care in Angus receive less than two hours a week. Are there different eligibility criteria? In other words, is there a postcode lottery for care? Is Angus Council pursuing a model of preventative care whereas others are pursuing models of crisis management?

Ron Culley: I will start with generalities and colleagues can then come in. After Lord Sutherland's review of free personal care, we designed a national system of eligibility criteria. It was ostensibly designed around the older people's agenda, but local authorities argued, from an equalities point of view, that it should apply to all population groups over the age of 18. The system of eligibility criteria has been rolled out across the country. We are about to embark on some empirical work to see where councils are with respect to the system. The same eligibility framework is being used across councils, but what might differ are eligibility thresholds—the points at which people can access formal care. Local authorities come to different views about where the balance should lie between supporting people with significant social care needs—higher-order needs—and the low-level, preventative agenda. It is a difficult balance to achieve. Some local authorities accentuate one over the other, and that is where there is some variation.

I am not sure whether it is possible, on the evidence provided by Angus Council and Fife Council, to come to a judgment on what you are asking about. It would probably require more detailed work.

Mary Scanlon: There has been a huge decrease in the number of people receiving home care of less than four hours a week. Over the past decade, the number of people receiving that minimal intervention has almost halved—it is down by 41 per cent. I understand that it is difficult for you to compare Angus and Fife but, across the board, we are almost halving that minimal, preventative care. That was one of the report's main conclusions—instead of putting the money into preventative services, we are putting it into emergency hospital admissions and crisis management. Could you address that point?

Ron Culley: I think that that is the big strategic question of the day, the answer to which we have not always got right. It asks a number of questions of all of us, about how we manage the situation. In truth, given that public finance has flatlined, there is a question about how we use resources that are deployed to the various agencies. Because we are not in a period of growth, in order to invest more upstream in the preventative agenda, we will clearly have to disinvest elsewhere. Disinvestment is always difficult in local authorities and probably more difficult in the NHS. Part of the integration agenda is about grappling with the difficult issue of how we invest the total resource in any particular locality to ensure that the system is capable of investing upstream and disinvesting downstream. We will work on putting that in place during the next few years,.

Mary Scanlon: Would it not be more sensible to change to a spend-to-save policy?

Ron Culley: There is no disagreement on that. The question is not about whether people want to move towards that but about where we disinvest. Where do we get the money that we need to invest upstream?

Mary Scanlon: Well, Angus Council managed to do it.

Ron Culley: Angus Council managed to do what?

Mary Scanlon: In Angus, 50 per cent of home care clients are getting two hours of care a week, so someone is keeping an eye on them.

Duncan MacKay: On that point, I draw your attention to my earlier comments about there being many ways to meet a need. That gives social care half a chance of managing to navigate its way through the next few years of ferocious budget reductions at a time of growing need. No one indicator shows the extent to which an authority and its partners are putting in place preventative approaches. A good proxy indicator is the proportion of older people, for example, who are being maintained in care homes, as against the proportion of those who are being maintained in the community. Angus Council happens to have

performed well in that respect, but there is considerable variation among local authorities.

The Angus Council indicator is not particularly helpful in itself because other authorities that are achieving similar results might be doing it in other ways. They might be really efficient in the way in which they are recruiting and deploying volunteers, or in their use of time banking, informal supports or sheltered housing complexes for communal purposes to support more vulnerable people. The use of assistive technology also varies across Scotland. A way of meeting a need does not necessarily have to be a formal service. If a way of meeting a need is always seen as having to be a formal service, we are all doomed, because the gap between assessed need and available resources is growing apace.

We have to find different ways of doing things and it is a legitimate point to make that commissioners have often asked providers to do "for" people, which often felt like asking them to do "to" people. Whether we work in local authorities, the NHS, the private sector or the voluntary sector, we have to shift focus much more to maximising someone's capacity to minimise the likelihood of their needing more formal services, or at least to defer the time when they do. We characterise that journey by doing things "with" people instead of "for" them and, eventually, wherever possible, letting them do for themselves. Surely that is the challenge that we all face, and it is what people want. People do not choose to come into our world of services if they do not have to or if other options are explored with them to promote independence. That is the big challenge.

