OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 8 November 2022

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 8 November 2022

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HEALTH, SOCIAL CARE AND SPORT COMMITTEE
31st Meeting 2022, Session 6

CONVENER

*Gillian Martin (Aberdeenshire East) (SNP)

DEPUTY CONVENER

*Paul O'Kane (West Scotland) (Lab)

COMMITTEE MEMBERS

*Stephanie Callaghan (Uddingston and Bellshill) (SNP)
*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Evelyn Tweed (Stirling) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Patricia Cassidy (Health and Social Care Scotland)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Derek Feeley (Independent Review of Adult Social Care)
Alison Keir (Royal College of Occupational Therapists)
Nick Morris (NHS Chairs Group in Scotland)
Alison White (Social Work Scotland)
Dr Chris Williams (Royal College of General Practitioners)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 8 November 2022

[The Convener opened the meeting at 09:30]

Decision on Taking Business in Private

The Convener (Gillian Martin): Good morning and welcome to the 31st meeting in 2022 of the Health, Social Care and Sport Committee. I have received apologies from David Torrance; James Dornan will be substituting for him. James joins us online, as does Tess White.

The first item on our agenda is a decision on whether to take item 4 in private. Do members agree to do so?

Members *indicated agreement.*

Subordinate Legislation

Feed Additives (Authorisations) (Scotland) Regulations 2022 (SSI 2022/288)

09:30

The Convener: The next item on our agenda is consideration of a negative instrument on feed additives.

The Delegated Powers and Law Reform Committee considered the instrument at its meeting on 25 October and it made no recommendations.

The purpose of the instrument is to implement the decision that was made by the Minister for Public Health, Women's Health and Sport in relation to 11 feed additives, authorising five new feed additives for placing on the market and for use in Scotland, and renewing, modifying, re-evaluating or extending the authorisation of six others.

The instrument also includes transitional arrangements for three existing feed additive authorisations. No motion to annul has been lodged in relation to the instrument. Would any members like to comment on the instrument?

Emma Harper (South Scotland) (SNP): I am interested in any legislation on feed additives that is introduced, and I will continue to be so because I think that it is really important that we know what we are consuming. We hear about novel foods and what is happening in other countries in relation to trade, and I know from my research that there are issues around hormones and other chemicals that are being added to products that might end up in our food supply chain. We also had an informal discussion with Food Standards Scotland last week. I just want to put on the record that this is an important issue and we should pay attention to it.

The Convener: Thank you, Emma. I expect no less from you. I know that you have a long-standing interest in this area.

As there are no other comments from members, I propose that the committee not make any recommendations in relation to the instrument. Do members agree?

Members *indicated agreement.*

National Care Service (Scotland) Bill: Stage 1

09:32

The Convener: The next item is further consideration of the National Care Service (Scotland) Bill. We have two evidence sessions. The first evidence session will focus on the bill as it relates to the future of integrated health and care services, including community health, prevention, local services, rural services and transfer of functions.

First, I welcome panel members who are joining us in person. We have Nick Morris, the chair of NHS board chief executives and chairs; Alison White, the convener of Social Work Scotland; and Dr Chris Williams, the joint chair of the Royal College of General Practitioners Scotland.

We have two witnesses who are joining us online—Patricia Cassidy, who is the chief officer for Falkirk Health and Social Care Partnership and is representing Health and Social Care Scotland chief officers; and Alison Keir, who is the professional practice lead in Scotland for the Royal College of Occupational Therapists. Welcome to you all.

I will start off by asking for your general views on whether the bill as presented—this framework bill—has the potential to improve integration of services. One point has been put to us in a lot of the submissions from service users. I will quote one unpaid carer, who said:

> "There is a lack of connection between health boards, councils, social care and public health. No joined up thinking."

That is coming from somebody who is using the services, so I guess that our starting point is to look at the gaps and see whether the bill provides the framework, at the very least, for better integration. I will go round to each one of you. We will not be able to go round to each of you for every question, but—convener's prerogative—I will allow everyone to answer my question, and then my colleagues will direct questions to individual witnesses.

A note for those who are joining us online—if I do not come to you in the first instance but you want to add anything, you can use the chat box to let me know that you want to come in. If you are in the room, just raise your hand and I will come to you. I will go round everyone in the order in which I introduced you. Nick Morris is first.

Nick Morris (NHS Chairs Group in Scotland): Can everybody hear me?

The Convener: Yes.

Nick Morris: There is a lot to be said that is positive about the development of the NCS, in its bringing together of stakeholders and in the voice of service users being more clearly amplified by their experiences in health and social care. Much of that work is understood at local level—we believe that significant work is going on to engage with stakeholders at local level about their perceptions of integration and their experiences of joint work within social services, social care systems and health. There are many things to learn from.

Our main concern is that the focus of the bill is forcing people to consider issues and consequences of structure, some of which are hard to interpret because of the evidence that is available in the bill. It sits as a framework bill; it does not provide much detail. At this point in our system pressures response, in both social care and health, we have to be careful about the distraction that that provides, given that we need to provide significant leadership in the provision of a response to those system pressures.

Social care and care services are going through a significant challenge in recruitment and workforce. It is right that the NCS should involve looking at issues of equity such as fair work and improving career progression opportunities. Potentially, there is a lot to be said for the development of integrated training and development programmes between health and social care practitioners, which will support integration in the long term. However, we need to do a lot of work to make sure that those staff on the ground are providing resilient care to their clients and that they are resilient within themselves. At this point in time, that is not the case. Social care services are in significant stress, as are our health and community services.

We welcome the general position of the bill and where it wishes to take things. We support the integration of health and social care, certainly at local level, but I have concerns about the fragmentation that might occur through some of the structures that are suggested, such as care boards. Although we do not yet know how the First Minister might structure departments, that might be a concern for us as well, in terms of fragmentation rather than integration.

We support the general tone of moving towards integration at team level—the development of multidisciplinary teams. We are not quite sure that the bill hits the nail on the head.

Alison White (Social Work Scotland): We echo much in what Nick Morris has highlighted about the challenges in social work and social care and about such a level of change at a time when we are experiencing such challenges in recruitment and retention. We have gone through

a pandemic, we have challenges around a workforce that is on its knees, in places—certainly in the care sector, in particular—and the cost of living crisis is significantly impacting front-line care staff.

Again, I echo that we are supportive of much in the bill, when it comes to the opportunity, for one of the first times, for a strong conversation about social work and social care—what it means, how it fits in, and the importance of those roles. Although I am following on from a national health service colleague, I say that there has been far too much focus on what is right for the NHS and how we deal with that. Given that we are looking at a whole-system approach, it is a real opportunity for us to focus on and highlight some of the impacts in social work and social care.

I am not sure that the bill addresses the issues of integration clearly enough, including employment legislation and what that might mean. Although I am here representing Social Work Scotland, in my day job, I am a chief officer of a health and social care partnership—an integration joint board—so I have such an integrated service. Something about my joint role enables, for me, managerial and strategic oversight of both health and social work services. It is difficult to know how that will move forward and embed in the bill and what that will look like, given that staffing arrangements will be different—the chief officer or chief executive role will sit in NCS rather than having that in-reach to NHS services. There is a real danger, certainly in the short term, that integration will be jeopardised as part of the process.

However, the bill does give a sense of co-design, how we have those conversations and what we need to do around making sure that we get that strong voice from people who use the services. You are right to say that people get a sense of a disconnect between some elements of the service. That does not happen all the time, but there is some disconnect. I am not sure that the bill addresses those areas of disconnect, unfortunately. However, if we can use the co-design process effectively in order to get that strength of voice, both from the people who use the services and from the people who deliver them, there is an opportunity for us to shape something that allows the development that we are looking for in the integration of services.

The Convener: That is very helpful, because the co-design will inform the secondary legislation, which should address the issues of detail that you have mentioned so far. I guess that you are behind the idea of co-design, but the co-design has to be meaningful.

