



OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 12 December 2017

Session 5



The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 12 December 2017

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HEALTH AND SPORT COMMITTEE

30th Meeting 2017, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Ash Denham (Edinburgh Eastern) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Emma Harper (South Scotland) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Ella Brown
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Brian Logan (Bield Housing & Care)
Dr Donald Macaskill (Scottish Care)
Fiona McKay (Fife Health and Social Care Partnership)
Paula McLeay (Convention of Scottish Local Authorities)
Michelle Miller (Edinburgh Health and Social Care Partnership)
Fraser Morton
Gordon Paterson (Care Inspectorate)
Sheenagh Simpson (Scottish Federation of Housing Associations)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 12 December 2017

[The Convener opened the meeting at 10:00]

Care Home Sustainability

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 30th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent. It is acceptable to use mobiles for social media, but please do not take photographs or record proceedings.

Agenda item 1 is a round-table evidence session on care home sustainability. I will briefly introduce myself, and then we will go anticlockwise round the table so that everyone can do the same. Before we start, though, I must apologise for the temperature in the room. There has been a problem with the heat sensors so it is a bit colder today, but we hope that the room will heat up quickly.

To begin, I am convener of the Health and Sport Committee and an MSP for Lothian.

Ash Denham (Edinburgh Eastern) (SNP): I am the MSP for Edinburgh Eastern and deputy convener of the committee.

Paula McLeay (Convention of Scottish Local Authorities): I am the chief officer for health and social care at the Convention of Scottish Local Authorities.

Miles Briggs (Lothian) (Con): I am a Conservative MSP for Lothian and the Conservative spokesman for health and sport.

Fiona McKay (Fife Health and Social Care Partnership): I am the head of strategic planning for performance and commissioning in the Fife health and social care partnership.

Alex Cole-Hamilton (Edinburgh Western) (LD): I am the Liberal Democrat MSP for Edinburgh Western and my party's health spokesperson.

Dr Donald Macaskill (Scottish Care): I am the chief executive of Scottish Care.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): I am the MSP for Mid Fife and Glenrothes.

Gordon Paterson (Care Inspectorate): I am the chief inspector of adult services at the Care Inspectorate.

Emma Harper (South Scotland) (SNP): I am an MSP for South Scotland.

Brian Logan (Bield Housing & Care): I am the chief executive of Bield Housing & Care.

Alison Johnstone (Lothian) (Green): I am an MSP for Lothian.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): I am director of the Coalition of Care and Support Providers in Scotland. For transparency, I should also say that I am a non-executive director of the Scottish Government, but I am not here in that capacity today.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

Michelle Miller (Edinburgh Health and Social Care Partnership): I am the interim chief officer for the Edinburgh health and social care partnership.

Brian Whittle (South Scotland) (Con): I am a Conservative MSP for South Scotland and the party's spokesman on health education, lifestyle and sport.

Sandra White (Glasgow Kelvin) (SNP): I am the MSP for Glasgow Kelvin.

Sheenagh Simpson (Scottish Federation of Housing Associations): I am the policy lead with the Scottish Federation of Housing Associations.

Colin Smyth (South Scotland) (Lab): I am an MSP for South Scotland and the Labour spokesperson on public health and social care.

The Convener: Thank you very much. We want to keep the discussion as free flowing as possible, so if you indicate to me, I will try as far as possible to bring you in.

We will take evidence in two sections. First, we will look at specific issues relating to the situation with Bield Housing & Care, and secondly, we will discuss the wider sectoral issues emerging on the back of that. Alex Cole-Hamilton will begin.

Alex Cole-Hamilton: Good morning. I am grateful to the panel members for their time, and I specifically thank Brian Logan from Bield Housing & Care for coming along today.

Obviously, the Bield situation has garnered a lot of attention in the media, not least this morning, and I am sure that in one way or another it has come up in casework for all my colleagues around the table, through either residents of homes in our constituencies or their concerned relatives. First, why were families and residents given so little notice of the intention to close the homes, and why were some people accepted to placements in

those homes just weeks before the decision was taken?

Brian Logan: We made our formal announcement on 10 October. In many cases, we have given residents and their families, and our partners in health and social care, six to nine months to find alternative accommodation. We started confidential discussions with our health and social care partnership colleagues in mid to late summer. Contractually, we are bound to give only 90 days' notice of our intention to withdraw from providing a service. We feel that we have given residents and their families more time—up to nine months, in some cases—to find alternative accommodation, and we are working very hard with other organisations to find alternative solutions, whether they involve a transfer to an alternative provider or finding alternative accommodation.

The minute that an organisation makes such an announcement, business starts to fall away and staff start to leave, so once we had made the decision we wanted to move on it pretty quickly. That is the sort of timescale to which we are working.

We also have a financial imperative; we are losing a significant amount of money on our care home business. Indeed, we have been doing so for a number of years, and we have had to subsidise the business from our reserves. We needed to take action quickly.

Alex Cole-Hamilton: What comfort can you offer residents—for example, those in Dunsmuir Court in my constituency, which is an assisted living facility rather than a care home—that there is no threat to the other types of social care facilities that you run?

Brian Logan: The facility in Corstorphine that you are talking about is a retirement housing complex. That sector is the bulk of our business; we manage more than 4,500 properties of that nature, and there is no impact on any residents who live in them. Those services will continue as they are, well into the foreseeable future.

Alex Cole-Hamilton: I want to broaden the question. Do we need to change the rules governing the amount of notice that care homes need to give their residents, and the families who support them, when such a closure happens? How hostile is the landscape? Do we know how many other organisations are in that kind of trouble? Perhaps Michelle Miller can tell us about organisations in Edinburgh.

Michelle Miller: I can speak only for Edinburgh, but there is a general availability issue. Currently we are running at a pretty steady state in which we are between 60 and 70 care home places short of meeting need. Any analysis of the reasons for that

will be complex and multifaceted, and I am not sure that I am able to come up with one single answer. Cost is inevitably an issue, and we need to think about what a reasonable and realistic rate for care home places would look like, but we cannot look at the issue of cost in isolation.

The national care home contract has served us well over the years, but as we move forward the model of service provision needs—and is likely—to change in order to reflect the aspirations of people who might not want to spend long periods of the latter part of their lives in traditional residential care. What does the personalisation agenda mean for the shape of the market? We need to look beyond individual residential care issues at social care provision for older people as a whole and consider what it might look like in the future, and within that, we need to decide on realistic expectations for standards and affordability. That question goes beyond individual partnerships and their budget arrangements. There is a wider discussion to be had across the piece on the care that we want to provide, what it looks like, how much it will cost us and how much we can afford, given the current availability of public resources.

Alex Cole-Hamilton: I see other hands coming up in response to my question, but I have a corollary to that point. You mentioned that 60 or 70 people are waiting for beds. What, typically, is happening to them right now? Are they in hospital or at home? Perhaps you do not have the figures for that. Indeed, how do you measure such things?

Michelle Miller: The majority are in hospital. Typically, people need a residential care placement, because their level of frailty and dependency is very high. The challenges in Edinburgh that arise from people being delayed in hospital as they wait for alternatives are well documented. Some might be in short-term high-dependency provision, but that is not a long-term residential care solution. That is where we get our figures from.

The Convener: Will a shortage of 70 places become a shortage of 90 or 100 when the two Bield homes in Edinburgh close?

Michelle Miller: Not specifically. In Edinburgh, we hope that there will be provision for the people who are currently in Bield care homes. We are hoping for a transfer, and we are still looking at that—

The Convener: But the capacity will come out of the system.

Michelle Miller: Yes.

The Convener: So the number of places that you need will go up, and the number of people

who are waiting is likely to increase, given that 28 places are being taken out of the system.

Michelle Miller: In straight numbers, the answer is, in theory, yes. Sixty or 70 people are waiting for a care home. However, there are vacancies across the city, although the costs involved are well beyond the national care home rate.

Jenny Gilruth: Good morning to everyone. In his submission, Dr Macaskill of Scottish Care states:

"The numbers employed in care homes have fallen slightly since 2008 ... Thus, an overall staffing reduction is in itself an issue of concern."

However, the table on page 7 of Brian Logan's submission shows that Bield essentially has a high ratio of staff to care home places. For example, in Finavon Court in Glenrothes, which is in the area that I represent, there are 24 service users and 25 staff, while in West Port in Linlithgow, there are 14 places and 25 staff. I also note the submission from Fife health and social partnership, which states:

"We continue to have capacity within care homes ... We have ... no other sustainability issues."

I have a direct question for Brian Logan: were staffing levels in Bield homes sustainable?

Brian Logan: The staffing levels that we had in place were suitable to deliver the services, which is why we consistently scored high grades with the Care Inspectorate. Our staffing levels vary depending on the size and physical layout of each care home. Some care homes were designed for a particular staffing model; we will have made changes to produce efficiencies over time, but in some homes we were simply not able to do that because of the physical layout of the building. That is why the ratios vary. We feel that we had in place appropriate levels of staffing to deliver high-quality care to our residents. Indeed, even throughout the current very difficult period, the feedback that we have received has been that the quality of care in our services has been first class.

Gordon Paterson: Before I focus on the Bield issue, I want to provide a wider context by highlighting the shifts in the market over the past five years. In 2013, there were 905 care homes for older people in Scotland, providing more than 38,000 beds. In the five years since, 56 care homes have come out of the market, which has reduced the number of beds by 883. One might have expected, given the demographic challenges that we face—and notwithstanding the policy to try to support people to live at home for as long as possible—to have seen an increase in the number of beds. That says something about capacity and sustainability issues.

On the Bield issue, it is quite unusual for us to see a situation in which a third-sector provider has decided to withdraw 12 well-performing care services from the market. We have seen care home closures over the years, and single care homes have been closed by a corporate company, but the Bield situation is most unusual. In fact, as far as I am aware, we have not encountered it in recent years.

The Convener: Why do you think it has happened?

Gordon Paterson: It is a combination of factors, which Bield has conveyed very effectively in its submission. It is partly to do with the service model that Bield sought to deliver, which was designed to meet the needs of people who had a greater degree of independence than is the case with the current clientele. It is also to do with the environmental model in which residents live in flatlets with large rooms, which makes it more difficult to provide them with support. Finally, rising costs have not been matched by increases in fees.

Dr Macaskill: I want to respond to Alex Cole-Hamilton's comment about a "hostile" environment. That is, if I may say so, an unfortunate term—the environment is actually fragile. As the Scottish Care submission articulates, we know of a number of organisations that are on the point of making decisions whether to withdraw from the market. Those organisations are part of the constituency—the voluntary and charitable sector—that Gordon Paterson highlighted.

10:15

Such decisions will be based on financial viability and on whether the organisations believe that they can continue to deliver dignified, rights-based, person-centred care with the allocated finance. Despite the degree of commitment from local authorities through the national care home contract, organisations are increasingly coming to the point of deciding whether funding is sufficient, given increased dependency and demand and given the huge recruitment and staffing difficulties, which we might want to talk about later. Is it possible for them to sustain themselves in the sector? It is not appropriate for me to comment on Bield, but I know of a number of other significant players who are profoundly concerned about their sustainability in the next calendar year.

Jenny Gilruth: I have a supplementary specifically on the constituency that I represent. Fiona McKay, your submission notes that a buyer might have already been found for the affected care home in Glenrothes. Are you able to share the name of that buyer—and any more detail—with the committee? Can you tell us a bit more

about the two affected care homes in Dunfermline? Brian Logan, too, might want to come in on that question.

Lastly, your submission states:

“the working group will re-convene in early December”.

Has that happened yet?

The Convener: Perhaps Fiona McKay can also comment on the future of those particular homes and how a new buyer can make them viable when the previous owner could not.

Fiona McKay: Finavon Court in Glenrothes has been bought by Kingdom Homes, which has written to the relatives. The sale is not concluded yet, because these things take time, but we have had from Bield a letter to say that ownership of the home will be transferred. We will support the service users, and their relatives and families, to ensure that the transfer happens smoothly. We know the company that has bought the home; it runs quite a lot of care homes in Fife, and we are confident that, if it can see the transfer through, this will be a good opportunity for it.