Mark Griffin: Before I begin, I declare an interest as a member of North Lanarkshire Council.

Scottish Care's submission refers to the fact that providers of care services have to be "properly qualified and registered". It also says that there is a gap and that commissioners of services do not need to be registered in the same way. The implied criticism is that those who are commissioning services are not qualified. Do you agree with that? Would there be any benefit to commissioners having a minimum standard of qualification and being registered?

11:45

Michelle Miller: I am not sure what that qualification would look like. There is certainly an issue about skills and understanding, and about systems that allow us to capture unmet need and give us a sense of the volume of demand and so on. It is perhaps more about ensuring that we have standards than it is about skills, so that all people who have an interest—service users and their representatives and carers in particular—are engaged in the process and have a real understanding of what commissioning is. A useful part of the earlier evidence was that we seem to have conflated the words "procurement" and "commissioning". We need only look in the dictionary to see that they are two very different things.

This is where there may be a dichotomy between the care functions of the local authority and the more corporate local authority. The latter might see procurement as a fairly straightforward exercise of making savings—it is about purchasing widgets and getting a company to produce the widgets for a bit less—whereas the more care-focused approach is about providing the right level of care for people who are vulnerable and frail, or people who, from the point of view of the criminal justice system, are challenging and dangerous. That requires specialist skills and should not be at the mercy of an approach that involves shaving 10 per cent off this year, 5 per cent next year and 5 per cent the year after that. At some point, it becomes impossible to provide the level of care with skilled and supported staff at the price that is being demanded of the system. There is an issue with the capacity of the public sector to fund a high level of need.

I am not sure that the issue is necessarily about registration. It is more about understanding the standards in relation to the commissioning process and being clear about what we mean and what we as a society are prepared to pay for. There is a challenge in there for us.

Ron Culley: I would connect the contribution from Scottish Care with the Scottish Government's submission, which refers to the national learning framework for commissioning, which we are trying to develop through Allan Gunning's group. Allan might want to expand on that later. Essentially we have recognised that we need to engage with the skills agenda in respect of commissioning. The development of that national learning framework is part of our response. We are aware of that and want to work towards it.

The Convener: It is striking that most of the discussion has been about commissioning and procurement in local authorities, yet we are meant to be talking about joint commissioning. Does the NHS side pull its weight in the commissioning strategies that are in place?

Duncan MacKay: I will have a go at answering that.

It is important to recognise that the act of commissioning does not necessarily mean the same thing in the NHS as it does in local authorities. NHS services are either directly provided—for example acute hospitals, district

nurses or health visitors—or contracted from general practitioners, dentists and pharmacists, under terms that are fairly well prescribed, if you will pardon the pun.

Unlike local authority spend, relatively little spend of direct NHS budgets is involved in the act of commissioning. For example, half of the North Lanarkshire Council social work budget is spent on commissioned providers, but you will not find anything like that proportion in any health board area in Scotland. That does not necessarily mean that there should not be robust joint commissioning strategies or clear partnership plans and financial contributions towards securing the right form of care, support and treatment for people.

In my opening remarks, I mentioned self-directed support and the fact that the Social Care (Self-directed Support) (Scotland) Bill imposes duties only on local authorities. Self-directed support releases us from the tyranny of hourly rates and changes the very nature of commissioning and the commissioning task. As it stands, the bill proposes a duty only on local authorities, not on the NHS. That is anomalous in the context of all that we have been discussing today and the Auditor General's report.

Colin Beattie: I declare an interest as a member of Midlothian Council—for another eight days.