Alison White: Yes. Certainly, Social Work Scotland's perspective is that the co-design should come before rather than after the legislation. Social Work Scotland is strongly behind the development of a national care service—including the strengthening of all of the rights-based approaches, staff development and how we support staff in meaningful employment—but we feel that the co-design process and the development of how the service looks should take place prior to rather than after the development of legislation.

Dr Chris Williams (Royal College of General Practitioners): The RCGP Scotland recognises that we have made substantial progress in Scotland with regard to integration of health and social care and, during the past several years, some very different cultures have had to meet and reconcile. We absolutely do not want to neglect social care, but we need resource to go in that direction and we need governance arrangements that make sense. The Feeley report certainly recognises that there are different governance models in different parts of Scotland, including the lead agency model in Highland.

As we have tried to think about the way forward, we have undergone a substantial programme of primary care reform in terms of the new general medical services contract. That work is still unfinished; there is still a lot of distance to go before our primary care services look and feel the modernised way that we intend.

General practice has had a historical connection to health boards with regard to how we are governed and managed, and we would not want to see the legislation disrupt that. Currently, we see assurance that that is not happening but, again, beyond the legislation, there will be a substantial amount of reform, so we cannot yet foresee how that co-design process will play out.

One of the most substantial aspects of the bill is information sharing. We have had discussions elsewhere with members of this committee around the desire for parts of the system to see aspects of other parts of the system, so that people do not to have to repeat their story. Although the legislation can do something about that, there is a larger body of work around the cultural side of things across the health and care parts of our workforce, as well as the investment in information technology infrastructure.

We continually underestimate the role that is played by things that we take for granted in other aspects of life, such as accessing banking through snazzy apps, or other online transactions. We still have a good way to go in Scotland on that. We await the national data strategy as well, because that will be helpful. I look forward to seeing what this legislation can do.

Patricia Cassidy (Health and Social Care Scotland): I concur with a lot of the earlier comments. We welcome the introduction of the bill and, in particular, the principles of the bill. We are keen to realise the opportunities that the framework in the bill offers to become a much more integrated system and have that person-centred focus. The bill would allow the potential new community health and social care boards to set the tone and culture for the staff who work to deliver the outcomes in the organisation, as well as support and facilitate a culture of co-production and innovation.

We need to learn from the current experience, the evidence from the integration joint boards and the variation that there has been across the system. There is also the challenge of bringing together two groups of staff from two organisational cultures and creating a new organisational culture. There is an opportunity to create an organisation with a new culture that has at its heart the person-centred approach and that listens to and works with our communities to shape and influence our services.

09:45

In the integration joint board partnerships, the principal partners are the NHS and local authorities, but the partnerships are much more than that. That is set out in the legislation, which refers to the representation and involvement of our communities, carers and service users. It is important that we build on the strengths that we have developed through integration and that we do not disintegrate some of the existing strong relationships. Some of the most interesting innovations have come from partnerships of local third sector and voluntary organisations and communities of interest that have developed new services. It is important that the framework takes account of that and provides an opportunity for an organisation with a new culture that involves a broader partnership than perhaps is the case among its constituent parts, and that absolutely has communities at its heart.

We have to learn from some of the strengths. One of the tensions and difficulties in the bill is about reducing variation across Scotland but not at the cost of local responsiveness. One real strength of being at the strategic planning group level is about the partnership groups, the links to community planning partnerships and the ability to flex across the system when there are transfers of care. It is also about the infrastructure support that is provided by, for example, leisure and cultural services or housing services in the local authority and primary care in the health boards. We need to be careful that we do not put existing connections at risk.

We need to consider how we can reduce and improve our IT systems and improve the way in which we handle, transfer and use data. We need to change the way in which we interact with people, which can be on several fronts, with people seeing five or six different professionals. We need to have one multidisciplinary team that has one source of shared information—potentially, the person will hold that information and share it with us.

There is a lot of scope for improvement, but it must be sensitive and guided by good conversations with the people who use our services. We must not forget prevention—we need to consider how we get in earlier and realise some of the benefits that we can have from that.

The Convener: Thank you. You mentioned quite a lot of things on which my colleagues have specific questions.

Alison Keir (Royal College of Occupational Therapists): Good morning. The Royal College of Occupational Therapists commends the ethos of the bill whereby there is to be a shift to early intervention and prevention, but it is not clear how that will be resourced, measured or achieved. We feel that the bill lacks detail on how we will know when we have achieved what we want to achieve.

We also have concerns about the use of the word “care”. Greater clarity is required on that, because “care” means different things to different people. For a huge proportion of the population, care means being looked after, but do we really mean care, or do we mean support? If we want to move to a model of earlier intervention and prevention, are we talking about supporting people to self-manage and live their best lives, or will we still have a model in which we look after people? Will we still be doing things for people, or will the national care service support us to do things with people, which is where we want to get to? I think that the title of the service confuses that and changes expectations.

There is also a lack of clarity on the purpose. The policy memorandum states that the purpose is

“to improve the quality and consistency”

of social work and social care services in Scotland. That does not describe all that we aspire to do with the national care service. We absolutely want to improve and grow our fabulous social work and social care services, but what about our community health colleagues?

Improvement of quality and consistency goes wider than social work and social care, and should include community health. That takes us to more lack of detail in the bill, in which “community health” is a sweeping statement. We can make assumptions about how community health is

defined, but there is no definition anywhere. Until we have clarity and definition, we risk making faulty assumptions. Therefore, we require more clarity on that.

We also need to think about matters such as eligibility criteria. If we achieve what we want to achieve through the national care service, we will move towards a model that is changing, but eligibility criteria are the gatekeepers to services. Unless we think more widely about how we support people to access services, we will not achieve that aspiration.

We need to think about how we commission and what we want from that—whether it is about outputs or outcomes for people—and about how we get to a point at which we are working in an outcomes-focused way to support people.

The Convener: I will stop you there, Alison, because there are specific questions coming your way on all the aspects that you mentioned. I really wanted a broad overview of the bill. I am sorry to stop you mid-flow, but we have a number of questions. Paul O'Kane is first.

Paul O'Kane (West Scotland) (Lab): Thank you, convener. I have two questions, but they will be directed to individual witnesses.

I will begin with Patricia Cassidy's comments. I am looking for a bit more clarity about where chief officers are on a number of issues. In many of the submissions that we received from local authorities, IJBs and health and social care partnerships, concern was expressed about what disruption to services will do to integration. Angus HSCP said that

"Significant work has gone into the establishment of IJBs",

and that a national care service

"could take the focus away from integration and continual improvement".

East Lothian HSCP said that

"It would be damaging and counterproductive to restructure services again, less than eight years since the integration of H&SC."

Are chief officers of the view that there needs to be structural change to the care boards, or is there a sense that there is not enough detail in the bill to make a judgment about whether we should move towards that and about what the change would look like?

Patricia Cassidy: We are very mindful of the amount of time that has been taken to achieve integration over the past seven or eight years, and we are mindful of the risk that further structural change might bring.

A number of contributors have mentioned workforce challenges; we are really concerned that we would need to tackle some elements quite quickly in order to secure and retain a well-qualified high-quality workforce. The recruitment and retention challenges that we have had across the sector post-Covid are well rehearsed. We need to bear in mind the cost and potential perceived benefits of further structural change, if that is what is decided on.

As it stands, there is not a lot of detail in the bill. As I have mentioned, we would be quite concerned about losing the integration, the positive relationships and the benefits that have been realised in a number of our partnerships—for example, inclusion of children's services and justice services, which some of our well-developed partnerships already have. The majority of our chief officers feel that those services should be in the new structure, but that view is not unanimous—some partnerships are not of that view.

There is variation among the chief officers, but there are, in coming through structural change, potential benefits in terms of our being freed, if you like, from some of the bureaucratic demands across the system in the current arrangements. Those arrangements include reporting to the council, to the NHS board and to the integration joint board. The amount of duplication of effort that that requires takes away resource and time from delivery of the day job, which is leadership in integration.