There is quite a lot of land around Finavon Court; we know that the new provider has in the past developed homes that it has bought, and I think that it will look at refurbishing this home. As Brian Logan has said, the care home in Glenrothes operates on a very different model from the care homes that the provider already runs, so work will probably be done to bring in more beds than are currently in place. It is good news that we have been able to find a new provider.

The situation in Dunfermline is very different. Bield has said that it wants to retain the buildings, but the people cannot stay, so we will have to look at different provision for those people. Luckily, there is quite a lot of new build happening in Fife. We are building care villages ourselves; one is due to open in April in Lumphinnans, which is not that far away.

We also have our own provision at present, and we are developing a new model of care in our own care homes; however, we have put a halt to that. The units are now sitting there with between eight and 10 beds each, and we hope to see whether people can transfer en masse from the care homes when we have carried out reviews of everyone. A lot of people want to go to the home that we have in mind, so it is really pleasing that we can produce a good outcome in that respect. Finally, the task group that we have set up is meeting again today to look at everybody who has been reviewed and what their choices are.

The Convener: I have a question for Brian Logan. Why could Bield not make the model work but another organisation can?

Brian Logan: First, I will comment on the situations in Glenrothes and Dunfermline, and then I will come back to that question.

With regard to Glenrothes, Fiona McKay is absolutely right; we are in advanced negotiations with Kingdom Homes to transfer the property across. We have had discussions with Kingdom and an offer has been made, and we are now going through a due diligence process. We are very hopeful that the transaction will be concluded as soon as possible in order to provide certainty for residents in that facility and their families, as well as for our staff.

We have not had any expressions of interest in the two smaller care facilities in Dunfermline. Since we made the announcement, we have had numerous expressions of interest across our suite of care properties, but there has been no interest in the Dunfermline properties. Obviously, if any expressions had come forward, we would have looked at them, but nothing has come forward to date—

Jenny Gilruth: Fiona McKay said that you want to retain the buildings. Is that the case?

Brian Logan: Hold on. I am just coming to that.

Jenny Gilruth: Sorry.

Brian Logan: Those two facilities are adjacent to and integrated with Bield retirement housing facilities. We will obviously undertake some sort of options appraisal, as we would for any surplus assets that we end up with, and consider what the best solution will be. However, given that we have retirement housing in those two developments that operates very successfully, it would make sense for us to extend the buildings and provide additional retirement housing facilities in those care homes. A bit of investment may be required to achieve that, but we think that that would be relatively straightforward, so we can do something with those assets—we can retain them within the Bield suite and continue to deliver some services for old people in Dunfermline.

On the question about how other providers can make the model work, it is not for me to comment on how other providers would make those individual facilities stack up—

The Convener: Wait a minute—you know the business and the market. How come other providers are making it work but you cannot do so?

Brian Logan: I am coming to that. Two private operators are taking over the facilities from us as a charitable organisation. If I were starting from scratch, I would, over time, move those facilities towards accommodating only self-funders, which would provide a higher level of income. I would potentially increase the level of fees in those

facilities to make the costs stack up. I would also look at pooling staff resources. Kingdom Homes has a number of facilities in a very narrow geographic area, so its ability to move staff between those facilities rather than having to use agency staff, who are very expensive, is much greater than ours. We have 12 care homes scattered across seven health and social care partnership areas, so our ability to deploy resources efficiently and effectively has been pretty limited.

As Fiona McKay alluded to, I would seek to increase the number of units in those facilities. In the past, we have increased the number of units in some of our care homes, but that requires significant investment. Given the level of losses that Bield has suffered, we feel that it is not an investment that we would be prepared to make.

The Convener: Just to be clear, the first thing that you said was that you would move out people who were funded by local authorities—

Brian Logan: No, no—

The Convener: You would do that over time, and ensure that there were more self-funders in order to increase income. That does not sound very charitable, I have to say.

Brian Logan: If I were a private sector operator, that is what I would do. However, that is not the business that we are in, which is exactly why—at least, it is one of the reasons—we have taken the decision to come out of the market. We are a charity and we have a social purpose. The reason why we set up those care homes in the first place was to provide good-quality care for people who were most in need, rather than people who could necessarily afford it. If we have to move to providing only for self-funders in order to make the business stack up financially, that is not a business that we want to be in.

The Convener: A number of people want to come in.

Sandra White: There are two strands to this particular conversation. The bigger strand concerns care homes, and staffing is also an issue. I have a question for Brian Logan—I declare an interest, as my mother and father were in a Bield home, although it was a residential home.

Can you clarify something for me? You seemed to say that your residential homes would continue to operate; the problems seem to have started since you entered the market for very sheltered and high-dependency homes. Everyone is talking about residential care homes, but nobody has mentioned high-dependency sheltered homes, although there was some mention of people being delayed in hospital. It is important to clarify the point that residential homes and high-dependency

homes are entirely different. When you went into the market—if you will pardon my use of the word—for high-dependency, very sheltered housing, was that when the problems began?

Brian Logan: For clarity, we provide three different types of accommodation-based service. We have what many of you will recognise as sheltered housing; we rebranded those facilities as retirement housing and withdrew support services some time ago, but we continue to provide an element of support to ensure that individuals in retirement housing can live comfortably and securely. There is no change to those properties as a result of the strategic change that we are discussing. As I said to Alex Cole-Hamilton, there is no change whatsoever for the 4,000-plus residents in those facilities.

The second tier is what would traditionally be described as very sheltered housing, which provides a higher level of support. Traditionally, we will have provided a bit more of an on-site staff presence and a meal service. We are currently making some changes to those services—again, because of pressures in housing support funding. We are withdrawing the housing support element, but we will continue to provide a meal service in those facilities. We hope that there will not be a substantial change for service users in those properties.

Our difficulties with our financial position have come about in the residential care home sector. That covers the 12 care homes that we are talking about, in which 167 Bield customers are affected. It is those homes that we seek to withdraw from, as we feel that we do not have a place in that market.

When we entered the care home market 20 or 30 years ago, it was a natural extension to our offering as a housing association and a provider for older people. As Gordon Paterson mentioned, we provided a level of service to people whose needs were far less complex than the needs of those who are now being admitted to care homes. It made sense for us to move into that market because it was still a way to promote independent living for older people. That is why the flats were designed to standards that provided double the amount of space that the Care Inspectorate would look for now; they have their own front doors and letterboxes, and their own kitchen facilities. For that reason, it was expected that people who were admitted to those care homes at that time would be able to live independent lives. That is not the case for the people who are now coming in. They have far more complex needs, often including dementia, and as a housing provider we no longer feel that that is a market that we should be in.

In addition to the financial loss that we are suffering on these particular care homes, we have

made a strategic decision, given that the situation has moved away substantially from our original intention 20 or 30 years ago.

Sandra White: I seek some clarity, as people have contacted me and other members for advice. Even if the changes to the national care contract that have been asked for were made, and extra moneys were provided—no matter what the offer was, or what we said or did—Bield would not continue to run that type of care home in the future and it would open up the facilities to other providers. Is that correct?

Brian Logan: That is correct. We feel that we cannot operate in that market any further. We are keen to keep those care facilities going if possible, as that is the best solution for residents and their families, and for our staff. We will do whatever we can to try to facilitate that, but Bield would not want to operate in that market.

Sandra White: So there is no way that we in this committee, or users out there, will be able to save your very sheltered and high-dependency care homes—you are withdrawing.

Brian Logan: We are not withdrawing from very sheltered homes—

Sandra White: We need clarity for the people who have contacted us.

10:30

Brian Logan: We are not withdrawing from provision of those services. They will continue, although they are being reformed. We are withdrawing from provision of 12 registered care homes. We are coming out of that market completely.

The Convener: That is absolutely clear.

Brian Whittle: Good morning, panel. I want to broaden the discussion by speaking about some care homes in my area that have gone into administration. As I understand it, in very recent times, the value of the business has plummeted. I know of one provider, for example, who invested a serious amount of money five or six years ago in developing and extending a care home against the value of the business, and then the business plummeted in value with the squeeze on income. The provider who purchases the company from administration will not be saddled with the same amount of debt as the previous owner was, if you follow me. For the period of time following the transfer, the model therefore becomes more sustainable, but it is surely not sustainable over a longer period of time. What does that suggest with regard to future investment in the sector? I hope that that all made sense.

The Convener: Perhaps Brian Logan can clarify one point about Bield's finances. Did Bield make a profit last year? Does it have reserves? If it does, what is the amount?

Brian Logan: First, on the issue of longer-term sustainability, the scenario that Brian Whittle described, which I guess concerns a private sector organisation, is for others to comment on. Our properties are currently debt free; there is no mortgage on the properties that are to be transferred. We have arrangements in place for the repayment of housing association grant money that was given to us to build the facilities in the first place, but we are factoring that into our financial calculations for running the business. There is nothing in Brian Whittle's general point with which I particularly disagree with regard to further investment in those properties and what that would mean for their longer-term sustainability.

In response to the convener's question on Bield's position, we said in our submission that, in relation to the care home sector, we lost something in the region of £375,000 last year. We have lost a similar level this year, and we have made losses in care homes for the past five years, which we have withstood by using our reserves.

With regard to Bield's overall position, we reported in our annual accounts an annual surplus of £1.7 million. As an accountant, I can say that the bottom-line figure in the accounts is an artificial number. I will not go into the intricacies of accounting treatment under international financial reporting standards, but it has rendered the bottom-line surplus that we report much less meaningful than it was previously. We have had to undertake a number of paper transactions around how we account for HAG money, pensions, planned maintenance work and shared ownership sales.

It is more telling that, if you look at our accounts and at our cash-flow statement in particular, you will see that there was a net cash outflow from Bield of £3 million last year. Obviously, part of that relates to the losses that we incurred around registered care. If you compare our operating surplus with the positions of the other 25 largest registered social landlords across Scotland—

The Convener: Mr Logan, I asked you a straightforward question. Did you make a profit last year, and what are your reserves? That is all that I am asking.

Brian Logan: I gave you the surplus position, which is £1.7 million. Our reserves position is over £60 million, but the bulk of that is made up of our housing assets. The only way to realise those reserves would be by selling those housing assets, which would mean that we would have no

business left. In terms of free cash reserves, we have an investment pot of £5 million—

The Convener: So Bield has no debt, £60 million of reserves and £1.7 million in profit. Is that correct?

Brian Logan: I said that we have no debt on our care homes. We are carrying some loans, but they are of relatively small magnitude in comparison with those of other housing associations.

The Convener: Thank you.

Alison Johnstone: We could discuss this topic over several weeks, but I am particularly interested in one aspect. One theme in the submission from Michelle Miller of the Edinburgh health and social care partnership is the increasing gap between the quality and security of care that is available to those who pay privately and to those who are supported by public funding.

Annie Gunner Logan pointed out in her submission that providers such as Bield are unwilling to run services at a deficit. She made a strong point in saying:

“To re-emphasise: this is not the result of a general improvement in the funding situation for social care. It is the result of providers either declining to enter the market in certain circumstances”

or withdrawing entirely, which obviously has a big impact.

COSLA pointed out in its submission that

“Local Authorities cannot afford to subsidise inefficient and/or unsustainable business models”.

We have spoken about facts and figures but, as MSPs, we are here to represent the people who are impacted by these decisions. You may have heard on the radio this morning campaigners articulating the cases of much-loved grandmothers who are going to lose their homes. The campaigners cite

“the right to respect for ... home”

in article 8 of the European convention on human rights, the United Nations principles for older persons, and the fact that relocation stress syndrome is recognised in North America.

We need to have a national conversation about what we can fund and how we fund social care, because funding is certainly insufficient at present. What about the people at the heart of this? Does Bield, for example, recognise relocation stress syndrome? What will be put in place for people who sold their homes because they saw Bield as a long-term alternative?

Brian Logan: We certainly acknowledge that such a move can cause significant distress and anxiety not only for the residents but for the

families. That is why the decision has been so tough for Bield to take, why we have wrestled with it over a number of years, and why we have tried to put in place many measures to avoid this particular situation. We absolutely understand the distress.