I will touch more briefly on the same question that I asked the previous panel. We have talked about councils' social care spending increasing by 46 per cent in real terms—in particular, within that, spending on adults with learning disabilities will receive a 68 per cent real-terms increase—in the face of an overall budget cut of 12.3 per cent over the next two or three years. When I put the question to the previous panel, I got the impression that we were talking about moving deck chairs on the Titanic and that, despite all this talk about changing strategies, new strategic approaches and so forth, the bottom line is that there is not enough money and, without more money, we are going to struggle, no matter what strategies are put in place. Is that the reality?

Councillor Yates: I think that I touched on that in my opening statement. Even the best commissioning in the world would not allow us to bridge the £3.5 billion funding gap that will open up between now and 2031. I suggested that we need to have a fundamental and mature debate about how our health and care system is going to be funded, focusing on the relationship between the responsibility of the citizens and the responsibility of the state. We must make better provision for the future, and each individual must do that as well.

Michelle Miller: Fundamentally, there is not enough money in the system. We have rehearsed that and it is set out in the report. However, if you were to say tomorrow, "Here's the money to fill that gap," and all that we did with that was more of what we have been doing, that would be absolutely the wrong thing, too. It is not one thing or the other; it is both. How we commission services, how people are allowed to take control and exercise self-determination over their own support needs and how communities contribute to that must change as well. We should not support a system that, on the whole, people would not want to see continue. It is a traditional, buildings-based, service provider-focused model of care, and people are telling us that that is not what they want. They want to determine their own lives and futures. They want to have choices and they want us to facilitate that through the public purse. Simply addressing the financial gap without making changes in the model of care and support would be unfortunate.

Ron Culley: I agree 100 per cent with that. When we started the work on reshaping care four or five years ago, it was predicated on answering two strategic questions. The first was about how we would optimise the provision of care and support to individuals, which is the agenda that led to the change fund, some of the work on integration and some of the commissioning issues that we are discussing now. It is important that that work continues, as we have certainly not completed that journey. The second question was about demographic change and strategic finance. That is an issue that the Government has grappled with at the UK level, through the work of Andrew Dilnot and his commission. I urge the committee to refer to their report, as it engages with some of the issues that we will have to engage with in Scotland. Indeed, I understand that the UK Government will shortly respond to Andrew Dilnot's commission through a white paper, which may or may not have implications for how we address the issue of funding in Scotland. That work has to be done. We cannot proceed by addressing only one of those strands. If we fail to address the strategic finance question, we will be stuck.

Colin Beattie: I take on board what you have said. However, if we assume that, over at least the next two or three years, there will be great difficulty in raising additional funding, and given the changes that everyone seems to have committed to make in relation to strategic commissioning, procurement and so forth, is it likely that we can cope with demand over the next five to 10 years by changing and improving what we have as opposed to injecting significant additional funds into it?

Councillor Yates: I am not sure that we can talk in terms of five or 10 years, but I certainly commend the Scottish Government's direction of travel, which I think is right. The change fund has been a shot in the arm. It is a catalyst for change and looking at things differently. We have redesigned a lot of things and all the councils are looking at how they can do things better and more efficiently, but not just to achieve cost savings. Many things have been implemented across councils to safeguard quality. We need to emphasise that we will not sacrifice quality but we need to do things differently. The change fund has given us a huge opportunity and a breathing space to be able to bring about changes and transfer some resources into early intervention to prevent problems from building up.

Ron Culley: We cannot wait 10 years to address the question. When I say that it is a strategic finance question, I mean more generally than just public finances. Colin Beattie is right that public finances are heavily constrained just now. Certainly, the forecast for the next few years is that public sector spend will not necessarily increase and that it will take some time for public spending to recover to 2009-10 levels.

Ranald Mair said earlier that the next generation of older people will be more consumerist. That is true, but that generation will also be the wealthiest generation of older people that there will ever have been. There is therefore a question about not just public finance but private finance. That is a very difficult issue and I do not pretend that we have any answers for you today in that regard. However, the issue is the complex interrelationship between private finance and public finance, which Andrew Dilnot has explored. We need to explore that in much more detail, but we have not really done that yet.

The Convener: We will have a quick question from Mr Keir.