There have been tremendous opportunities—particularly with the focus on strategic planning groups and the involvement of and links to community planning—to really enrich the way in which we deliver services and respond to local need. We have, and are required to have, strategic needs assessments down to locality level, which help us with our planning and targeting of resources.

We have to try to establish how not to throw the baby out with the bath water, if you like. That is about taking the strengths of the current systems into the opportunities that will potentially come with having an organisation that plans and manages integrated multidisciplinary teams that work at locality level, but with the benefit of a national infrastructure and an organisational culture that is consistent. That is absolutely about the ethos and principles in the bill.

I hope that that is helpful.

Paul O'Kane: Thank you. I will move on to Alison White. I appreciate that you are here to represent Social Work Scotland, so I will not ask you necessarily to respond as a chief officer.

I want to ask about Social Work Scotland's view at the moment. It has called for a pause in the legislative process. Is that to do with what you said

about co-design? You said that there should have been a process of co-design prior to this point, rather than it happening through secondary legislation. Is there anything that you want to add about how Social Work Scotland arrived at that position?

Alison White: I will touch slightly on your first question to Patricia Cassidy. At times, disruption can be good. Social Work Scotland is not suggesting that where we are at the moment is where we need to be; there is a real sense in Social Work Scotland that things need to change. We need to strengthen the social work profession and how we respond to and deal with social care, and we need to do that in an integrated structure.

There is a strong commitment to that, but there is a sense that there is already disruption. In particular, we are going through one of the worst crises, in terms of the workforce. We are seeing challenges: in our hospital settings from the number of delayed discharges, for example; in the design and delivery programmes that we already have across the wider social work setting; and in terms of the Promise and aspirations in respect of justice services within that. The workforce pressures and the cost of living crisis are impacting on the people whom we support and on our staff team—especially some of our lowest-paid staff. Also, in terms of the budget that we have available to us at the moment, it feels as though there is already a lot of disruption.

We have a strong commitment. There is nothing that we would take away in terms of the ethos and values that we see in the National Care Service (Scotland) Bill. We are whole-heartedly supportive of all of the aspects that we see, but we need the design process and the shifts to be done collaboratively, rather than through framework legislation. When we looked across the piece, it was felt that there were some challenges in terms of the bill being framework legislation, and we feel that there should be a meaningful co-design process.

The challenge for us is the timeframes that have been set out in the bill. I will take you back to all the disruption that we are experiencing in the system at the moment. It is quite challenging for Social Work Scotland and others to engage in a meaningful process. We should be able to set out a really clear co-design process at the early stages, looking at the interdependencies. We certainly welcomed the pause on decisions about whether children's services and justice would be included until more work could be done. There might be a challenge if we design a national care service in which children's services and justice are an add-on, rather than being ingrained and central from the early stages of deciding what the service should look like, if the decision is that they should be included.

There are some timing challenges, and the concern is not about the value base or the development of a national care service. Ultimately, it is just about the order in which we will do some of the work.

The Convener: A couple of members have supplementary questions. It will need to be one question each, because we need to move on. We will have Tess White first. Could you aim your question at someone in particular? We will then come to Sandesh Gulhane.

Tess White (North East Scotland) (Con): I have one question for Alison White. I noticed that you said that co-design should come before the legislation, not after it. My question relates to what you said about your concern that further integration could make adult social care a delayed-discharges service. Could you go into more detail as to how that might happen?

10:00

Alison White: As a chief officer, I spend my life talking about delayed discharges. It is a critical issue for a number of reasons—not just the impact that it has on hospital care and on how we deliver care more generally. At the point when someone is fit for discharge, it is right that they get home and that we support them in a meaningful way.

In adult services we often focus on delayed discharges, so we spend less time talking about people with learning disabilities, people with complex mental health issues, people in the justice system and people who have substance misuse issues. If we look at the ministerial strategic group indicators, the primary focus—IJBs already need to focus on this—is predominantly hospital activity for older people and what that means for delayed discharge and unoccupied-bed days.

Our concern is that we end up focusing on how we support that aspect, rather than looking at people holistically. It should not be the only focus; if we get preventative early intervention right and we support carers well, that should flow through the whole system. All aspects are important in that. Adult social care being subsumed into a national care service without children's services and justice services will be a challenge. If we do not know where mental health and learning disabilities fit, the social work aspect will become purely transactional: it will be about getting a person a package of care to get them out of hospital, rather than thinking about social work as holistic advocacy that takes a human rights-based approach.

That does not take away from the fact that people who are fit to be discharged need to be home; I am not suggesting that that is not a priority for us, but it should not be a priority above all the other aspects of care and support and how we work with people. Social Work Scotland is concerned about the potentially transactional situation of social work being only a bridge between a person having healthcare and their having social care, because social work as a profession is so much more than that.

The Convener: Sandesh Gulhane.

Tess White: What you said on co-design—

The Convener: Tess, can I stop you? We do not have time for multiple questions. I will come back to you.

Sandesh Gulhane (Glasgow) (Con): Dr Williams spoke about the general medical services contract in his opening remarks. I see lots of parallels between the national care service and the general practitioner contract in relation to centralisation and there being a policy memorandum that was full of aspiration that was not fulfilled. A second memorandum of understanding was then created, but there were issues with the contract in the Highlands and other rural areas. It is obvious that detail and delivery are key. The national care service would be far bigger than the GP contract, which did not go well. Do you have any concerns that GPs being rolled into the national care service will have a negative impact on primary care?

Dr Williams: Certainly, many aspects of the GP contract have brought progress and it has newly brought parts of the workforce into general practice. The shortage of GPs is important: part of the design element might consider where there are shortages.

I will come back to delayed discharge. We want a community pool of support to be ready and waiting when the treatment that people need in hospital has finished. Otherwise, we run the risk that parts of the system will be doing things for which they are not intended or set up. As Sandesh Gulhane suggested, there are processes that do not play out properly, especially in areas of the country that look and feel very different.

We want consistency and we very much want person-focused care. When we start a design process, things can happen in a short couple of years. For example, a pandemic came along that changed many perspectives and much of the practice that we were used to. However, some forms of disruption—Alison White mentioned disruption—are helpful.

The recruitment and retention issues that we face in general practice, and more broadly in health and social care, are a limiting factor. I hope that we do not design a solution that we cannot staff or that we do not have the infrastructure to deliver.

We absolutely need to embrace the ethos of the bill and its human rights-based approach. We then need to consider the practicalities of what our workforce looks like in the different parts of the country, where there are good arrangements that we can build on, and whether we can ensure the right links to the various other agencies that improve people's lives. We also need to ensure that we do not disrupt things that are quietly working away in favour of our citizens.

The Convener: Alison Keir wants to come back in. I imagine that you want to speak about what was said in response to Tess White's question, so I am happy to bring you in before we move on.

Alison Keir: I just want to add something to what Alison White said about the transactional relationship and the need to consider social determinants of health. Unless we think in a longer-term way about the social determinants that keep us well—good homes, relationships and occupations—we will not change the trajectory of people who end up in hospital and become some of our delayed discharges. We also need to think differently about where we support people in the system.

The Convener: We move on to questions about community health, which will be led by Paul O'Kane

Paul O'Kane: I am keen to understand more about the approach to community health services and where they should sit within the structure. I appreciate that it is difficult at this stage to fully understand and discuss this, but should responsibility for community health services sit with health boards or the proposed new care boards?

Nick Morris: I think it should remain with health boards. I do not believe that responsibility should go to the potential new care boards, and I need to get across some points to help us understand why that is.

If we are not careful, care boards could potentially be seen as a logical extension of IJBs, but in reality, health and social care partnerships develop integration at the local level while IJBs have not developed much integration. In fact, when Audit Scotland did its report, the examples of good practice seemed to come merely from the fact that IJBs were not shouting at each other. Although IJBs might be seen as a good construct, some of the governance issues around them are not helpful to either health or social care, but health and social care partnerships are helpful.