Day and daily, stories come to me—I, too, heard the radio reports that you mentioned—that cause me significant distress. None of us wanted to be in this situation, but we are in a position of last resort. Our focus now is on ensuring that the transition, whether it is to an alternative provider who will take over the care home lock, stock and barrel, or whether it involves transferring individuals to other care accommodation, is as smooth as it possibly can be. I give all credit to our staff on the ground, who have tried their very best—successfully, I think—over a number of months to continue to deliver a high-quality care service and to avoid any anxiety or disruption for the residents. They are trying to keep things as calm as possible.

Alison Johnstone: Can I—

The Convener: I will bring you back in. Annie Gunner Logan has something to say just now.

Annie Gunner Logan: I want to pick up on a number of important points that have been made. The convener asked why one organisation can make something work when another organisation cannot. We could equally ask why any number of third sector and independent sector organisations make the national care home contract rate work when public authorities cannot do so for their directly provided care homes, which are generally funded at a much higher rate. We might want to introduce that question into the discussion.

In the non-residential care sector, service contracts are transferred all the time because authorities re-tender them in pursuit of cost savings, and some providers come in at lower rates than others. We now have the living wage in the care sector, so the wage competition is not so great, which is a relief to everybody. However, there are still issues around pension provision, organisational overheads and the amount of supervision that staff get, which are all areas in which cuts can be made to make a service cheaper.

As our submission advises, more and more third sector providers are declining to enter those competitions, for the same reasons that caused Bield to withdraw. In the case of Bield, people are losing their homes, but every day people lose their trusted supporters because a service contract is transferred from one organisation to another but not all staff are transferred under the Transfer of Undertakings (Protection of Employment) Regulations. It is important to make that point.

On the point about profit, I want to be clear that charities can make operating surpluses—they can make profits. They are non-profit distributing, which means that any surplus that they return has to be reinvested in the organisation or the service. Most charities have a range of activities, and some return a surplus, but others do not. The extent to which a charity can cross-subsidise one area of activity from another is a matter for the charity itself and for the funding route through which it gets its money. For example, a council that was funding a charity to a break-even or surplus position would have something to say if that charity transferred surplus money to prop up a different service that another council was not funding to the same degree.

The point about charitable organisations concerns the extent to which we would expect a charity to prop up a public service from charitable income or from its own resources. That point is critical, because we are talking about public services that need to be publicly funded.

Michelle Miller: Annie Gunner Logan has made some really good points. Alison Johnstone described the tone of my submission with regard to standards as effectively saying, “National care home contract bad, private provider good.” If a service costs between two and three times the national care home contract rate, there will be opportunities for the quality to be improved. I recognise Annie Gunner Logan’s point but, in my view, the issue is less about the immediate debate about which model is better and how one organisation can do something while another cannot, and more about the fact that the system overall is underfunded in terms of what it can deliver. Within that, we can argue about the different models and how they might be more—

The Convener: I will stop you there, because we will come on to wider issues in a moment. I want to keep us on the Bield issue just for the next few minutes, because we are almost halfway through our session. Perhaps people can indicate if they want to raise any issues that relate specifically to Bield.

If no one wants to raise any more specific issues, we will move on to wider issues. Does Alison Johnstone want to make any final points?

Alison Johnstone: I feel that there is a conflict around prioritising quality individualised care over economies of scale. It feels as if the approach is finance driven rather than needs driven. I am very concerned about that, and I would like to hear more from COSLA and from Michelle Miller of the Edinburgh health and social care partnership about how local authorities are working together, especially now that we have integration. We are being presented with a very challenging picture today.

The Convener: There are a number of questions that I and perhaps other members have for Bield specifically. We will write to Brian Logan with those questions after the meeting, if that is okay. Would anyone like to address the issue that Alison Johnstone raised?

Dr Macaskill: Alison Johnstone quite rightly referred earlier to the heartfelt stories that were broadcast on the radio and television this morning, which a number of us heard and saw. Ultimately, nobody works in the delivery of care if they do not have people at the heart of their concern and attention. However, Alison Johnstone was also right to say that the problems with social care are a human rights issue. My background is essentially in the realm of human rights, and I highlight that this is human rights week and that Sunday was human rights day. We are talking about not only the profound rights of individuals but the priority that we in Scotland place on care and support for older people.

Michelle Miller is absolutely right: Bield is a symptom of a disease, which is the current underfunding of social care in Scotland. That is profoundly the case not only in the care home sector, which we are discussing today, but in care at home, housing support and other areas. It is quite right that we home in on individual stories of pain, distress and emotional trauma that individuals experience when their home—a care home placement is somebody’s home—is taken away from them through no fault of their own and as a result of factors beyond their control. However, it is extremely important that we concentrate on the bigger picture, which is the question of how much—at the end of the day, it is a financial question—we in Scotland are prepared to pay for the support and care of most of our vulnerable citizens, whether they are in a care home or in the community.

10:45

The Convener: I think that we would all agree that that is the nub of the debate. We brought Bield before the committee to discuss whether the fact that such a long-standing, credible and well-established provider is in trouble indicates that there are underlying problems in the whole system. That is what we want to find out today.

Dr Macaskill: The submission from Scottish Care highlights that issue. Bield has a long history of dedicated, person-centred care; it is not a member of Scottish Care, but I know of its reputation and—like Sandra White—I know individuals who have been residents of Bield homes. If a charitable organisation such as Bield is unable to continue to deliver the care that it has delivered thus far, that raises profound concerns. You are quite right to say that other organisations

are thinking seriously about whether they can continue to deliver services, given what public authorities are able to pay. To date, the national care home contract has enabled a level of sustainability in Scotland that has not been possible elsewhere, but that sustainability is now profoundly in question.

The Convener: Perhaps Paula McLeay can comment on COSLA's position.

Paula McLeay: On which bit?

The Convener: The whole bit. [*Laughter.*]

Paula McLeay: A lot has been said about the national care home contract, and I know that members will have specific questions on not only the contract and the rate but the whole system. I do not know whether you want to ask me individual questions, or just have me speak—

The Convener: Basically, we are discussing the fundamental issue of the sustainability of the system in which all the panel members operate.

Paula McLeay: COSLA's submission on the spending review and on fairer funding for local government makes clear our grave and significant concerns about whether social care in the round can be sustainably funded in the future. We look to the Scottish Government, through the spending review, to provide assurances; to support local government to support social care; and to provide fair funding and invest in care services, which are critical to all our communities. We are concerned about a combination of issues—keeping up with demand, the complexity of care, demographic change and workforce pressures—and the ability of local government to respond to them when our core budgets are being cut, services are being underfunded and additional burdens are being placed on councils.

Having made that statement, I agree with everybody round the table about the need to prioritise care, and to ask fundamental questions about how much we, as a society, are prepared to pay for social care and where we can get that resourcing from.

Local government is currently in the position of making very difficult budget choices. Historically, we have prioritised social care budgets, in which there have been real-terms increases over the past 10 years despite significant cuts to other aspects of local government funding. However, there is a question about how long we can continue to prioritise and protect social care funding, while acknowledging that, despite our historical prioritisation of that budget, we are not keeping pace with demand and are having to make difficult choices.

In making those choices, we need to look at the system in the round. We have to ask how we

ensure that we balance the need to meet the demands of our communities, and the number of people in the system who are asking for and who need support, with support for businesses and independent third sector providers whose business model might not, over time, have kept pace with the efficiency model. I know that Bield has highlighted the size of its businesses, the historical configuration of the capital and so on as issues that are specific to its circumstances.

There are difficult choices to make. In making them, each local authority and integration joint board is very concerned to protect individual outcomes and look at what is best for the older people who receive care in those institutions, and to ensure that, if a situation such as the closure of Bield homes arises, they are supported to manage the transition so that they do not experience relocation stress and so on. However, the issues that I have described are symptoms of overall underfunding in the system.

On the national care home contract, I want to put on record that local government in Scotland has prioritised and protected its relationship with the care home sector. Over the past 10 years, there have been year-on-year increases in the national care home contract rate, which has gone up by more than 42 per cent during that period. That is in stark contrast to the situation in the rest of the United Kingdom, where 81 per cent of local authorities have reduced their care home rate and more than 50 per cent of authorities have reduced it by more than 10 per cent.

Local authorities have a strong record of valuing—and, as partners, investing in—the sustainability of the care home sector. However, the environment is shifting, and we need to understand what is required for care to be sustainable into the future. That is partly about the business models and the models of care that are used. However, needs are becoming more complex, and we need to look at how the system responds to that. Integration is in that space; it involves looking at how people who are currently in hospital can be better supported in care homes through different models of care.

We are looking at shifting the balance of care. However, we face further pressures in the system that are not all about the rate. There are issues with workforce availability in different parts of the country—in Edinburgh, for example, where there are difficulties in finding people to provide social care.

The Convener: I will stop you there—we will come on to the issues around workforce and provision soon.

Paula McLeay: All those issues, alongside the rate, contribute to our thinking about sustainability

in the round. The national care home contract rate is, and has been, a good foundation for care home sustainability over the past 10 years, but local government has recognised that a single contract with a single rate is in itself perhaps not sustainable into the future. We have different markets in different parts of Scotland, and there are issues with market competition and with actual capacity in the market. In some areas, the capacity meets the need, whereas in other areas it does not. In some areas, investment is needed, whereas in other areas it is not. We need a more sophisticated model, and we are seeking to reform the contract in order to respond to that need.

Ash Denham: I want to pick up on a point that is made in the COSLA submission. It says that, historically, Scottish providers have been “relatively stable and protected”. As you said, that is partly a result of the care home contract. There is currently a programme to reform and develop the contract, and to develop a cost-of-care calculator. How will a cost-of-care calculator help the sector? Are additional reforms needed as part of that development?

Paula McLeay: The cost-of-care calculator is, at its core, a way for providers and commissioners to develop a shared, transparent understanding of what it takes to provide a care home place. However, as you are aware, there are different business models and different markets across Scotland, so even if there is a shared understanding of how a single cost for care provision in a care home is broken down, that might not reflect the specific business pressures on each care home facility in each local authority.

Alongside our work on the cost-of-care calculator, we are looking at how we enable variation in the contract in order to respond to different models of care—such as enhanced nursing care or enhanced residential care—so that we can provide integration authorities with the tools to commission more responsive models in their care homes and with a transparent funding basis on which they can come to an agreement as to how those services will be paid for. There is a mix—we are not only developing a cost-of-care calculator but looking at a mechanism to vary that according to the models of care that authorities would like to commission to respond to the needs in their community.

Ivan McKee: I will move on to the types of model that are out there, and integration, but first I want to explore Dr Macaskill’s comments a wee bit further. He said that there is an underfunding issue, which I understand. It is clear that, in the current environment, the provision of care is becoming more expensive year on year—as we have seen over the past five to 10 years—as a result of various issues. Can you quantify how big

the underfunding gap is in the current year, and what it might look like over the next five to 10 years as trends such as the ageing of the population and the change in the profile of needs continue?

Dr Macaskill: That is a good question; I wish that I had had some notice of it as, unlike Brian Logan, I am not an accountant. A fortnight ago, the Competition and Markets Authority issued its report on the state of care homes in the United Kingdom—

Ivan McKee: I am talking specifically about Scotland.

Dr Macaskill: In that report, the CMA indicated that there was a shortfall of £1 billion across the UK. In Scotland, as Paula McLeay of COSLA indicated, we are not facing the same degree of percentage differential between what is paid by a self-funder and what is paid by someone who is funded by the public purse.

In the current year’s deal, there was a 2.8 per cent increase in the national care home rate, 1.8 per cent of which went on statutory duties on salaries and the national and the Scottish living wage. It is true that, in the past three years, there has been an increase of 18 per cent for charitable and independent care home providers, but 72 per cent of that has gone towards paying the salaries of the workforce; I know that we will go on to talk about the workforce in a minute.

We estimate—to use last year’s figures as an example—that the 1 per cent that went to non-salary related costs fell short by 7 per cent. We are working extremely closely with our colleagues in local government to draw up a transparent cost-of-care calculator. By “transparent”, I mean that if I go into a care home, I should know what my money is buying; that a local authority or integration joint board that buys care provision should know what it is buying; and that providers, whatever their business model, should know what is expected of them. Transparency is extremely important.