Colin Keir: My question has been answered, convener.

The Convener: I appreciate that.

Willie Coffey: For the last time at this committee, I declare an interest as a current member of East Ayrshire Council.

The overall message that I took from the Audit Scotland report was a positive one that highlighted that there is good service provision across Scotland. Mr Culley mentioned specifically in his opening remarks that people appreciate and enjoy the level of care that they get. I put on record that I certainly do not share some of the doom and gloom-laden messages that we might have heard around the table.

Gazing into the future, do you think that the strategic commissioning approach will help us, particularly when we commission residential care for children? That is very expensive and it can hit council budgets severely. At the other end of the scale, will there be more demand for a housing solution for care of the elderly rather than the residential home solution, which we all know can be very expensive?

Councillor Yates: COSLA has been looking at that issue very carefully in terms of the provision of certain places. Ron Culley will say more about this because he has been closer to it and has been involved in some of the discussions about secure care, for example. Ranald Mair talked about the difficulty with Southern Cross and the provision of care homes. It is difficult to assess what capacity we need in the system. However, Ron Culley will give you more detail on that, as he has been involved in it.

12:00

Ron Culley: I, in turn, will defer shortly to Michelle Miller and Duncan MacKay. We can approach the residential care issue from a number of perspectives. Douglas Yates mentioned secure care, which is far more specialist than general residential care for children. Through our colleagues in Scotland Excel, which is the national procurement organisation for local government in Scotland, we have put in place a national contract on that. That has been relatively successful. It has generated more of a focus on outcomes and has delivered, or is capable of delivering, some savings.

There is a bigger agenda in relation to wider residential care work. It may or may not be the case that we do that work nationally. The work of COSLA and our colleagues at a national level should increasingly be about supporting good and effective local commissioning rather than defaulting to a national approach. We are aware of the issue and hope to address it over the next few years.

Similarly, a key part of the agenda that we will have to advance over the next year—we have already advanced it—is to keep people independent in their own homes rather than have them go into care homes. That will require an assessment of what we use care homes for. There is probably a sense that we want to use care homes differently in the future. Our submission states that we want to take more of a commissioning approach to care homes. The overall policy objective has to be to keep people independent in their own home. We can refer you to lots of good work on that. For example, the work that the City of Edinburgh Council is doing on reablement and the work that North Lanarkshire

Council is doing on self-directed support facilitate a move in that general direction. There is genuine reason for optimism on that agenda.

Michelle Miller: A clear similarity in children's services lies in the need to reduce the need for residential provision for children. For example, the work that was done on the secure care contract was not only about asking whether we could control the price but about ensuring that we have the right type of service at the right time to achieve the outcomes that we want for children and young people. That whole contract included taking capacity out of the system, because we recognise that, in the main, children should not be in secure accommodation and certainly should not be in secure accommodation as the default or long-term position. The residual provision must be of extremely high quality and is likely to be expensive.

Along with Ron Culley, I would not advocate a national care home contract for straight residential care for children and young people, but the same principle applies, which is that, on the whole, children and young people should be at home or in homely settings in the same way as older people or adults should be at home or in homely settings rather than in residential provision. We need to focus on that, rather on how we manage the contractual arrangements or pricing issues. There are similarities in the principles, but the mechanics of it are quite different.

Willie Coffey: I will not ask a follow-up question.

The Convener: Thank you. That brings the evidence session to a close. I apologise once again for being so much later than we had indicated that we would be. We try to keep to time but have not done so today.

Michelle Miller: I would like to make one final comment. I appreciate that I might have caused offence with my comments about the care inspectorate. That was not my intention and I certainly did not want to be critical. The care inspectorate and the City of Edinburgh Council are working closely on piloting an arrangement that will, if it is successful, change the face of inspection, because we hope that there are better ways of evaluating quality. It is about recognising that a change is required as opposed to being critical of the organisations.

The Convener: Thank you for that clarification. I thank Duncan MacKay, Michelle Miller, Douglas Yates and Ron Culley.