Plenty of evidence has emerged through the advancement of community services—the integration of mental health care, for example. Significant advances in the integration of healthcare across health and social care services can be demonstrated. Those include having co-located members of staff who work closely with primary care and GP services. The staff understand the relationship between themselves and the acute hospital when people present with specific, acute needs and they are able to ensure that that care pathway works for people.

The greatest risk is that we create a further fracture in the health and social care system by creating a care board that relates to what we currently have—health and social care partnerships. That is why I support my colleagues in saying that we have to do a lot of the design work in advance, before we get to the legislation.

The other risk is that the current guidance in the framework bill leads to the conclusion that no staff would be employed through the care board—certainly, no healthcare staff would be transferred to the care board—but that the board would be responsible for the development of provision and the planning and commission of services.

We need to work out who is accountable for the delivery of those services, both organisationally and at the level of the individual practitioner. All our staff, such as OTs—I am sure that Alison Keir will support me—social workers and GPs, require an understanding of their professional accountability systems and clinical governance arrangements. Those will be completely fractured by an arrangement that puts in place a care board as described by the framework. Clearly, there is not much evidence or detail in there yet, but that is what it seems is being implied.

To come in on some of the earlier conversations about care boards, the process to date has not seen healthcare as a significant stakeholder. We were not involved as a formally acknowledged stakeholder in the initial consultation process, yet potentially one third of NHS funding will get transferred into the new arrangement, if it goes the way that the framework suggests. That has a major implication for the NHS. We need to work closely with our colleagues in social work, the Convention of Scottish Local Authorities and the other organisations on a co-design process that is built around the Delphi model. That, I believe, will get us to significant consensus on the design. I do not think that the bill, as structured, will get us there.

The Convener: Patricia Cassidy wants to come in.

Patricia Cassidy: Under the Public Bodies (Joint Working) (Scotland) Act 2014, integration joint boards currently have the responsibility for strategic planning and the budgets for community health services—indeed, operationally, those are managed within the health and social care partnerships. It is critical that we take a whole-system approach to looking at the care journeys and health journeys of individuals, and that we smooth out any bumps and gaps between those services.

When it comes to the potential for the boards not to have the operational management of the integrated multidisciplinary team, having such management has been a real win-win in the partnerships. We have been able to bring the staff together, to co-locate them and, through matrix management, to manage them, with professional accountability going up through the chief social work officer, nurse director, allied health professional lead and so on. Models are already working in that regard.

From the chief officer perspective, we feel that it is critical that we are able to bring staff together. Potentially, having staff groups on different terms and conditions involves issues of parity of esteem, equality et cetera. That is a current challenge. However, there are unanswered questions in the bill, as it stands, about what the detail of that will mean. There is an opportunity to look at that wider public sector reform, where those new care boards could fit within the broader public sector, what the arrangements would be for organisational and operational management and the way in which we work with and employ staff.

Paul O'Kane: Thank you both for those responses. There is an issue about the structures around care boards, the culture that is embedded through HSCPs, and some of that integration work.

I have a question for Alison White on the point about potential staff transfer. Last week, we heard from COSLA, which, obviously, was very concerned about the local government space and what might happen to local government staff. As you represent social workers, can you give me a sense of what the anxieties are for the social work profession about what their future might look like?

Alison White: There is a huge level of uncertainty. Obviously, given that it is a framework bill, some of the questions that people might have are not answered at this stage. The answers would come through a co-design process. A huge level of anxiety is being caused.

Patricia Cassidy highlighted the fact that, across the partnerships that we already have, there is a range of difference. Whatever comes out of this, we know that there will be change somewhere. In some areas, children's services are in; in others, they are out. Whatever the decision is about

where children's services sit, there will be changes somewhere in Scotland. There is a level of anxiety about that.

Some people welcome a level of change. They think that it is an opportunity. They may feel that they have not been sufficiently protected and valued, and that there is an opportunity within a national care service to have a strong voice for social work and social care. However, at the same time, we are already struggling to fill vacancies in social work in particular—on the front line, at team lead level and in some of the senior management roles. In addition, some people who are close to retirement may think that they do not want yet another structural and organisational change, so there is a real sense that we might lose a level of experience as part of the restructure.

10:15

People might say those things and then not move, but recruitment is difficult now and any uncertainty can be challenging when recruitment is difficult.

There are opportunities here because of some of the fair work policies. We will go through a discussion process about what that means and how we create parity and support. It is also worth saying that there are differences in different areas: what suits Edinburgh and Glasgow does not suit our colleagues in more rural areas, who are already experiencing even more significant challenges than are faced by those of us who offer support in more urban areas.

There is a mix, but there are real concerns about what this might mean for continuity of staffing.

The Convener: Alison Keir wants to come in.

Alison Keir: The issue of terms and conditions is a big one for occupational therapists. We come into integrated teams from a health or from a social work background. We have different terms and conditions, pay scales and holidays, but we sit together in integrated teams, doing the same job. The bill gives no opportunity to explore how to make that more equitable. It works now because of the good will of staff, who have worked really hard to get over that and to make their teams work, but their terms and conditions are fundamentally different and that will be a big issue in the long term if we do not challenge it.

Emma Harper: It is interesting to listen to everyone. It is my understanding that this is a framework bill to create a more integrated service. It includes fair work, human rights and improvements in the quality and equity of services. I have the recommendations of the Feeley report in front of me. The report lays out the case for the creation of a national care service. Recommendation 20 is:

> "The National Care Service's driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers, and improvements in the conditions of employment, training and development of the workforce."

There is a lot even in that single recommendation. It is my understanding that this is about people with lived experience and about people who need care in order to prevent hospital admission. It is not just about dealing with delayed discharge; it is not a delayed-discharge bill. I am trying to get my head around how we support co-production, co-creation and innovation.

The framework bill is supposed to set out what further statutory instruments will come afterwards. Those will come from people—whether they are service users, service providers, NHS leads or others—working together. I would be interested to hear comments about Derek Feeley's recommendation number 20 on the case for the national care service. Nick Morris has his hand up.

Nick Morris: There is no doubt among the stakeholders: we applaud the principles and the aspiration of Derek Feeley's report and the extension of that into the national care service consultation process. We agree that significant improvements are needed on the integration of services at local level, in order to meet the needs of people with lived experience. I think that we meet the needs of a significant number of those people well, but there are lessons to learn from people whose care needs are less well met.

There are two reasons why we are asking for significant design work ahead of the bill. One is that, by default, the framework bill makes us look at the issues that are in the bill, and that bill refers to structures. It diverts people's attention into conversations about structure, which are not particularly helpful at this point. It diverts us from the task at hand of dealing with the immediate pressures in health and social care. That is a concern because there is a need to address the issue of integration. We cannot always put off the things that we need to do in the future because of the pressures that we have now.

There is another key issue. The most significant improvement that we can make for people with significant health or social care problems is in the design of work at multidisciplinary team level and at local level. My background is in psychiatric nursing; I spent 30 years of my 40-year NHS career working in integrated health and social care systems, so I worked in social care as well as in health.

The most significant thing that we can do at the moment is develop at the local level integrated

mental health community teams and GP primary care teams, who understand the voice of local communities and how we should respond to them, and identify clients rather than wait for referrals, so that we are more proactive in our understanding of those people in need.

We have some clients who will have very short interventions—they can come into the service and then go away—but most of the lived experience concerns that are being expressed to us are from people who have multiple issues. Their concerns are about being passed around from department to department, getting multiple assessments, et cetera. The only way that we will tackle that is by having at the local level integrated co-located teams who understand their local populations and which individuals are in need of care and who can make sure that they remain captured in the care system in order that they are supported, rather than continually discharged then re-referred.

All that work needs to take place to ensure that we have integrated health and social care services. That will lead to a fantastic future NCS operation. We need the structural design to understand what we need to do for people at the local level. Picking up on what Alison Keir said, we need to understand the outputs that we are trying to deliver—the outcomes for individuals—and what the local performance requirements are. We need to understand, from the individual person's perspective, whether we are meeting their expectations. Then we can aggregate that up to a national performance framework that impacts on health and social care and takes us away from some of the focus on things such as accident and emergency waiting times, which are important but will not get us to a healthier Scottish population. They will deal with the people who are ill, but we need to deal with a healthy Scottish population.