As a result of that exercise, we are, along with our COSLA colleagues, profoundly concerned that, although our model has been fundamentally sustainable to date, the issue of sustainability is facing us very sharply. As I said earlier, it is about not just numbers but people.

Ivan McKee: I understand all that, but I want to press you on the question. If I was Derek Mackay sitting here, with the budget coming up this week, and I asked you for a number, what number would you give me?

Dr Macaskill: If you are talking about the whole of social care in Scotland—

Ivan McKee: In Scotland—yes.

Dr Macaskill: I estimate that we need to invest north of £1 billion across the realm of social care to enable our integration joint boards to properly fund delivery. As COSLA highlights in its submission, it was promised that £500 million would be set aside to be transferred from the acute sector to community and primary care, but that transfer has not happened. Integration joint boards and by implication providers, and by further implication the people who receive care, have not seen that transfer from the acute sector of the national health service to the community.

That highlights the gap that exists. With regard to sustainability and our ability to maintain current services, never mind developing the rights-based system that the Care Inspectorate requires in its new national care standards, we are some distance away. I am more than happy to go away and do some thorough arithmetical exercises with colleagues—

Ivan McKee: Is it not your job to understand this stuff?

Dr Macaskill: Yes.

11:00

Ivan McKee: I am hearing a lot of words, but not much in the way of numbers, and the numbers that I am hearing are all over the place. You have said that an extra £1 billion is needed across the UK, but you have also said that £1 billion is needed for Scotland. Can you be quite specific, or do you not have the number?

Dr Macaskill: The £1 billion extra for the UK is for the care home sector. In the Scottish context, my conservative estimate, given the gaps in the whole of social care provision from children's services to older people's services, is that we need a further £1 billion over the next three years.

Ivan McKee: So you are talking about an extra £1 billion over the next three years.

Dr Macaskill: Yes.

Ivan McKee: Which would equate to approximately a third of that amount per year.

Dr Macaskill: Yes. One of the reasons for saying that is that the Government has committed £500 million to early years provision, which will create 20,000 jobs in the next 18 months. Meanwhile, we are faced with a critical shortfall in social care, given that nine out of 10 providers are finding it difficult to recruit. People can earn more for stacking shelves in a supermarket in Edinburgh than they can for caring. Over the next 18 months, we will be faced with an even greater criticality. The only way that we can hold on to carers and the workforce, and build caring as a career of

choice, is by having fiscal investment across the board.

Ivan McKee: So you are talking about more than £300 million this year, just for social care.

Dr Macaskill: Yes.

Ivan McKee: That is on top of everything else that is added in to the health sector spend, such as what is happening in childcare, education and so on. How would you fund that?

Dr Macaskill: I am not a politician—it is inappropriate for me to comment on what mechanism should be used. With due respect, that is up to the elected members round the table.

Ivan McKee: You understand—because it is your business to do so—the changes in requirements that have taken place over the past five to 10 years. If you project that forward, what percentage increase do you think would be required to maintain pace with the changes in age profile and in requirements?

Dr Macaskill: We know that the demographics will go in only one direction, which is great. People are living longer, which is fantastic. However, one of the consequences is that people are living with multiple conditions much later into life—

Ivan McKee: We know that—I am asking for a figure.

Dr Macaskill: From that perspective, I have to say that we need a grown-up, non-party-political debate about how we fund social care.

Ivan McKee: That is not what I am asking you.

Dr Macaskill: To be blunt, Mr McKee, nobody in Scotland has done the analysis to find the true cost of social care—we do not currently have the arithmetic. I can undertake an analysis from my perspective of the cost of care at home, housing support and care homes for older people, but nobody has done the arithmetic to look at the total picture of how Scotland will be able to afford to care for our most vulnerable.

Ivan McKee: I am sorry, but is it not your job, as the head of Scottish Care, to understand that? I am asking you, based on historical trends in increases, to give me a figure for the percentage increase that is required. You understand the demographics, the age profile and the cost pressures. Are you not able to put a number on that going forward?

Dr Macaskill: I have just put a number on it. In my estimate, we need £1 billion over the next three years—

Ivan McKee: But you cannot give me a percentage increase year on year going beyond—

Dr Macaskill: Beyond three years? I would not want to do that, because it would be inappropriate.

Ivan McKee: Okay—

The Convener: Sorry, Ivan, but we might want to open up the discussion.

Ivan McKee: I will throw in a couple of things to broaden out the point a wee bit. We have discussed a range of provision, from hospital care to staying at home and everything in between, including very sheltered housing and different models of care home provision. Is there an issue there? Bield was providing one aspect of care, which sat between very sheltered housing and more traditional care home provision. Is there an issue with the way in which the model is configured that means that it does not support that aspect, which is clearly more expensive, or is such provision not needed in the model?

I have a second point, which the witnesses may want to pick up on. A couple of the submissions highlighted issues around the transfer of funding through the integration model, which was mentioned earlier, and the problem of bed blocking, which is clearly very expensive—it is more expensive than care home or at-home provision. The submissions seemed to suggest that, despite integration, there are issues with the mechanisms for transferring funding. Looking at the whole system, it is clear that that is problematic, because the money is not going to the right places.

The Convener: Paula McLeay and Michelle Miller indicated earlier that they wanted to come in—perhaps they can cover those issues as well.

Paula McLeay: As a point of information, in its recent audit of social work, Audit Scotland estimated that if nothing changed in how we provide social care, the sector would still need 16 to 21 per cent more investment by 2020. Obviously, we cannot continue without looking at how we might change our models of care, if only because we will not have the workforce to continually grow what we do. The Audit Scotland estimate assumes that everything will stay the same, which will not happen, but it provides an independent analysis of how much pressure there is in the system.

Michelle Miller: Much as an extra £1 billion over the next three years, as Dr Macaskill requested, would be fantastic, my concern would be that, if we were to use that money simply—I use that word advisedly—to shore up or fund the model that we have historically used, and which has grown in size to its current level, we would then come back in three years' time and ask for another £1 billion, and another £1 billion after that.

We need to make a fundamental change. The integration authorities have not just an opportunity but a statutory responsibility, through their strategic planning and shaping of the market, to say that we need a different model of care that focuses on individual choice, self-determination, control and prevention. A wide range of different aspects is involved, which will end up creating a system of social care to which individuals aspire and which is sustainable.

If the committee said, "Here's £1 billion—just fix the problem", our answer should be no. We need to spend that £1 billion very differently. We need to change the model not only in order for it to be affordable, but because it should provide something that is better and that people want more of as opposed to what has gone before. I do not wish to imply any criticism of what has gone before, but the world has changed. People tell us that they want more control. The voluntary sector has driven a lot of innovation, but we should not rely on individual small pockets of innovation and change. We should be thinking about the whole landscape and how we garner all the available resources to create a different picture for social care as we move forward. We can seek input from the people who use our services and from those who care for those people to help to shape that model, rather than just promoting something that has always been.

Annie Gunner Logan: I share some of Ivan McKee's frustration about the numbers in this area. Each of our member organisations could tell you how much more they need to keep their operation going and their services sustainable, and I could add that all up and put it to the committee, but that would not get us very far.

To go back to what Michelle Miller said, the duty of integration joint boards to plan strategically for future care needs is partly what the whole issue is about. It is still early days in that respect, but a number of organisations, including user-led organisations, have been pressing the Scottish Government for a number of years to look at setting up a commission, or a similar exercise, on the funding of social care. Such an exercise could gather all the necessary information from Donald Macaskill, Michelle Miller, me and everyone else, and look at the pan-Scotland, whole-systems picture. That has never happened, and the committee could help us by pressing for the establishment of something like that.

Dr Macaskill: The chair of the Scottish Human Rights Commission, in a lecture that was published on human rights day on Sunday, made a strong and passionate case for the establishment of a commission on funding social care in Scotland.

Alex Cole-Hamilton: The politicians round the table visibly recoiled at the idea of having to find £300 million every year for the next three years, and additional percentages on top of that. However, it is not as black and white as that—there is a virtuous circle. If that money was able to fund places for 80 people who would otherwise be waiting in hospital at a cost of £400 or £500 a night, it would free up capacity and improve the flow in the health sector as a whole, which would have an impact across the spending chain. Am I right?

Michelle Miller: Absolutely. On the one hand, having the levers to shift those resources is one of the real opportunities of integration. On the other hand, although it is still early days, the weakness is that we have not achieved that shift. We need to focus on driving that change, because the reason for integration in the first place was partly to enable us to look at two big bureaucracies that are doing different things with an awful lot of duplication and preservation, and to be the grit in the system that changes that situation and allows the significant shifts from acute care to community care, prevention and so on that will make a difference. We have the framework to enable that to happen, but it has not happened yet. That is one of the really important aspects that we need to unlock in relation to social care.

Colin Smyth: A lot of people have spoken about the need for change; I have a couple of questions on that. What exactly are the barriers to those changes? Most of the submissions say that the national care home contract has served its purpose but that, to be frank, it is no longer fit for purpose and needs to be reformed. Paula McLeay mentioned the work on the cost-of-care calculator that is currently taking place. When will those reforms actually be implemented, and when will we see the changes taking place?

Paula McLeay: We have been working on the national care home contract reforms for more than 18 months. That work is coming to a head, but it is not complete. We have made a commitment to local authorities, IJBs and providers alike to circulate a progress report by the end of December and to take a decision by the end of January on whether we will progress with a reformed national arrangement. Thereafter, we will complete the work that needs to be done as part of the reform process.

Some things will not be delivered within that timescale. We will not have all the answers on how we will configure variations to the contract by that time, but we have made a commitment that that is how we want to approach the relationship between commissioners and providers for the foreseeable future. If that work is not endorsed by our respective partnerships, we would be looking

at local negotiations, and the contract and its national configuration would end.

Colin Smyth: Why would IJBs or local authorities not endorse a model that reflected the additional services that they would require? Would such a decision be purely financial?

Paula McLeay: No—those are all choices to be made collectively. Scotland is not one market, and there are different conditions locally, so when authorities and IJBs look at the arrangements that we are working up, they will need to reflect on whether those are suitable for them and provide them with what they need.

We hope that we will have done our job by engaging with, consulting and surveying our members, and that we will propose a solution that everybody will endorse, but our constituencies will have to make their own choices. COSLA offers no guarantees in that regard.

Colin Smyth: On the wider point, what other barriers are there to the changes that we need? There is a major need for a substantial increase in investment in social care—there is no question about that—but, with the best will in the world, you are probably not going to get £1 billion over the next three years. Michelle Miller said that, if you got that money to spend under the current model, it still would not be enough. Why are those changes not happening?

Paula McLeay: One of the biggest barriers is our inability to shift the current balance of care from acute care to community and social care. Our inability to utilise the budgets as per the provisions in the Public Bodies (Joint Working) (Scotland) Act 2014 is a major barrier to the future sustainability of social care.

The Convener: Is that because of the lack of transitional cash to make that happen?

Paula McLeay: It is because of the lack of transitional cash and our inability to shape and utilise the unscheduled care budget.

11:15

Dr Macaskill: I completely agree with that point. Just in case any hares were set running, I was asking for £1 billion to be spent not on the status quo, but on reforming the system. There is a considerable degree of unanimity among providers, commissioners and people who use services around the idea that we need to do things differently.

The real challenge goes beyond finance. Even if we get across the line at the beginning of the year—I hope that we will; there is a lot of energy behind that drive—will there be people out there who want to care? Every day, I get an email from

someone who says that they are handing back work because they cannot find staff who are willing to care. This morning, I got an email from someone whose husband is living with dementia and his behaviour has deteriorated to such an extent that the local provision can no longer support him. There are no other care homes in her remote area that could provide that support, so she will, with her husband, have to decide whether to have him placed in a hospital setting, which will deliver fantastic care but at some distance from their home.