12:04

Meeting suspended.

12:08

On resuming—

The Convener: Unfortunately, NHS Tayside was unable to provide a witness for our third panel, but I welcome to the meeting Dr Allan Gunning, executive director of policy planning and performance for NHS Ayrshire and Arran. Do you wish to make any opening remarks, Dr Gunning?

Dr Allan Gunning (NHS Ayrshire and Arran): Just very brief ones, convener—I am aware of the time.

The recommendations in the Audit Scotland report that refer to the NHS are fair and focus on various critical areas such as the preventative spending agenda, which has been raised more than once this morning; the need for commissioning strategies for social care that set out very clear parameters; the risks involved in contracting services from the voluntary and private sector; and self-directed support, which is a key strategic area and whose implementation will require the NHS to work alongside partners.

With that, I am happy to take members' questions.

The Convener: In our earlier evidence sessions, we talked a lot about local authorities and joint commissioning. Another part of the structure that was supposed to deliver greater partnership or integration was the community health partnerships, which this report—and indeed a previous, more substantive Audit Scotland report on the matter—suggests are largely NHS bodies when in fact they were originally meant to be the place for partnership between the NHS and local authorities. Do CHPs feel to you like NHS bodies or genuinely partnership bodies?

Dr Gunning: Ayrshire has had two community health partnership models, the first of which was based on the view that, if such partnerships were to be successful, they would need to have as many NHS services as possible delegated and devolved to them. In Ayrshire, that included the totality of mental health services. However, we reached the conclusion that such a model essentially transformed CHPs into a service delivery arm of the NHS and did not address the partnership issue.

As a result, a few years ago, we refocused our CHPs and gave them a very clear mandate to focus on pursuing closer integration. To do that, we took the health component of the single outcome agreement, which should capture such partnership work, and made it the critical success measure for the partnerships. We also beefed up

elected representative membership of CHP committees, which are now all chaired by the local councillor, who is also a non-executive director on the NHS board. As you will see from our submission, we have used the CHPs to drive the change fund initiatives and the integrated resource framework and feel that they are now better placed to contribute to the closer integration of health and social care.

The Convener: That was very helpful.

Mary Scanlon: I know that you sat through the two previous evidence sessions but it is perhaps unfair of me to ask you the questions that I put to our previous panels about councils and independent funding and the eligibility criteria that different councils use. To save some time, therefore, I will ask you about a hobby-horse of mine. Under the Highland model, NHS Highland looks after adult and elderly care and the Highland Council is responsible for children's care, with significant staff moves in both directions, obviously under the Transfer of Undertakings (Protection of Employment) Regulations. I very much support that model—probably because I know it best—but do you feel that it has all the right attributes for it to work elsewhere in Scotland?

Dr Gunning: It is a potential model. Of course, it went live on 1 April—

Mary Scanlon: Three weeks ago.

Dr Gunning: Indeed, and all partners in Scotland will have a very close eye on it.

I think that with any outcomes-based approach, providing that we are clear about the outcomes that we are striving to deliver, the delivery method will come down to local circumstances. As a result, we must focus on and be very clear about the outcomes instead of focusing on the processes and inputs that must be in place.

Mary Scanlon: I will not pursue the matter but will simply put on record the fact that, since 1 April, I have been approached by two families with a family member in hospital whom they had been desperately trying to get into a care home. Under the new model, those moves happened almost within 48 hours without anyone having to go to the NHS or the council. I appreciate that it is still early days but, in its first three weeks, this model of having a single agency be fully accountable and take all these decisions seems to be putting people first and the outcomes look good.

12:15

Mark Griffin: What have been the barriers to joint working and joint commissioning? Where has there been management or budget overlap? Can you outline the main difficulties with joint working?