We need to start focusing on an integrated health and social care performance framework that aggregates up from what individuals require in terms of preventative care and co-ordinated care within local multidisciplinary teams.

Stephanie Callaghan (Uddingston and Bellshill) (SNP): My question is for Patricia Cassidy. What co-design is already under way with social work and social care staff? Is that presenting opportunities for social workers, for example, to better apply their expertise?

Patricia Cassidy: I will speak about local practice in Falkirk and NHS Forth Valley. We have redesigned a number of our key services in partnership with people who use them: families, their carers and service providers, if that is appropriate.

We have undertaken significant redesign of our services for people with learning disabilities. Six or seven years ago, we offered five building-based day services, and we had people who had been attending those services for, in some cases, 30 years. They would be picked up by a bus in the morning, would do a range of activities and would then be dropped off at home at night.

We have done a range of consultations. We used a third sector organisation to be the interface for us with our social work staff. We did about 14 months of consultation to look at what was important for people and what they would like to do. That formed the basis of a collaborative piece of work on redesigning our services.

We did not withdraw our services; we changed the way that we delivered them. We retrained our staff to deliver much more community-based support and services. We commissioned new providers to come into the area to provide a range of social, leisure, training and educational opportunities. We did more concentrated work with individuals to help them to become more independent, for example by travelling by bus and accessing mainstream services.

Doing that level of change was quite challenging for the council. Our local elected members were concerned that there might have been a significant backlash in the community, but the co-design work that we did and the continual feedback loops into the consultation groups and the stakeholders were such that we did not hear even a murmur of dissent in the community.

We transformed the service. We reduced our service down to two day services, which became hubs for people to come into to access support, and people with more complex needs have had a much wider range of services. The council had a couple of million pounds set aside in the capital programme to re-roof one of the buildings, but we were able to close it, and the council agreed to our request to use that capital to invest in changing places toilets. We did not have any of that physical infrastructure in Falkirk—we had no changing places toilets. We now have five, and a spin-off group is working in our communities to look at where more provision is required. We have another two or three to build, and the families are absolutely at the heart of that co-design work.

That is one simple example of how we have worked collaboratively. We are now in a phase in which we are looking again at the way that we deliver those services, and we are working with Healthcare Improvement Scotland, neighbourhood networks, social work staff and our health service staff on the next phase.

That is an example of how we are coming at things differently, pulling in external expertise and listening and responding meaningfully. The more we spoke to individuals and groups of people, the

more they wanted to know and to contribute. That is a microcosm of the potential of co-design.

The Convener: A number of members have questions. I ask them to be succinct and focused, because we have only half an hour left with our colleagues.

James Dornan (Glasgow Cathcart) (SNP): I was on a health and social care partnership when I was a councillor, and I saw the benefit of that joint working, although the silo mentality was still very strong then. I am pleased to hear that things have improved in the IJBs.

I have a question for Alison Keir. The bill is a framework bill, so you all have an opportunity to feed in what you would like to see and to co-design the service. You mentioned the specifics of different terms and conditions. Surely the bill will go some way towards alleviating the problems that arise from the staff of the two bodies having different terms and conditions.

Alison Keir: It is not clear that, with the bill, we will tackle different staff in different agencies being on different terms and conditions. My understanding is that we may end up with what we have just now. We still have staff from health who are on one lot of Ts and Cs and staff from social work and social care who are on different Ts and Cs working together in the same team and doing the same job. We have not tackled that problem.

James Dornan: However, we are at the very beginning of the process. This is the time—

Alison Keir: Absolutely. It is important that we tackle that.

Carol Mochan (South Scotland) (Lab): I think that Nick Morris might be able to answer this question. I am interested to know whether the framework bill gives us enough information about some of the legislative stuff around adults with incapacity and mental health issues. Is there enough in the framework bill to help the transition with the multi-agency public protection arrangements and so on?

Nick Morris: I do not think that there is any detail on that in the bill. I know that, as part of the design process, a consultation document has just been launched around mental health related to the NCS. We will be keen to engage with that, but it came out only this week. There is lots of potential in the design process to pick up issues that are related to those significantly disadvantaged people, but I do not think that the bill makes reference to that.

I say again that the reason why we have concerns about the framework bill is that it focuses on some of the structural elements that the Government wishes the legislation eventually to bring into place, which is not allowing us to have the conversations about the design work at local level, or is discouraging us from having those conversations. They need to take place.

Carol Mochan: That is helpful. Thank you.

The Convener: We will move on to talk about prevention and early intervention. Our questions on that theme will be led by Gillian Mackay.

Gillian Mackay (Central Scotland) (Green): Good morning. I ask Alison White to answer this question first, if that is okay. How can the bill help to deliver on the recommendations of the Christie commission? We have heard concerns this morning about a lack of detail regarding prevention and early intervention. What would you like to be included?

Alison White: We already have a real strength because of the self-directed support legislation, which enables us to have good conversations with people about choice and control and how we look at people's rights and responsibilities within that. I am not saying that that has been rolled out in every area as fully as we would want it to have been at this point in time, but I think that we have in place a piece of framework legislation for how we work with people, have good conversations and work to support people at the earliest possible stage.

10:30

Nonetheless, there are some elements that we need to get into. We have referred to the eligibility criteria and how we work with those, but we have not touched on the financial memorandum and what that will look like. All those aspects come with significant costs associated with them, but they have not been costed as yet—we have not done that design work in order to work out what something new would look like and how we would cost it.

In times of austerity, when budget cuts are required, it is often the preventative and early intervention services that end up being cut, because we need to maintain delivery of critical services. However, we all know, and feel, that investing in those earlier intervention and prevention services is the right thing to do, as it prevents crises from arising all the time.

We need to do some of that design work in order to fully understand what the costs of those aspirations are. There is nothing in the Feeley report that we would not whole-heartedly support, because we think that it is the right thing to do for the people and communities that we support. Nonetheless, we need to understand the cost implications of doing those things and how we share the budget around to allow us to do that.

I would like to touch briefly on the previous question about protection issues. I do not think that those are fully covered in the legislation; one aspect in particular that is missed in the bill as it is currently drafted concerns the role of chief social work officer. We can see from the legislative framework that there is a clear role for the chief social worker. Although the role of social worker is mentioned in the bill, it rarely—if at all—mentions the role of chief social work officer in relation to the governance around ensuring that we keep people's rights safe.

If we are looking at a wholesale shift of that responsibility to ministers, as opposed to the responsibility sitting with local authorities, we need to consider the scale of legislative change that would be required to ensure that we maintain that safety, in particular with regard to the data sharing and health and care record aspects of the bill. We need to be mindful that some of the data that will be stored from a social work perspective relates specifically to the protection agenda and is very different from the types of data that might be shared elsewhere. We are engaged in those conversations, but I wanted to touch on that issue.

Gillian Mackay: Earlier this week, I had a meeting with Alison Bavidge about social work within the NCS bill, and she usefully described social workers as the GPs of social care. I am interested in hearing your thoughts on how we ensure through the bill that social work, rather than continuing to deliver small things, gets back to the holistic cross-wellbeing view that social workers would like to see—a restoration of the profession, if you like.

Obviously, social work is an area that is heavily based on legislation, and the bill is another piece of legislation to add to the spectrum. I would like to hear your thoughts on how we ensure that we get back to a cross-issue view, rather than delivering pieces of justice, and how we do investigative work and other things in looking at the whole wellbeing piece.

Alison White: I do not know whether you have seen the "Setting the Bar for Social Work in Scotland" report that Social Work Scotland produced, which looked at the workforce issues that we are experiencing and surveyed all our staff about some of those challenges.