The reason why that care cannot be delivered locally relates not to money but to people. Fundamentally, we have a problem in that there is an insufficient number of people out there who are prepared to care. That is maybe not surprising, given that the national average hourly rate for a labourer is £11.50, whereas for carers the average is £8.45, going up to £8.75. That is the bigger picture, which goes way beyond care homes into the fabric of care itself.

Emma Harper: Donald Macaskill touched on the issue of staffing, in which I am interested. The Scottish Care submission states:

“Nurses are critical to ensuring safe and effective delivery”.

My first job, before I started my training as a nurse, was in a care home. If we look at the statistics on nurses who are giving up their registration, or the stats on recruitment this year in comparison with last year, we see that there are major challenges. Are there recruitment challenges in rural as well as urban care homes? What will be the impact of our exit from the European Union in terms of the care home staff who are providing care right now?

Dr Macaskill: Brexit is already having an impact—and it will be quite profound. We estimate that 8 per cent of individuals who work in social care nursing, and 6 per cent of general social care staff who work in care homes or provide care-at-home services for older people in particular, come from the European Economic Area.

We have profound concerns. There is a nursing vacancy level of 31 per cent in social care, and we are actively seeking solutions and working with the chief nursing officer to address those issues. A fundamental issue is highlighted in the survey results that were published this morning by the Royal College of Nursing Scotland, which reveal the degree of distress and emotional fatigue that the job of nursing is leading to. I suggest that the impact in the care sector is even greater. Last month, we produced a harrowing and disturbing report called “Fragile foundations: Exploring the mental health of the social care workforce and the people they support”. We need to start caring for

the carers, or our current recruitment difficulties will appear small in comparison with the potential future situation.

Emma Harper: I have a supplementary on the earlier questions about different models of care. As we have seen, technology is being used to support the delivery of care. There is Interreg funding across Ayrshire and Arran, and Dumfries and Galloway is looking at the mPower programme and the use of CoSign digital technology. We need to invest in technology to support the delivery of care, although that is not the whole answer.

Dr Macaskill: Absolutely—technology has a role in enabling the delivery of care, but it can never replace the presence of people, especially for individuals who are at the end of their life. Most people nowadays are in a care home for about 18 months; many of them will die there, and it will be the last place that they call home. They will be supported at that point by dedicated palliative and end-of-life staff. Technology has a role and a presence in supporting that care, but ultimately most people, at the end of their life, will want to have a human touch there.

Providers are among the most innovative and entrepreneurial individuals in their efforts to make care more person centred. We need to maximise technology to enable care, but it will never replace presence.

Sandra White: I have a very small question on staffing—most of my questions have been answered. Do you agree that working in the care sector is frowned on? I hate to use the word “sexy”; I mean that people do not see it as the type of career that they want to go into. In addition, caring is predominantly a job that is done by women. There has to be a decent wage for those who work in care, but, given that we are talking about the establishment of a commission to look at care, we should also look at training people up and offering careers in the care sector that people want, rather than having them just going into and out of care jobs. My big worry is agency nursing. Why are so many agency nurses, rather than bank nurses, being used?

The Convener: I ask Donald Macaskill to hold off for the moment—you have had quite a say, Donald. Does anyone else want to respond to Sandra White’s points? If not, I will bring Donald in.

Annie Gunner Logan: There are 200,000 people working in care just now, and not all of them are miserable—a lot of people are doing a fantastic job and are really enjoying it.

Forgive me, convener, but it is never long before I start talking about commissioning. We commission services that involve 15-minute visits

by carers who simply go in and out, and that role is not particularly attractive to people. If we worked much more collaboratively with providers to look at all the different models—we have talked about the changes that we need to make—we could redesign care in such a way that people would be very attracted to it as a sector in which to work.

There is quite a difference between services that support adults who have learning disabilities and services that involve 15-minute timed-task visits to older people, which is where many of the acute recruitment problems are. The way in which we commission care means that the jobs are often not very attractive; we could go much further in sorting that issue out.

Sandra White: We put a lot of emphasis on, and money into, training people through apprenticeships. A care career could be similar, and the end product could even be a career in nursing. My other question, on agency nurses, is perhaps for another time.

Miles Briggs: The committee has done work on making caring a career choice, although we have had no response from the Government on a number of the points that we raised. I want to look at the future and the issues that we know are coming.

As Donald Macaskill highlighted, the Government is focusing on putting 11,000 staff into childcare rather than adult care. How will that impact on the potential pool of people who might be looking to take up a career in the sector? Also, the Government is drafting a bill on safe and effective staffing, which will cover the social care sector and nursing provision. What are your thoughts on the bill at this point, before it is introduced to Parliament?

The Convener: We are very short of time—we have only seven minutes left for this evidence session, so I ask the witnesses to be quick in their responses.

Paula McLeay: Those are very good questions from Miles Briggs. On the workforce issue, we make the point that we cannot look at adult social care in isolation. We have to look at the social care workforce across adult and children's services, in the context of local labour markets. The existing workforce pressures, and those that are coming as a result of the early years entitlement, extensions to free personal care and so on, raise significant questions about where we will find staff. There is a significant question about how older people's care can be competitive in the workforce when set against children's services. Such tensions will really affect the sustainability of the care sector in the immediate and foreseeable future.

COSLA is very disappointed by the way in which the Government's safe and effective staffing bill was belatedly extended to cover social care; I am sure that we will be back to discuss it in some detail in the future.

Annie Gunner Logan: On the point about the childcare jobs, there is some anxiety in our sector—although it is just speculation—that they will be populated by people who are currently working in adult care. That may be to do with the promotional activity for that sector—activity that is missing in relation to social care. Donald Macaskill and I, and a number of other people, have made that exact point very strongly in our discussions on the national workforce plan for health and social care, which is an on-going initiative.

To back up what Paula McLeay said about the bill on safe and effective staffing, the first time that CCPS and its constituency of third sector providers knew about the extension of the bill to cover social care was about three weeks ago. A consultation was done much earlier in the year, but it was framed entirely around nursing and midwifery, so we and our members did not prioritise a response to it. Social care has been brought into the bill very late in the day, and we share COSLA's concerns about that.

The Convener: I have a few questions to finish with. This committee has a real focus on health inequality. The submission from the Edinburgh health and social care partnership states:

"On the one hand, we see ... providers in the ... affluent parts of the city who can ... charge"

top dollar to cover all the costs and who employ well-trained staff who provide an excellent service. It goes on to say:

"On the other hand, we have a market where provision tends to be clustered in older buildings, in less-affluent parts of the city, with the increased challenges of maintaining"

grades, recruitment and so on.

Are we now seeing a growing gulf in inequality of care surroundings and facilities, and the whole package that is provided to people, on the basis of their income?

Michelle Miller: The answer is probably yes, but the issue is much wider. The inequality gap is growing generally across the board, and the negative potential of that is significant. There is an awful lot of talk and strategic intention around the need to reduce those inequalities—not just in health, but across the board—and the impact that that could have, but we do not seem to focus our resources on actually doing something about it.

The Convener: Absolutely.

Michelle Miller: All the research shows that if we tackle the inequality gap, rather than just leaving it or letting it grow, there is a disproportionate impact on the whole population and on all the issues. We need to turn that research, and what we know, into strategic planning, commissioning, action and resource allocation to start to tackle that inequality. That is what I was trying to get at in referring to the longer-term vision that we need to develop about what the system needs to look like and how we might have more detailed discussions about how we fund it.

The Convener: We hear a lot of rhetoric from leaders in the sector, members of Government, civil servants or whoever about how we are reducing the health inequality gap, but in this regard the rhetoric is not matched by the reality on the ground. Is that correct?

Michelle Miller: The rhetoric seems to be about the intention, but we do not see the action and the resourcing, and the evidence that things are making a difference. We are looking at an increase rather than a reduction in inequality. We absolutely applaud the intention, but fundamentally, we need to do something proactive that will make a difference rather than just talking about it.

The Convener: I have a daft-laddie question about the charges for care. If self-funders are in the same care home and are presumably getting the same service as people who are funded by the local authority, why are their charges much higher?

Dr Macaskill: They are not necessarily getting the same service. The Office of Fair Trading has made it clear that there must be a differential to justify a provider charging an individual more than the cost in their business model.

11:30

As we have heard from several people today, the provider will ascertain the true cost of care. We are developing a model for calculating the true cost of care so that the true cost of everybody's care will be transparent, whether they are self-funded, publicly funded, local-authority funded, privately funded or charitably funded. We hope to complete that work by the end of January.

The Convener: Presumably, a large number of people who are funded by local authorities or are publicly funded in some way live next to someone who is self-funding but who is paying exactly the same rate. Do those people exist in large numbers?

Dr Macaskill: According to the most recent research, about 33 per cent of individuals in

Scotland are self-funders. The majority of care home provision in Scotland serves individuals who are paid for from the public purse.

The Convener: I am asking a very specific question about someone who is paid for by the public purse living next door to someone who is self-funding and who is getting the same service. Are there significant numbers of people in that situation who are paying exactly the same rate?

Dr Macaskill: A self-funder will be paying more than the public rate.

The Convener: Irrespective of whether or not they get the same service.

Dr Macaskill: Under the law, a self-funder is required to receive a better or different service. We talk about health inequalities, but we are actually talking about care inequality. I agree with you, convener: it is unacceptable that because someone is able to pay, they get, in effect, better-quality care and support.

I am being very careful in choosing my words. The quality of care that people receive must meet the criteria of the Care Inspectorate; I see that Gordon Paterson wants to come in on that point. However, additional services such as a cinema, and the ability to go out and engage in activities—all those extra things that make a difference for individuals—will not be possible for many individuals in a publicly funded care home, while they will be possible for individuals who live in a certain part of Scotland and who have the resources to enable that to happen. I agree that that is inequitable, and it is part of what the national care home contract discussions are looking at: how can we transform the system so that we create care equality?

Gordon Paterson: The Care Inspectorate does not have sight of how people who are receiving care are funded and what their contractual arrangements are—we concern ourselves with the quality of care regardless of those aspects, and we do not have a locus in that respect. However, to use our grades as an indicator of shifts in quality in the care home market for older people in Scotland, we have seen improvements. In 2013, 7 per cent of services attracted our lowest two grades and 34 per cent attracted our top two grades, whereas this year the figures are 2 per cent and 41 per cent respectively.

Against that backdrop, we are seeing improvements. That may well be because the poorly performing care homes are no longer operating and have exited the market, or it may be a consequence of our commitment, as the regulator, to support improvement and sustainability and to seek to advance a number of means to do so. Nonetheless, we do not have sight of whether the experience of people who are

state funded is different from the experience of those who are self-funded.

The Convener: I would be very interested to see what the differentials are between people in those properties, and what is gained for the extra money. What we are really saying is that people who are publicly funded are getting the base-level service, and everyone who is self-funded is getting an additional or enhanced service. That is what we are saying, is it not?

Paula McLeay: No—I would object to that.

The Convener: How would you describe it, then?

Paula McLeay: Under the national care home contract, we ask that the rate covers everything that is required to meet an individual's needs according to the quality standards that the Care Inspectorate applies. We are not paying for substandard care or for less care—we are paying for care that meets an individual's needs at the rate that is set. I am not negotiating a national care home contract that will pay for cinemas, but leaving that aside—

The Convener: What are the people who are self-funding paying for?

Paula McLeay: That is a question for providers, but just because self-funders get more for paying more, it does not mean that people whose places are paid for by the local authority are getting substandard care—they are not. We are not paying below the cost of care for substandard care—we are paying for high-quality care to meet individuals' needs.

The Convener: But those who are publicly funded are missing out on something. If some people are getting something that they are not getting, surely they are missing out.

Dr Macaskill: As Paula McLeay highlighted, the national care home contract delivers high-quality care, but other individuals, because they have personal resources, are able to purchase additional services and provision in the same way that all of us, if we have greater wealth, are able to exercise a degree of choice. In that sense, somebody is missing out on something. The critical issue is how we improve the level of care—which is already good, as Gordon Paterson articulated—to such an extent that individuals are able to exercise a greater degree of control—

The Convener: I am sorry: I just want to make a final point. Self-funders do not have the option not to purchase those additional services; they only have the option to purchase additional services, because they are self-financing. They cannot go in at the same rate as someone who is publicly funded—that is what you told me earlier.