Dr Gunning: There are loads of examples of effective joint working between health services and councils, in which what have appeared to be barriers have been overcome. Some really radical service transformations have taken place, for example, in services for people with learning disabilities. The partners took a person-centred approach, had a clear understanding of the resources and were able to work effectively with users, carers and the recipients of services to transform the service from an institutional model of care to one that was community based. Although we may speak of barriers, there are plenty of examples of the partners working together to change radically the face of service provision.

The consultation document on health and social care integration will come out after the May elections. The key proposal to have a single accountable officer, the integration of resources and clarity around outcomes—which I talked about earlier—are important touchstones. If we want to look at it negatively and talk about barriers, we can see that there have been a number of challenges in those three areas, but I am confident that the proposals for closer integration of health and social care will start to address those in a more specific way.

Mark Griffin: The sharing of resource through the reshaping care for older people change fund will address a lot of the problems in services for older people. How do you see—speaking in negative terms, as has been suggested—the barriers being overcome in other areas that the change fund possibly will not cover?

Dr Gunning: The committee will know that there are three change funds, which are focused on older people's services, children's services and reducing reoffending. We should take a strategic look at those three areas in relation to the preventative spend agenda that was discussed earlier.

In broader terms, initiatives such as the integrated resource framework, which I mention in my written submission, are allowing all stakeholders a better understanding of where resources are being utilised, where variation lies and where that variation cannot be readily explained through differences in population, deprivation or other characteristics. Linked to that, there are other potential ways of looking at resource utilisation, such as programme budgeting and marginal analysis.

For me, there are three broader issues. There is understanding of the resources and how they are being used; there is being clear about the outcomes that partners are trying to deliver; and there is being clear about the delivery chain. The example that was given earlier relating to the effectiveness of hospital discharge was, in

essence, about the delivery chain. Those three things provide a model whereby the barriers can be tackled and overcome.

The Convener: Because we are looking at an audit, we tend—as Mr Beattie said earlier—to look backwards rather than forwards and ask why more progress has not been made. The Auditor General made it clear that he was unhappy with the progress that he had seen, and colleagues from local government on the previous panel felt that they were being given quite a hard time about that—they felt that they were taking the blame.

In the spirit of evening things up a bit, I suggest an alternative analysis of what has happened, in which great swathes of responsibility for care have shifted from the NHS to local government. Responsibility for learning disability is one example. Older people still access NHS care, but far fewer older people are in long-term NHS care. The NHS has been adept at allowing responsibility to shift to local government. In some cases, it has made a one-off resource transfer and then washed its hands of responsibility.

Similarly, with preventative projects that are designed to prevent people from ending up in the acute sector, most local government colleagues would say that it is quite difficult to get the NHS to acknowledge that it will benefit from such projects and to put money into them. Perhaps the only area in which the NHS makes such investment readily is delayed discharge, but that is because addressing delayed discharge frees up beds that the NHS needs.

Has the NHS played its part in the progress that has been made, or has it acted as a barrier to progress?

Dr Gunning: There is no denying the fact that there is room for improvement, but it is important to bear in mind that resource transfer is a recurring expense, as there is a recurring need for replacement services.

I will provide some context. Earlier, the difference between the spend of the NHS and the spend of local authorities was discussed. In the NHS, the two big chunks of revenue spend are on hospital and community services and family health services. In Ayrshire, 93 per cent of the hospital and community services spend goes on directly provided NHS services. After that, the biggest chunk—6 per cent—goes on resource transfer or support finance and payments to voluntary organisations and charities. Less than 1 per cent of it goes to the private sector. Family health—general practitioners and so on—accounts for the other big chunk of spend and receives about £175 million. Therefore, the resource transfer element is quite important.

In Ayrshire, we have moved that model forward through the change fund. We no longer talk about resource transfer; we talk about those things that we will add in to the change fund. For example, in Ayrshire the partnerships have just identified an additional £450,000 to supplement the change fund for older people.

It is easy to make broad-brush statements. Over the past 10 years, the hospitalisation rate in Ayrshire has increased by 20 per cent, so it is not the case that there has been a reduction in demand and that, as a result, the NHS has somehow made resource savings. The answer is transparency, which is why initiatives such as the integrated resource framework are extremely important. They allow everyone to see where the money is going, and they get away from an approach that involves chipping at bits of the strategic issues.