As part of the report, we mapped out some of the legislative issues that social work has needed to pick up over the previous period. It did not quite cover all of them, but it highlighted the significant change that we have needed to deliver without having proper reinvestment, both in terms of the skill set that we are looking at and how we deliver. At times, there are challenges within social work around the fact that some of the pieces of legislation do not sit as comfortably with one another as they might. We almost have to choose which bit of legislation fits best for the individuals with whom we are working.

To some extent, with the national care service and the development of the bill around the role of social care and social work in particular, there is a real opportunity for us. As I said, we are not against the development of the national care service and the conversations that we can have as a result. We think that social work has the skill set, and the real strength, to really drive forward much of what we see in the Feeley report. That sits within the training and development that we, as social workers, have had.

That is not to say that people in other professions have not had that training. We have a mixed-profession group here, and I am not suggesting that only social workers have that training, but something in our core value set and how we work with people through good conversations meant that the Feeley report really resonated with most of us as regards what we want to do and how we drive that forward. If nothing else, we welcome the opportunity to have a conversation on the role that social work can play.

Stephanie Callaghan: That was really great—what you said was dead helpful. The point about protections for chief social work officers was well made, although I note that it could apply to heads of service as well, and not just at the very top level.

My question picks up on Gillian Mackay's points. In my constituency, Enable Scotland uses SDS and delivers personal assistants. The approach is about focusing on the individual and what matters to them, and it involves taking a wellbeing approach and a preventative approach, rather than picking from a choice of services that happen to be available. I am really interested in that approach. You mentioned the costs that are associated with it, but Enable has said that, actually, most of the time, it does not cost more, which is interesting. What recommendations would you like us to make in our report to ensure that that issue is front and centre in the bill and that we have it covered?

Alison White: It is about the co-design process, and making sure that we have the strong voice of people who use our services and those who are caring. We need an equally strong voice for people who assess and deliver services. We all understand different bits of the system, and I suppose that, to create something new, we need to understand all aspects of the system and not just have a perception of part of the system.

We all think that something needs to change, although there is fantastic work out there. Patricia

Cassidy mentioned some good areas of development, and we could have stories from all the different areas. However, equally, we all think that we can do more to develop services.

It is about the co-design process, but we need the time and scope to do that properly and we need to ensure that we have the right people involved. We also need to think about the interdependencies, because this is such a large-scale change. In the plan of work for the NCS, there are around 70 workstreams, and there are clear interdependencies between them all. To get that strong voice from us as Social Work Scotland and from our members who are social workers and who are part of the process, we need to ensure that we have time to have those really good conversations that begin to shape what we need in the service redesign.

There is a strong commitment to making things happen, although some strong pieces are already in place. We have mentioned the self-directed support legislation. Some strong and good legislation is already in place and, although it might not be fully embedded in all areas, it has the right principles and framework. We need to ensure that we make a success of some of those areas of work rather than losing some aspects, because they already have all the principles of co-design, working well with individuals and really thinking about what matters to them and what outcomes are important to them.

The Convener: There is a gap between the framework legislation, which will set the course, and the secondary legislation. You mentioned 70 workstreams. The national care service is not expected to be delivered until the end of this session of Parliament. Do you agree that that is a fair amount of time for the process to happen?

Alison White: It is. The only thing that we would change is that we would do the co-design prior to some of that set of legislation. It is not an unrealistic timeframe for us to do some of that work; it is the timing that we question.

The Convener: Our next theme is on keeping things local. The questions will be led by Evelyn Tweed.

Evelyn Tweed (Stirling) (SNP): You will be pleased to hear that many of my questions have been answered, convener, as a lot has been said about co-design already. My focus, which ties in neatly to what we have just been speaking about, is on front-line staff, who are very busy. We have talked about the challenges, such as the pandemic and workload. How can we ensure that front-line staff are front and centre of the co-design? How can we ensure that they have the time to participate fully in what is happening? We have just heard that there will be significant time, but how do we ensure that they are at the front of that process?

Dr Williams: Initially, in the consultation stages, the headspace of many of our members immediately went to the threat that the management of general practice might be absorbed into an organisation that does not have a long, established track record of managing general practice. You might find that sort of behaviour unfolding in other professional groups. Are people ready for the suggestion that there might be a reorganisation? Are professional groups already discussing how we can best synergise our activities?

Do we have the right groupings? We have various hubs and co-locations of different services. We would do well to put some effort and energy into working out how we maximise impact. In general practice, one of the issues that we encounter is not having enough time and resource to be able to stop and reflect on where we are at the moment. Are we maximising the systems that are continually changing round about us?

Dr Gulhane picked up on some of the issues. When we go into changes, do we have the correct IT models? Are we going to find out that we are paying for software licences for somebody to work in one specific place and that it then costs a lot more when we ask one person to work in multiple GP surgeries? There are many specifics that people will be able to tell us about that will enable us to work out how we build a health and social care service that is better integrated in some of the fine bits of working where there are good economies of scale.

We need a process as well as the legislation. Once we have primary legislation, it gives people certainty about what is happening, but we need to give people confidence that there has been enough mapping out of what things will look like or where things will need to move from if we are going to find new structures and teams that look slightly different. If you can explain to my OT colleagues that the bill will definitively solve a problem that is mentioned, you will find a lot more buy-in.

If you can remove some of the potential threats that the different professions feel—they might be perceptions rather than real threats—that would be welcome. The history that we have in Scotland of being able to design person-centred services is really strong, but a little bit more discussion in the background would provide confidence.

Alison Keir: It is also about getting the right people around the table so that we have time to hear each other's stories and the lessons that we have learned. In Dumfries and Galloway, 65 per cent of people who are discharged from hospital

and go through the occupational therapy reablement programme regain independence. How do we share that good practice so that we can scale it up?

From RCOT figures, we know that OTs are 4 per cent of the regulated health and care workforce but address 35 to 45 per cent of all referrals. We are not a huge number, but our outputs are significant. How can we be part of the wider dialogue so that we think about how we can all be part of the new future and so that everybody around the table has an equal voice?

10:45

Patricia Cassidy: The national care service provides a great opportunity to reposition our whole health and care workforce in a value-based culture, with recognition of its value. There are a number of formal structures in place through our trade unions, the staff side and the professional bodies. We also have joint staff forums at integration joint board level, where we bring together those representatives. That all needs to be enriched and augmented with the voices of front-line and other staff. They know their communities and their jobs, they can see where things could be improved or changed and they understand where some of the solution lies. I suggest that we also need to talk to our potential workforce—to young people in schools—to develop an understanding of types of employment, of rewards and enjoyment, and of what their motivation is. How can we attract young people into the various professions and positions? We have significant workforce challenges. How do we engineer in the fact that we are growing a workforce for the future?

There are a number of elements there. Critically, we need to hear from staff at all levels, and they need to be able to see what they have said being reflected in what comes out through the legislation.

Nick Morris: Patricia Cassidy raises a very important point. The question was about how we engage our staff in the conversations about the development of the NCS. That is fundamentally important, and we have to do it.

I remind everybody that the systems pressure that we are under means that most of our staff are struggling to get any reflective time at all, either in the healthcare system or in the social care system. They are working with their nose to the grindstone all the time. There is an issue there about the current position.

The convener said that we now have three and a half years, I think it is, before the end of this session of the Parliament in which to produce a bill. Our constituencies would urge great care about pace: they would rather that we got things right than get things done at pace. The NHS was originally conceived in the 1930s, and the original bill to create it—the bill for emergency hospitals—was in 1938, but it took 10 years to get to the NHS. It then took until the 1980s before we managed to integrate community services and GP family practitioner services properly. Even then, we had left social care services out of the process, with different arrangements. Over all those decades, it took a long time even to get to where we are now. We would rather build on where we are going than distract from it.

The final point that has been raised concerns the current recruitment problem. People who are looking to join a workforce of health and social care practitioners will want to have some understanding of what they are walking into. At this point in time, it is difficult for people to understand who their accountable manager will be and who is going to own them as a body. We need to be very careful about the structures, as that could detract from our ability to recruit at this point. People will not know what they are signing up for.

Tess White: Dr Williams, the NCS risks taking power away from local decision makers. What impact do you expect that to have?