Dr Macaskill: No. It would be unusual for somebody who was funding themselves to be charged the publicly funded rate because the organisation would normally be delivering additional services. If someone is cared for under the national care home contract, and they need additional services, there is provision for those services to be funded. Each individual's needs are assessed on their own particular outcomes. We should bear in mind the fact that the majority of people go into nursing care with high-level clinical needs, and the national care home contract currently enables a focus on delivering high-quality care to those people. In residential care, somebody might move in of their own volition and choice and might stay there for five or six years, and it is in that sector that there is a greater rates differential.

The Convener: We could be here all day talking about some of this stuff. We are way over time already, and we still have a very important session to come. I will whizz round the table and give people 20 seconds to have their final say, or final ask. I also ask everyone to comment on Annie Gunner Logan's suggestion that the Government should establish a major commission on social care. I know that various political parties have called for such a commission—I led the call in my own party, and I think other parties have done the same; it is a very informative process. Perhaps people could comment on whether that would be a good approach. You each have 20 seconds and no more.

Paula McLeay: COSLA's position on care homes and on social care in the round is that we need to look at whether there is sufficient resource in local government in general, and specifically in social care, to meet future needs and demands. How we do that—whether it is through a commission or something else—is another question, but we need more reassurance that the core budgets that are in place, and the additional budgets that have been agreed generally through financial memorandums that support legislation, are adequate at the time that they are agreed and on an on-going basis thereafter where there are increases in cost.

The Convener: You are well over time.

Fiona McKay: I welcome the discussion—we really need to look at setting up a major commission in order to move forward. As we started to deliver new models of care, we struggled with getting general practitioners involved, but with integration we are starting to have better conversations. Nonetheless, when people come into a service or a model for four or five weeks and then move on, it is a big ask for a GP to keep picking them up, especially if they are

no longer in the vicinity. I would welcome taking a look at establishing a major commission.

Dr Macaskill: Scottish Care supports COSLA's statement that we need to look seriously at the overall funding of social care. In addition, we argue that, while we applaud local initiatives and individual policy initiatives, we need to join those up. I was one of the early signatories to the call for an independent commission to look at the funding of social care, which would include looking at the role of the citizen in funding care, so we certainly support that idea. That is different from looking at the system and how we reform that—we are all involved in that, but nobody is really looking at how we are going to pay for it.

Gordon Paterson: We have been advocating an asset-based approach to individuals who use care services, so that we do not define them according to what they lack but instead see them as citizens who have ambitions and hopes. We need to think about the social care system the same way. We need to see it as a positive thing rather than a drain, an investment rather than a cost and a career of choice in which people are rewarded and remunerated and in which they find security and fulfilment.

The Convener: Do you support Annie Gunner Logan's suggestion that a commission should be established?

Gordon Paterson: Yes—we support the idea that we should look more forensically at some of the challenges and opportunities.

Brian Logan: I simply reiterate that the decision to pull out of the market has been intensely difficult for Bield, but if any good has come out of it, it is that it has pushed the issue up the political agenda and opened up the debate. I hope that the outcome of that will be an on-going sustainable solution for the future of social care. I very much support the suggestion that a commission should be set up.

Annie Gunner Logan: I will cover three things in 20 seconds. Sustainability is a real concern, not just in care homes but across care and support. As our submission notes, 33 per cent of providers have withdrawn from service provision in the past year, and another 10 per cent are thinking about doing so before the year ends. That is a big issue.

Secondly, I have brought the idea of a commission on care funding to the committee's attention, but I cannot claim credit for making the call. A number of us did that through an initiative that was set out in "Our shared ambition for the future of social care support in Scotland" and which—critically—was led by the independent living in Scotland project and Inclusion Scotland. Those are both user-led organisations, so the suggestion is not a commercial pitch—it comes

primarily from people who use services and are looking for change.

Finally, generally speaking, in care homes and many other areas of adult care, a higher quality of care is achieved—Gordon Paterson's work will bear this out—through third-sector provision than through the public sector or the private sector. Our main focus is on publicly funded places. That is why we should all be very concerned about what has happened at Bield, which is not alone in the situation that it has experienced.

Michelle Miller: I certainly support the proposal for a commission. I hope that it will take us away from what feels like a slightly sterile and diametrically opposed debate in which people take strong positions like, "Local authority bad, voluntary sector good" and "NHS good, private sector bad." We should be saying that, fundamentally, we all want to achieve a model that provides quality care for people who need it; we can all contribute and subscribe to that. I certainly want to have that debate.

My last plea is that we should ensure that we fund public services more effectively, but not by funding the status quo. We need to fund something that is both more visionary and more anchored in what people who use services are telling us that they want.

Sheenagh Simpson: I echo some of the comments that have been made on the need to look at new models of care. The majority of our members who provide care and housing support would certainly want us to do that. In addition, the majority of our members provide general-needs housing, and we would welcome a bigger debate and a national conversation on adequate funding for preventative services and adaptations to homes. I also echo COSLA's point about locality planning—housing providers are very keen to engage with IJBs on how we can make that work.

The Convener: Thank you very much—the session has been very interesting and informative. I suspend the meeting briefly for a change of panel.

11:44

Meeting suspended.

11:51

On resuming—

NHS Governance

The Convener: Agenda item 2 is an evidence-taking session on NHS clinical governance, and I welcome to the meeting Fraser Morton and Ella Brown. At the start of the committee's work on this issue, we heard from Fraser and Ella at an informal evidence session in which NHS patients told us about their experience of the NHS. I thank both of you for coming along that morning and, indeed, for coming along this morning, too. Your willingness to share information on such difficult and emotive personal experiences is greatly appreciated by all of us on the committee.

Before we begin, I will provide a brief introduction to both your experiences. Mr Morton's baby son Lucas was stillborn at Crosshouse hospital in Kilmarnock in November 2015, and Mr Morton and his wife June were among a number of families who called for a public inquiry into infant deaths at the hospital's maternity unit. The Cabinet Secretary for Health and Sport subsequently instructed an investigation by Healthcare Improvement Scotland into the management of adverse events in the maternity unit. The report from that investigation, which was published in 2016, made a number of recommendations for NHS Ayrshire and Arran and, indeed, the whole of the NHS in Scotland.

Ms Ella Brown lost her father following a fall at Victoria hospital in Fife. Since then, she has worked with the NHS board to bring about changes aimed at reducing hospital falls, including the "Falls call to action" events, which have brought together staff, patients and carer expertise with the aim of reducing by a fifth the incidence of harmful falls through improving practice, patient care pathways and the hospital environment in general.

In recent weeks, we have taken evidence from a range of stakeholders on NHS clinical governance, and we were keen for both Fraser Morton and Ella Brown to have a further opportunity to speak to the committee and to comment on the themes and issues relating to NHS clinical governance that have been raised at our evidence sessions.

We will now move to questions, and we will probably try to wrap things up by about 20 minutes to 1. Once again, you are very welcome to the committee, and thank you very much for coming.

Alison Johnstone: Thank you very much for coming this morning and for all the very helpful evidence that you have provided. I know that you are following the committee's evidence very carefully, and in my first question, which is

specifically for Mr Morton, I want to refer to evidence that we recently received from Professor Leitch.

Professor Leitch confirmed that there is no central monitoring of serious adverse events and suggested that their

"definitions are so broad and varied"

that centralised reporting might not actually be helpful. He also believes that

"We have to rely on the boards to have processes in place such as clinical quality committees and regular morbidity and mortality meetings".—[*Official Report, Health and Sport Committee*, 28 November 2017; c 20.]

so that individual clinicians can discuss cases. How do you feel about those comments?

Fraser Morton: To be honest, I do not understand them. My understanding is that there is a national framework for adverse events, which came out in 2012 or 2013 and has recently been updated, and I believe that there should be some standardisation of what such events are.

Since its review of NHS Ayrshire and Arran in 2012, Healthcare Improvement Scotland has described adverse events as the "springboard" for driving improvement to ensure that they do not happen again. If that is the case, there should be some sort of standardisation to help us identify not only adverse events but any recurring themes or trends in Scotland.

The fact is that statistics are not being collated. We were told at a meeting with an HIS review team that everybody is basically doing their own thing, despite there being a national framework in place. Some sort of methodology or standardisation has to be put in place to allow us to collate statistics so that we can address the matter and target our finite resources. When we talk about adverse events, we are basically talking about things that have gone badly wrong and about fatalities—they are not just statistics.

Ella Brown: From what I know from NHS Fife, adverse events were always just one thing rather than all these different things. I have no problems with what NHS Fife is doing; I see all the monthly falls reports from every ward and every hospital in Fife, and I can see that things are improving. There are blips and ups and downs, but you can have too many charts and different things. This is not about paperwork; it is about people—nurses, doctors and everybody—speaking to each other and working together. Nurses are complaining about having to do too much paperwork and having to spend half their time filling in forms, and we need to get back to a hands-on approach.

I have no complaints about NHS Fife, but the last time that I was here, I heard different things. Not all the health boards are working the same

way, and there are great gaps between what is good and what is bad. However, you will never get everybody in Scotland singing from the same hymn sheet—that will never happen.

Alison Johnstone: To what extent are inadequate staff levels or staff training a factor in things going wrong in the NHS? For example, I am very much aware that the campaigning that Mr Morton and other families have done will ensure that multidisciplinary cardiotocography—or CTG—training is made mandatory.

Ella Brown: Staff training and staffing levels were not good when my father fell and fractured his skull. After I started to work with the NHS, I had a campaign, and we got six more ward nurses who were funded by the Government. A lot more funding is going into things like that, but the issue is one of staff levels.

Alison Johnstone: Mr Morton, staffing levels seem to have increased markedly as a result of the work and the campaigns by you and other families. Can you comment on that?

Fraser Morton: On staffing levels? On the evening our son died, we were initially told that staffing levels in the maternity ward were short by 30 per cent.

Going back to the issue of missed opportunities, I think that if you correctly monitor, collate and—to use the buzz phrase—drill down into adverse events, you should be able to identify recurring themes. One recurring theme is inadequate staffing, and I can give you an overview of that. The “Each baby counts” campaign identified that a lack of resources can contribute to one in four stillbirth or neonatal deaths. That is a national figure, but there is a problem with staff levels and resources. I should also point out that, over and above the adverse events statistics that are produced, a programme called MBRRACE-UK—it stands for mothers and babies: reducing risk through audits and confidential enquiries across the UK—produces stillbirth and neonatal death statistics.

In 2013, NHS Ayrshire and Arran was one of the worst boards in the UK, if not the worst in mainland UK; it was second only to Belfast Health and Social Care Trust, for obvious reasons. Because of those statistics, the board was red flagged, which committed it to doing an internal review and investigation. I have read that internal investigation, and I found it to be very outward looking. It took a scattergun approach, looking at multiple deprivation, drug taking, obesity and smoking; indeed, it looked at everything apart from the board itself. It was not inward or introspective, and I believe that it was an opportunity missed. That investigation was conducted in 2015, because of the lag in collating statistics and so on.

Only two years later, as a result of the recent HIS review, we have in place 16 additional midwives, two sonographers, one additional consultant and a labour suite risk management midwife—or something to that effect. That is a huge number of staff, and such a requirement could and should have been identified earlier. If the adverse events had been collated and monitored properly and if a proper investigation had been done into MBRRACE’s red flag figures in 2013, those shortcomings could have been identified earlier, as they should have been.

12:00

Ash Denham: Good morning. I wanted to ask about your feelings with regard to levels of accountability for boards. Over the past few weeks, we have heard that boards are investigating serious events or other types of complaints and responding to them themselves without much higher-level involvement. Are boards being held sufficiently to account for what they are delivering?

Fraser Morton: To be honest, my quick answer would be no. NHS Ayrshire and Arran defines clinical governance as

“a statutory obligation”

and

“a framework through which”

the board is

“accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.”

If that is a statutory obligation, I have not, despite my best efforts, been able to establish which piece of legislation covers it. Moreover, if the board is indeed accountable, I do not know whom it is accountable to.