For example, to go back to emergency admissions, in Ayrshire we have made some progress in reducing the number of admissions among older people, but that has been more than compensated for by an increase in admissions of younger people, who often have alcohol or other addiction-related problems. Transparency is needed. Instead of looking at specific areas, we have to understand the big picture, and strategic commissioning helps us to do that.

The Convener: On strategic commissioning, there has been some discussion about the quality of the commissioning process and the skills that exist in that area. A previous witness made reference to a learning framework that you are involved in, so it might be helpful if you could say a few words about that.

Dr Gunning: We have a group that is overseeing our contribution on strategic commissioning as part of the closer integration agenda. We started off thinking that the learning framework would be the key output. It will be an important output, but although it is still early days for the group, one of the issues that we have addressed early on is definitions. I do not think that I was here for the debate about commissioning and procurement. It is important to get such things right, particularly among the partners. In the NHS, commissioning has particular connotations to do with the internal market that we had prior to 2004.

The whole idea of the learning framework chimes with some of the recommendations in the Audit Scotland report. The report says that a load of guidance has been issued, but that the feedback shows that help and assistance on the ground is required to allow people to implement that guidance and understand how the delivery process works. The learning framework will

assess where the gaps are and what we need to do to fill them.

There are examples from the NHS on the procurement side that are relevant to some of Audit Scotland's findings. I am involved in some work on procurement with the west of Scotland boards; that work concerns products, but there are similar challenges. One difficulty is that the procurement staff work to get the best deal on a particular product, but the clinical staff sometimes say that the product is not of the quality that they require. We have set up technical user groups to address that. We must get the what-to-buy decision right, and the how-to-buy decision must follow so that there is not a disconnect. I see some parallels with the commissioning process, albeit that that process is very specific.

Willie Coffey: The questions that I was going to ask related to the convener's questions about Dr Gunning's efforts in Ayrshire and Arran and how closely they match the Scottish Government's intended approach.

To ask the £3.5 billion question, will all the discussion and effort that is going on close the gap? If we continue to do what we are doing in the same way, we will have a £3.5 billion gap in the next 20 years. Is there any evidence—even at this early stage—that, through your efforts in doing things differently and taking a different approach to commissioning, we can close the gap and still deliver a quality service for the people who expect it?

Dr Gunning: With regard to the integrated resource framework, we have been doing deep dives—as we call them—into learning disability services in East Ayrshire.

Willie Coffey: I was going to ask about deep dives.

Dr Gunning: We tried to track in detail where resources were flowing, and we discussed with the recipients of those services whether that was the best use of resources.

Without exception, users and carers have strong views about the best use of resources. Often, when they see the quantum of cost that is involved, those views become stronger. There is then a stronger partnership between what a good result for the individual looks like and how the statutory agencies and others can help to achieve that result.

I will give a specific example in which risk is important. The cost of a sleepover stay in a learning disability package tends to be quite high, but if we discuss that and say that we do not think that such a stay is really needed, there is a discussion about how that resource can be redeployed more effectively.

There is an understanding among users that we are talking about public money. The issue is how we build a more effective partnership in order to get better resource use from person-centred planning.

In East Ayrshire, we have almost attained the personalisation agenda and the approach of self-directed support—although not the mechanisms for that support—through the natural process of the deep dive. It is different in North Ayrshire, where one of the pathfinders will take a sampling approach to self-directed support and work with individuals and carers in testing to find the best-fit solutions.

There are a variety of ways in which we can approach the issue. I would not say that we have taken any more than smallish steps in Ayrshire, but they have been positive steps.

Willie Coffey: Good—that is encouraging.

The Convener: Thank you, Dr Gunning. I appreciate your evidence, and I apologise for keeping you later than we had expected.

The committee will now move into private session.

12:30

Meeting continued in private until 12:49.

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