Dr Williams: That is quite a broad question. I will start by answering from a general practice perspective. Generally, general practice is set up as independent contractors. As we have mentioned earlier, primary care reform is still unfinished business, and we still have a lot to concentrate on in general practice. General practitioners have been on health and social care partnerships, playing a positive part in helping to navigate meetings of cultures. Many of us around this table do not mind reorganisation as such, especially when it is generating a positive direction, with discussions that are enabled.

Part of what we have just heard is that, at the moment, a lot of parts of the system are too busy to have a good, clear focus on some of the new design that is required. There is a flotilla of ships out there that we are trying to keep afloat.

Coming back to what I was saying earlier, you need to provide our various professions with the confidence that enough thought is going into the structures that are envisaged, that those structures will be resourced and that building elements of one part of the system will not rob other parts of the system. I have mentioned bringing new parts of the workforce into general practice, such as pharmacists and physiotherapists, who were not working there before but who have new roles and are doing fabulous new things. However, there are a limited number of pharmacists and physiotherapists in our care system across Scotland. We need to be

careful in our workforce planning as to the pace at which we think we can develop and, again, which parts of the system we can simultaneously build and remodel and modernise.

The Convener: Thank you. We are rapidly running out of time and have about 10 minutes left in this session. Our final theme is on rural areas. Sandesh Gulhane will lead the questions.

Sandesh Gulhane: The Scottish Association of Social Workers raised concerns that these national care service proposals could exacerbate recruitment issues, as Dr Williams mentioned in his earlier answer to me about a system that we cannot staff. Alison White, do you agree with that assessment? If so, how would the proposals exacerbate those issues?

Alison White: We are already experiencing recruitment issues. Colleagues of mine who work in rural areas are very vocal about some of the challenges that they are experiencing. In many cases in rural areas, the issues are not just about the volume of staff but about having affordable housing; it is about the broader community planning aspect of how we support our workforce and staff in those areas and not just about attracting people to those posts. A colleague was highlighting that they had been able to appoint someone but the person ultimately withdrew after spending six weeks trying to find accommodation in the area and not being able to find it. It remains critical that, whatever we do, we work in that broader community planning environment to ensure that things such as housing are available for people.

We are experiencing those issues, and I think that any level of increased uncertainty can add challenges. It is not just rural areas that are experiencing those problems. I hope that, as we go through this process and look at the fair work agenda, there will be opportunities in it to look at what fair work might mean, what is a fair wage and how we manage that. However, there are significant differences between the urban and rural areas that we need to be mindful of in the planning stage.

Sandesh Gulhane: Rural and island communities face significantly different challenges to the rest of the country. What impact do you anticipate that a one-size-fits-all approach to a national care service would have on those communities?

Nick Morris: The logical conclusion that is suggested by the NCS proposals at the moment is that the island communities would have less control of the NHS elements of care, because it would all go to a care board. I cannot see why there would be a care board and an NHS structure on one of the islands at the same time, as that would duplicate too much effort, so it is likely that NHS programmes would be planned from one of the mainland boards—we do not know how many mainland boards will be retained, but we can assume that they will stay roughly the same as they are. The island communities are likely to have only a care board under the current proposals. I think that people are worried about the degree to which they will be able to influence through their locality arrangements the structure of NHS care for their own population.

That concern is replicated in rural areas, where we have significant distance from the urban central belt. In many ways, places such as Dumfries and Galloway reflect the same needs of rural communities. In D and G, we created an IJB that includes all our acute hospital services as well as our community services. We want to retain that model, as it gives us some sovereignty with regard to the degree of health and social care integration, from primary care right through, potentially, to referral to tertiary care.

Some of the more populated urban areas—Glasgow and the Lothians—might be able to develop a different model. However, some of the rural areas might want to develop a model that is consistent with what is being considered for the islands, which is a single integrated health and social care system, from primary care right through to secondary and tertiary care. Highland Council might want to do that as well.

Sandesh Gulhane: Dr Williams, if we are looking at a fully integrated service, GP care and primary care in general need to be part of that. However, given the change that is happening to the IJBs and, in particular, the lack of GPs and primary care practitioners in the Highlands and rural areas, does the national care service not pose a risk?

Dr Williams: On whether it could destabilise things, I refer to what Nick Morris said about the way in which boards are configured differently depending on their size, and, from the general practice perspective, it is difficult to know the answer to that from looking at the framework legislation. What we build through that legislation will either build confidence or give me other thoughts. However, with regard to how much resource we have for the different parts of the system, how we build on what we know about the changes that have occurred over the past couple of years will be more informative.

Earlier, the terminology of admission prevention was used and we spoke about how general practice plays a role in advance care planning. We are able to speak to people to understand their wishes as they look ahead. Those conversations happen a lot in general practice, and if we can find better, more efficient ways to feed that into the

social care side of things, all the better. Therefore, to respond to your premise, general practice is a busy place: we face lots of workforce challenges, and many things carry a potential threat.

The Convener: I will pick up on your point about workforce challenges. The recruitment of GPs is an issue, as is the recruitment of ancillary staff who are currently provided as part of the GP contract. There is no one solution, but does the national care service offer the potential for a drive to recruit more people to the sector, given that parity of esteem for the care service and the health service is something that has come out in many of the consultation responses? I am happy to hear from anyone on that.

Dr Williams: I will reflect on our experience in general practice. When the new contract came in, we did not go for a big-bang overnight change. It was an iterative multiyear approach, and health boards were allowed to select their priorities for the parts of the workforce that they intended to develop. In fact, a great deal changed during that period. However, there was throttling up in different parts of the service. There was development and some degree of reflection on what was working and which of the new changes were bedding in well. We thought that the Scottish Ambulance Service would have a role in that but, ultimately, that did not pan out as expected and our efforts to make arrangements for urgent and unscheduled care went in different directions. I think that there is something there to try and replicate. If we can build different parts, and pause and learn from what is being built, that might offer more comfort than having some large overnight reorganisations.

11:00

Nick Morris: There is every potential that the development of the NCS and the focus on social care and social work could increase the potential for recruitment into those care areas. Social work is often not at the celebratory end of what goes right; it is often at the butt end of when things have gone wrong, yet social work practitioners deliver tremendous things from day to day that nobody ever hears about.

If there is an opportunity to bring into the public's perception what social work does and the positive contributions that it makes to supporting people, navigating them through into their communities and helping them to prosper and develop meaningful lives, there is an opportunity to enhance the role of social work and social care practitioners. If we tie that in with core and branch training programmes for people who might enter at certificate level and want to work up to degree level, that would mean that people can branch from social care, healthcare or whatever. That, too, is a strong opportunity out of the NCS developments.

Alison White: Thank you, Nick; that was a very nice reference to social work.

I think that it links back to fair work. I agree that NCS can have an impact on that, but it is about making sure that we get it right in terms of training and development, opportunities, fair work and pay, and terms and conditions. That is probably less the case for some of the social work staff, but for social care, in particular, given the myriad of providers that we have out there, if we want to attract people in, we need to be able to see that there is parity of esteem. If there is a focus on that, there will be a real benefit. However, it is not just about parity of esteem; people still have bills and mortgages to pay and everything else that goes with that.

The Convener: It is parity, full stop.

Alison White: It is parity, full stop. It is not just parity of esteem that we need to look for.

The Convener: That is very helpful. The final questions are from Emma Harper.

Emma Harper: I will pick up on what Nick Morris said about the national health service, which was created 70-plus years ago but is obviously still a work in progress, given the changes that we see happening in it. I take on board what you are saying about the creation of a national care service needing to be done with consideration. We need to do it carefully and make sure that we get the legislation right.

However, that brings me back to the beginning. This is a framework bill and there will probably be amendments after our stage 1 report, but I am interested in how we make sure that we bring everybody along with us. It is great that we are singing the praises of social workers and that we can use this to value their work. That could be done using national approaches to skills development, education and things like that, as well. I am interested in your thoughts on that.