I can talk only about our own circumstances at NHS Ayrshire and Arran. Looking back, the terms “clinical governance” and “adverse events” were alien to me and my family until November 2015, but I quickly became aware of the intervention by the first of three cabinet secretaries in 2012 and the first of three HIS reports in 2012. Going back further still, in 2009, NHS Ayrshire and Arran admitted to difficulties in applying its management of adverse events policy. I can take you back even further: I have looked at action plans going back to 2006 that were produced on the back of adverse events, and I was shocked to see the same themes and trends and the same failings in care with regard to staffing, training, handover and communication. Those were the same areas that failed Lucas in 2015.

In the intervening period, we have had the intervention of three cabinet secretaries. In 2012, Alex Neil challenged the non-executive directors of NHS Ayrshire and Arran and the wider NHS Scotland to apply a greater degree of scrutiny to the executive management team. There was also an investigation by what was Strathclyde Police into 40 suspicious deaths in Ayrshire and Arran.

On top of that, according to Jason Leitch, the Scottish Government collates or looks at the adverse events statistics by going through health board papers, although, as someone point out, it is difficult to lift that information out of a 500 or 600-page document. If that is indeed the case, I do not know how the Government missed the fact that NHS Ayrshire and Arran was averaging 19 adverse events per year, which, as Robbie Pearson stated in his report in 2012, was low. The following year, the figure was zero. That was happening during a period when there was supposedly a national framework and supposedly greater scrutiny by the Scottish Government. You would like to think there would be greater scrutiny by the actual board of the health board and by HIS, which helped to implement the policy, but the issue was missed for three years.

Ella Brown: I have worked a lot with patient relations; indeed, that is how I got to know the health board and all the things that are going on. I see all the reports. I work with patient relations a lot, and I think it is doing fine. It is five years since my father died, but we are moving on all the time. I have spoken at conferences and have done all sorts of things; I have got the issue out into the public domain; and I have spoken to people and got them to speak to each other. What I do is a hands-on thing; I do not know figures or facts—I just work on my own initiative.

I was so angry when the incident happened, and I felt that I had to do something. That is why I started, and I just did it. I still feel driven to do it; that is my way of approaching things. It is all about speaking to people and keeping the issue in the public domain. My experience with NHS Fife is that it is working very hard on patient relations, and it is doing a major amount of work involving all the different departments of the board. Nothing is perfect, but the situation is much better than it was five years ago, and it is still improving.

Ash Denham: Mr Morton, I want to follow up on your last answer. Do you think that the boards should have less discretion over how they manage such events? Should there be some other way of managing them, and would it involve more central control over the boards? How would you visualise that?

Fraser Morton: I am not sure. I am not a healthcare professional, but the board and the senior management of NHS Ayrshire and Arran

obviously missed an opportunity. However, in Ayrshire and Arran, things work through a kind of silo system of clinical directorates; matters are progressed to the risk management committee, which I believe is chaired by the chief executive officer of NHS Ayrshire and Arran; and the adverse events are then put forward to the healthcare governance committee, which I believe non-executive directors of the board sit on. Whether or not it involves an adverse event, the final decision is taken by either the medical director or the nursing director.

The system is in place, and things in Ayrshire and Arran have definitely improved. Back in 2012, however, an opportunity was definitely missed by the executive management team and the board; it was missed by the wider NHS Scotland and the Scottish Government; and it was missed by Healthcare Improvement Scotland. Nobody was collating the information. Such events might be the springboard for driving safety and improvement, but you cannot improve what you do not measure. The statistics were not even being collated. If you look at the disparity in the figures throughout Scotland's 14 health boards, you will see clearly that there is no standardisation and that the national framework is not being implemented.

Brian Whittle: I bring it to the committee's attention that Mr Morton is a constituent of mine and I have been working on his specific case.

Good morning, Mr Morton and Ms Brown. I want to ask about the HIS investigation. Do you reckon that it was instructed in response to the media attention, or was the Scottish Government already aware of and managing the issue?

Fraser Morton: I found the failings to be so deep and widespread in NHS Ayrshire and Arran that we, as a family, circumvented the complaints policy, you could say. I wrote to the medical director and the CEO, but the response was not what I had hoped for. I then wrote to the health secretary and got a response from someone in her office. I wrote again. Reluctantly, after a year of trying, I wrote to everybody. During that period, I was dealing with the Scottish fatalities investigation unit. We reluctantly sought media attention and, as far as I am concerned, the intervention was initiated only after the adverse media publicity.

Brian Whittle: Regarding the HIS review, is HIS fit for purpose in this arena?

Fraser Morton: The neat answer is no, but I will expand on that a wee bit. We have had three HIS investigations in Ayrshire and Arran. The first was in 2012 and the follow-up was in 2013, which missed the fact that NHS Ayrshire and Arran had already decided to circumvent the recently embedded management of adverse events policy.

Its decision to do that basically negated any chance of learning from the failings and of putting measures in place to prevent them from happening in the future.

It is interesting that, in 2017, HIS stated that it expected material progress to have been made since the previous failings were initially identified, in 2012. You might not be aware of that comment, because it was in the draft report that I received through a freedom of information request and it never made the final report—I do not know why. You can judge for yourselves why that comment never made the final report.

I do not know about HIS, but I have previously described its mission creep. It is like the Acme of NHS Scotland. It has a wide remit and it is taking on too much.

The Convener: I want to ask something about both your cases. There were guidance and standards that medical staff were supposed to be guided by, which I presume were not adhered to. You then raised a complaint. Did you do that at a ward level first, or did you go to a higher level initially? Did you go straight through the complaints process? Was the complaints process adhered to? Was there a failure in the guidance or in the complaints process? Ultimately, how did you get to bring about a change?

Ella Brown: I did not go through all the committees or do the different things that Fraser Morton did. My father was in the ward for a hip replacement when the Victoria hospital changed over from the old to the new, and there were a lot of problems with that. When he was in that ward, I could see that it was totally understaffed. I told the staff that my father would wander, and they said, “Oh, yes,” and other things, keeping it short. I told the nurses, “Watch him—he’ll wander.” The short story is that they did not watch him and, the next night, he got up, went to the toilet, fell and fractured his skull, so he died.

I was very angry at the time. The staff were very good with me, with different people helping me. I went home for about month but it was no good. It was getting to me, and I felt it would destroy me if I did not do something about it. The social worker who had been my dad’s social worker told me that I could write to a new service that had just started, which was called patient relations.

I was hurt that, during that month, nobody had contacted me, come to the funeral or done anything at all—I was just abandoned. I wrote a six or eight-page letter—I poured the whole lot out—and sent it off to patient relations on a Monday night. On the Tuesday morning at 9 o’clock, I got a phone call from someone at patient relations. They were absolutely horrified at what

had happened. I started working through patient relations—it was all done through that service.

The Convener: Is patient relations part of NHS Fife?

Ella Brown: It is part of NHS Fife, but it is independent. The people there look at the situation from both points of view and take people’s complaints to the higher-ups. That is where it all started.

The Convener: But is it—

Ella Brown: It is not a totally independent organisation, but its staff care about the patients and what has happened. It is a sort of buffer between the public and the health board.

The Convener: Initially, when the incident happened and you were, I presume, horrified at what had happened, did you raise the matter with the ward management?

Ella Brown: Yes, and the doctors came and spoke to the nurses.

The Convener: The issue was largely dismissed, was it?

Ella Brown: No, it was not dismissed. They dealt with it, but I saw that there were a lot of problems that had to be addressed and I wanted to address them. The staff did what they could and were very sympathetic. It took 10 days for my dad to die, and they were very good during that time, but I knew that there was a big gap and lots of problems. I just felt so angry, and I wanted to address the problems.

Fraser Morton: Regarding the complaints process, within hours of Lucas dying, I was really uneasy about what had occurred so I did a bit of research. I came across the 2012 review and, according to the papers, NHS Ayrshire and Arran had been accused of suppressing adverse events. I downloaded the management of adverse events policy and familiarised myself with it.

I must say that the care that we got from individual staff following Lucas’s death was second to none. It was great—I could not fault it. We were assured that the matter would be taken very seriously and that there would be a serious investigation. What spurred things for me—the final straw—was being given a death certificate that stated “unknown”. Following previous family deaths, I was aware that certain deaths have to be notified to the Crown Office—to what is now the Scottish fatalities investigation unit. I quickly made a call and the staff I spoke to had no record of Lucas’s death.

That resulted in me and my partner, June, being interviewed by two police officers. We were actually split up. That was within weeks of Lucas’s death, and we were split up in our own home. I

have no complaints about Police Scotland—it is just the process—but it was awkward to give our statements in that way. Lucas's death should have been notified to the Crown Office. I can pick up on that point later.

I lost all faith in the complaints process, which is what initiated my complaints at a higher level. That is why I circumvented the complaints process. On the basis of what I had learned about the history of NHS Ayrshire and Arran and what I perceived to be shortcomings in the notification of our son's death, I took the matter to the board and further afield, into the political domain.

12:15

Ivan McKee: I thank both of you very much for coming along this morning. It is commendable that you are pursuing your respective issues, which I hope will generate benefits across the whole health service.

I want to compare and contrast. I am sure that there are shades of grey here, but, looking at your situations from the outside, it looks as if there have been two tragic events. In your case, Ms Brown, after a while, NHS Fife has embraced your perspective of the incident and has involved you in the process. From what I have seen, the board is making significant progress and the processes and procedures are changing for the benefit of everybody. In Mr Morton's case, however, we see the opposite. If I am not mistaken, you seem to be have been kept at a distance, Mr Morton, and the outcome in your case has been more confrontational. Is that a fair comment? Do we think that it comes down to the different leadership in the respective health boards and how things have been viewed from their side?

Ella Brown: I think so. The staff in Fife were shocked and horrified at what had happened, and they were very kind to me in different ways. There was a police investigation and all the rest of it. The staff did not put up any barriers—I was welcomed in from the first minute, and I said that I wanted to work with them. I got letters and phone calls and so on from people, and they said that I could come and work on their committees. They changed all the boards and did lots of other things. They took me round to let me see everything. Five years on, I am still working with NHS Fife in different ways and on different committees.

At the time, NHS Fife was battered daily in the papers about everything. I thought, "This has to stop. Somebody has to do something about it." That was I why I tried to get the staff and the public—everybody—to work together and talk to each other instead of putting up barriers and being frightened of each other. That has worked.

The Convener: Has that been your experience, Fraser?

Fraser Morton: What Mr McKee said is a fair comment, although things have changed as recently as yesterday, when I met John Burns from NHS Ayrshire and Arran. I would like to think that the board is now turning a corner. It would have been a fair comment until very recently, because that was our experience: we were definitely held at arm's length from the process. We received a root-cause analysis report of 12 words. The summation was: "We could not find a root cause for this event." That is what Lucas's death was—an "event".

That is where it would have been left. His cause of death would have been "unknown" according to the National Records of Scotland, and the hospital did "not find a root cause for this event." It is only through our efforts—which have really taken a toll on me and our family—that we have got to where we are.

The Convener: Are you saying that there has been a change in attitude or communication in the past few days?

Fraser Morton: It was only yesterday that I met John Burns and a member of the board.

The Convener: I wonder why that was. May I suggest that it is no coincidence that you are appearing here today and Mr Burns was here last week?

Fraser Morton: I am not going to speculate.

The Convener: Yes, let us not speculate. It is good news that things appear to be moving on. What came out of that conversation, if you do not mind my asking?

Fraser Morton: Mr Burns gave me an overview of the implementations and the changes that the board is making. I believe that it is putting things in place over and above the recommendations of the HIS review and the commitments by the cabinet secretary and the chief medical officer to make multidisciplinary CTG training mandatory.

According to the national figures, the medical legal costs relating to CTG are huge, and it seems to be a false economy to scrimp on it. That has not always been the case. CTG training was all but abandoned in NHS Ayrshire and Arran due to insufficient staffing numbers. I got that confirmed, again through a lengthy FOI process. I had to appeal to the commissioner to get that information. The training was abandoned for 13 months, from December 2015, the month after Lucas died, when we were told that it would never happen again.

Significant changes have been put in place, and I believe that the board is trying to embed, as mandatory, a training package called PROMPT—

practical obstetric multi-professional training—which is internationally recognised for improving outcomes and reducing the number of fatalities.

Miles Briggs: I welcome you both to the committee. Over the course of the work that we have been doing, the work that you have both done has been shown to be making a huge difference, specifically in those hospitals where the incidents occurred. They related to the culture of our health service—a matter to which we keep returning—in which some incidents are covered up or not really engaged with because they are seen as failures. I am interested to know your personal views about the culture, having seen it and having seen it change in both your cases.

Ella Brown: When the incident happened, NHS Fife was absolutely terrified of the suing society. People would admit to nothing, say nothing, not talk to anybody and not raise their heads above the parapet in case somebody sued them. I said right at the beginning, though, that I had no interest in suing anybody, as money would not bring my father back; I wanted to improve things. That made a difference.

The board has got braver as the years have gone on, and there is a totally new atmosphere in NHS Fife. I can only speak about going backwards and forwards to the Victoria hospital. You go through the front door now and it is totally different. I have done training videos with people and I have worked on duty of candour videos. I have been asked to speak at conferences and to get staff to work together and do training on how the patients feel from their own perspective. I have no complaints about NHS Fife at all. We are all learning all the time.

Miles Briggs: How has the management in the health service specifically changed, as far as you can see? It is very much front-line staff that you have referred to.

Ella Brown: I have worked with both front-line staff and all the senior directors of nursing. I work with higher people, too. They have all changed—they are all much more open, and I have not found any problems. Tricia Marwick is now in charge of the board, whereas it used to be Allan Burns, but I do not see any difference: it is still working in the same way, going forward all the time.

Miles Briggs: Good.

Fraser Morton: In reference to what Ella Brown has said about the legal culture, I must say that our experience was somewhat different. We were challenged to sue—that is the best way that I can describe it. We were actually challenged: “Why don’t you just sue us?” That was in response to difficult questions that we were asking about the failings surrounding our son’s death.

Jenny Gilruth: I have two supplementary questions for Ms Brown. First, why do you think the culture has changed? You alluded to the NHS board chair having changed and that not having had an impact. What do you think has been the impetus behind the shift in culture?

Secondly, do you think that what happened to your dad could happen again, or are there structures in place, or have changes been made, that make you feel confident that it could not happen again?

Ella Brown: I do not think that it could happen again, given all the different measures that the board has put in place and what I have seen to prevent falls—from coloured wrist bands to falls protocols and all sorts of other things. We meet every two months and we see those things happening.

When I talk about things not changing, I do not feel that there has been a backward step or that issues have been ignored or shoved in a drawer and forgotten about while the top management has changed. The issues are still on-going. All the committees that I am involved in are still on-going, and there are a range of people on those committees, including geriatric clinicians. The doctors are all coming on board with the nurses, and it is all working amazingly well. I am not saying that it is perfect—nothing is perfect—but the situation is improving. I am quite confident about that.

The Convener: I have a question about all the practical things—the real things—that have happened. We hear a lot of people say, “We all work together.” However, when we ask them what working together means, they sometimes cannot tell us. What practical things have happened in the wards that increase your confidence that such incidents could not happen again?

Ella Brown: My father was in the early stage of Alzheimer’s, but he also had a fractured hip, so he was put into an orthopaedic ward. Many of the orthopaedic nurses were not used to dealing with elderly people with dementia and other conditions, so the board started to bring in dementia nurses, and call bells and all sorts of other things were introduced. That change is still happening. The board has evolved in that way, with different areas working together.

The Convener: Were there changes within systems that had to be rolled out?

Ella Brown: Yes. All the hospitals in Fife work within the same systems.

The Convener: Did that require a whole module of training for people?

Ella Brown: Yes. People were brought in to give training, including from the psychiatric

hospital at Stratheden. St Andrews hospital is different from Victoria hospital, but the staff were all given training, with training managers and training plans set out. I saw all that for myself. The plans were all sent to me to be scrutinised.

The Convener: Excellent. That is good. You have told us more about how some of these things are rolled out than some senior managers and senior executives.

Ella Brown: I am a people person. I do not read brochures; I just talk to people. I watch and I pick up things.

The Convener: We could perhaps do with you as the chief executive of an NHS board.

Ella Brown: Well, I am available.

Emma Harper: Thank you for coming today. You have described how the culture has changed in both places, even if it is a recent change in Ayrshire and Arran NHS.

My background is in clinical education and nursing. I know that there are learning modules about falls prevention in the community and in acute care. There will be development of and roll-out of training, whether face to face or otherwise. Delirium assessment occurs in orthopaedic units now. I am interested in how you see the national picture evolving. How would you spread the best culture nationally across all boards?

Fraser Morton: The culture is really improving: I do not think that anybody is arguing against the idea that a culture of continuous learning and improvement is the way to improve patient safety and the quality of care. However, I see no reason why that cannot happen within a regulatory framework, which is currently missing. Regulations set goals and objectives and come into play when the objectives and goals are not achieved—which I believe was the case for Ella Brown and me. People's behaviour is governed by regulations.

Currently, however, I do not believe that there is a regulatory structure for when the culture of improvement and learning falls short of achieving its goals. I would like something like that to be put in place. How it would be done, I do not know, although nobody is asking for an organisation like the Care Quality Commission to be uplifted and embedded, warts and all, within NHS Scotland. Some people and some organisations need to acknowledge that we have a Scottish problem for which we need to find a Scottish solution.

Alex Cole-Hamilton: Emma Harper has, largely, asked about what I was going to focus on.

Succinctly, are you confident that lessons have been learned in your health boards with regard to the terrible circumstances that you encountered? Are you confident that that learning has been

passed on to every one of the 14 health boards in the country, or is it a victim of the silo culture—which the committee has repeatedly encountered—of the 14 health boards, where what works for one is often not replicated in others? Are you aware of how much best practice has been passed on?

Ella Brown: From what I have heard at the committee, from speaking to MSPs before meetings and from what I have heard about other people trying to complain, I do not think that best practice has been passed on. For example, at Ninewells hospital people cannot get anywhere. I can really speak only from my experience in Fife, but I do not think that best practice is being passed on. There is still a long way to go. I have suggested to people that they should call patient relations departments and they will help, but some boards seem not to have patient relations departments. There is a long way still to go.

Fraser Morton: On NHS Ayrshire and Arran, I do not understand how an organisation that had admitted to having serious problems with its management of adverse events was allowed, in 2012, to formulate and try to bed in its own policy on adverse events. I believe that it is the responsibility of Healthcare Improvement Scotland to create a culture of learning across the whole of NHS Scotland. That did not happen in that case.

Adverse events, which I have looked into in great detail, are not collated in a standard way by Scotland's 14 health boards, and they are not routinely monitored by Healthcare Improvement Scotland. I do not believe that the greater NHS Scotland or the Scottish Government—I am not sure which it would be—looks into that by monitoring boards' papers. I do not think that that would be possible. It would be an untidy and awkward way of getting what should be a simple collation of figures to drill down into and to use for greater learning. You have tripartite failings.

Going wider, if we look into deaths such as Lucas's, the Crown Office does not even collate the number of deaths or look for themes, patterns or trends in the deaths that are notified by each of Scotland's health boards to the Scottish fatalities investigation unit or the Crown Office.

12:30

On other deaths, we go back to HIS, which has a death certificate review service. There were 57,000 deaths in 2015, for example: more than 47 per cent—roughly 27,000 deaths—of the death certificates were found to be not in order. I think that it would be fair to suggest that some of those 27,000 death certificates would have met the criteria for notification to the Crown Office, based on the guidelines that have been issued by it. I

have an FOI request pending on whether that is the case, and whether any of those 27,000 deaths have been retrospectively submitted to the Crown Office for greater scrutiny. I will not go into great detail, but looking back into the findings of the Shipman inquiry, that is something that we need to have in place. That would be an important safety net, that I believe is missing from our society.

The Convener: You mentioned 27,000 deaths. Over what period was that?

Fraser Morton: That was in 2015. It was 47.1 per cent of deaths. This is about medical certificates that are sent to National Records of Scotland. Since 2015 there has been the death certification review service, under the umbrella of HIS. I do not know what happened before then, if anything. It examined a sample of 5 per cent of certificates from 2015 and found that, of those, 47.1 per cent were not in order.

The Convener: Is that work being continued?

Fraser Morton: Yes. In 2016 the figure fell slightly, to just below 40 per cent. I do not know what processes and improvements were put in place to drive that improvement, but it fell to 39 point something per cent in 2016.

The Convener: Within that, has the service identified issues?

Fraser Morton: Well, this is the thing: if adverse events are a springboard from which to drive improvement, and if you consider patterns—

The Convener: No—you are talking about inaccurate death certificates.

Fraser Morton: Yes.

The Convener: So, has the service identified what the inaccuracies were?

Fraser Morton: No. That was not in the document that I looked at.

The Convener: That is helpful. Thanks.

Brian Whittle: I should have noted at the start that I have a relative working in NHS Ayrshire and Arran. I apologise for not saying that earlier.

It is interesting to hear about two completely different experiences. The key thing for me is the implementation of recommendations, once we have them, having drawn on reviews and your experiences. Can you highlight the differences in how investigations have been conducted? I am very aware of Fraser Morton's case, but Ella Brown seems to have had a much better experience. For me, that is the key.

Ella Brown: Yes, I did. I wanted to bring that to people's attention the last time I came to committee, and to prove that I had had a much better experience. I was abandoned for the first

month but, after that, I was much more accepted. I have done what I wanted to do, and I am still doing it. I have been taken on to do interviews for patient relations jobs, and so on. I like to do things like that and to offer the public's perspective.

I feel that the board is much less frightened of being sued now—it has come out from behind its barrier and is getting in touch with the public.

Brian Whittle: So, your experience of implementation of the recommendations was very positive.

Ella Brown: Yes. It has all been very positive.

Brian Whittle: Mr Morton would perhaps say something slightly different.

Fraser Morton: I thought immediately they were announced that the terms of reference of the recent review are too narrow and the timeframe is too short. The timeframe was based on improvements that had been made by NHS Ayrshire and Arran. One of the findings of the review team was it would expect material improvement. The terms of reference dealt only with the maternity service, but the adverse event policy covers every department. At this moment, we do not know the full extent of avoidable deaths within NHS Ayrshire and Arran. It is a common policy, but the board has concentrated on one small area.

Brian Whittle: Who set the criteria?

Fraser Morton: I believe that they were set by the Scottish Government, in conjunction with Healthcare Improvement Scotland. The timeframe conveniently missed encompassing the 2012 review. It is almost as if Healthcare Improvement Scotland did not want to examine its own part in the process. That is how it seemed to me.

I wrote to the Cabinet Secretary for Health and Sport and to Robbie Pearson. To digress a wee bit, there is a lot of talk in Parliament now about health and justice collaboration. I asked for the terms of reference to be expanded: I asked for a memorandum of understanding to include the Health and Safety Executive, the Crown Office and an expert in human factors. Specifically relating to our son's death, one of the things that we were told was that people cannot see what happens inside a person's head. We question why, for instance, my partner June's case was not escalated, as per the guidelines. I therefore think that it is reasonable to request an expert in human factors.

The Health and Safety Executive agreed that there were systemic failures and failings in clinical governance—its view was diametrically opposed to that of the health board. The situation has just been left at that. The HSE agreed that there were clinical failings, and the hospital initially did not

admit to any clinical failings. We just moved forward without anything being addressed.

The memorandum of understanding was reasonable—it was a feature of the Morecambe Bay inquiry—so I do not know how the remit of the recent review in Scotland could not have been expanded.

The Convener: We have come to the end of our time. We greatly appreciate your coming forward. You have done your families proud, not just by giving evidence today, which is a difficult thing, but because you are pursuing issues that you care passionately about. We hope that that will change the system for the better, so that other people do not experience what you experienced. Thank you for your evidence.

12:36

Meeting continued in private until 12:59.

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