Nick Morris: If you listen to the contributions that we have made, including those of Patricia Cassidy and Alison Keir on screen, you will know that there is far more that we have collective understanding of and agreement on than we have differences on. However, we do have differences of opinion, and there is often a perception that social workers, medical staff, nursing staff and whoever disagree with each other and that that is wrong.

If you are going to get a multidisciplinary team to work well, you have to bring those different frames of reference into the conversations about patient care in order to do the right thing for the patient. My concern about the framework legislation at the

moment is that the conversations that we are beginning to have are about the things that we need to do in order to drive the future, and it feels that the framework legislation potentially gets in the way of doing that because it is focusing on conversations around structures, care boards and so on.

We all aspire to having a national care service. I agree with the First Minister's initial aspiration that we ought to have an NCS that builds on and reflects on the significance of the NHS in 1948. That is a fantastic aspiration, but we need to understand what the NCS is, because it is not going to be a co-existence of all healthcare systems, as the NHS is. That is all provided by one organisation. Social care is provided by thousands of organisations, so it cannot be one body; it has to be multiple bodies. The NCS is a structure for bringing those things together, and if we are not careful, we will end up having conversations about governance, management entities and all those sorts of things before we have had the conversations about what unites us, which is the individuals on the ground who need all our contributions to support them.

I do not knock the NCS concept at all—we fully applaud it and the aspirations of the Feeley report. It just has to be very carefully delivered. Those conversations, from grass roots to senior leadership, need to bring together what that consensus looks like, so that we can inform the bill. That is my position on that, I am afraid.

Alison Keir: It is important that we capture the value of allied health professionals in the national care service. We have talked a lot about doctors, nurses and social workers, but allied health professionals are key, as is rehabilitation—how we enable people to have the skills to live their best lives, including reablement to help people to regain lost function, regain their independence and not need the support of a national care service. Rehab and AHPs are key to the future of the national care service.

The Convener: Thank you. We have reached the end of our time with our first panel. I thank each and every witness for the time that you have spent with us this morning. It has all been very helpful.

I suspend the meeting for a 10-minute break.

11:05

Meeting suspended.

11:21

On resuming—

The Convener: Our second evidence-taking session focuses on the independent review of adult social care, which was commissioned by the Scottish Government. Certain recommendations from the review have been incorporated into the National Care Service (Scotland) Bill and accompanying policy memorandum.

I welcome to the committee Derek Feeley, the former chair of the independent review. We will move straight to questions.

The case for a national care service formed a number of recommendations in your report. I will run through them for everyone who is watching. You said that

"Accountability for social care support should move ... to Scottish Ministers"

and that a

"national care service for Scotland should be established in statute"

that would

"oversee local commissioning and procurement"

of all the services—there is a list of services that should come under its remit.

You also said that it

"should oversee social care provision at national level for people whose needs are very complex"

and that the

"driving focus should be improvements in the consistency, quality and equity of care and support experienced by service users, their families and carers",

as well as

"improvements in the conditions of employment, training and development of the workforce."

Does the bill encapsulate those recommendations?

Derek Feeley (Independent Review of Adult Social Care): I think that it does. As you said, we hoped that the national care service would be able to achieve clarification of accountability. One thing that the pandemic taught us was that the public held the Scottish ministers accountable for what happened in social care, but the way in which our system of social care support was set up did not provide ministers with all the levers that they needed to give effect to that accountability. It was difficult for parliamentarians to hold any individual or individuals to account. I remember, as director general for health and social care, being regularly in front of the Health and Sport Committee and the Finance Committee on healthcare matters but never on social care matters. Therefore, a strengthening of accountability seemed important to us and the bill captures that. The idea that we ought to be able to set some kind of a national strategy, funding and direction for social care support is well captured in the bill.

In several areas much will depend not on how the national care service is established but on what it does. We would all expect the national care service to be interested in removing some of the variation that people described as the "postcode lottery" when we discussed the issue with them, and to pay some attention to the portability of support packages across geographical boundaries, which is currently a challenge. The importance of fair work and national terms and conditions was also mentioned. Some of that is difficult to codify in a bill and will depend very much on how the national care service operates. However, I did not see anything that was particularly missing from the bill as a basic infrastructure on which we can hang some of those things.

The Convener: You might be aware of the views of witnesses in previous evidence sessions that there is not enough detail in the bill. When doing the review, your approach was to work with people who are accessing the current services as well as with people who work in the current services. The Scottish Government proposes to follow a similar process by having a framework in place and then going to the various and many stakeholders and involving them in a co-design process that will inform secondary legislation. Is that the right approach?

Derek Feeley: It is always important to involve people with lived experience of social care support. We did that in our independent review. Some of that was done in the consultation process that preceded the publication of the bill. I am never going to argue against further co-design with people with lived experience; indeed, I would like to see them as strongly represented as is humanly possible at every level of the national care service, including at the most senior levels.

There is also a need for some pace now. It is 18 months or so since we published the report. I have had conversations with people in disabled persons organisations, for example, and they would like to see things moving. A balance will need to be struck between that essential co-design and keeping up the pace of the reform programme and process.

The Convener: That is contrary to what we have heard. You are hearing that people want the pace to increase and then to be maintained, yet some people—including witnesses today and last week—are calling for a pause. How does that square with what you are hearing from people?

Derek Feeley: I am not sure. I was not able to listen to the evidence from the earlier panel, so I do not know who is calling for a pause. The folks that I am hearing from are people who have lived experience and who are in disabled persons organisations, for example. They feel that the creation of a national care service is the right thing to do and are anxious that some of the benefits begin to accrue. That is what I am hearing from those people.

Paul O'Kane: I will pick up on that point about the framework bill and the way that this has come about. Some witnesses have said that the concern about its being a framework bill is that co-design could have happened prior to publication of the bill. The bill could have been co-designed and if it had been, we would now be having a different discussion. The views of those who are calling for a pause, including Social Work Scotland, Unison the union and COSLA, have been fairly well documented.

I am keen to get your views on whether there should have been a co-design process prior to the bill's introduction. I do not think that anyone disagrees with what you have said about the fact that people want to see tangible benefits. Do we need more pace on other parts of your review recommendations—for example, removal of charges for non-residential social care support? Should we invest money now in order to move the dial on those things, rather than waiting for the delivery of a national care service by, potentially, the end of this session of Parliament?

11:30

Derek Feeley: First, there has already been a fair amount of co-design in the conduct of the independent review. The vast majority of what you see in that report are views and proposals from people with lived experience. This morning, to get myself ready for the committee, I watched again the short video that we produced to go along with the report. If members have not watched it, I recommend that they do so, because the language that people used in it is the language of co-design. In that video, one lady says that it is time to stop seeing disabled people as part of the problem and to start seeing them as part of the solution.

There is a good deal of co-design in the report itself and a lengthy and substantial consultation process followed publication of the report and led to the bill. I am not sure that I agree with the characterisation of the process as being one that has not yet involved any co-design. People might have different views on whether it has been sufficient, but there has been some co-design, which got us to this stage. I am not suggesting for a second that we ought to stop that process. We should continue that process during the bill's progress through Parliament. Once we have established a national care service, we will need to switch from co-design to co-production. Voices must continue to be elevated and amplified and be central to the decisions that are made about the

priorities of the national care service and how we allocate resources.

On your second point, I am glad to hear that you recognise that our report contained things other than the creation of a national care service. We recommended a completely different way to think about social care support—a new narrative for social care support—which is something that we could change right now without legislation. We recommended a host of changes to the commissioning process and we recommended implementation of, for example, self-directed support and support for unpaid carers. Again, it is encouraging to see those in the bill, but there are probably some things that we could do now without the infrastructure that the legislation would provide. It will be a matter for the Parliament whether the work on the bill is paused, but I hope that we continue to make the changes that people asked us to make on their behalf.

Paul O'Kane: Thank you for that response. I appreciate absolutely what you said about co-design; I witnessed some of that in a previous role before I became an MSP. As the framework bill stands, does it meet your expectations and the expectations of those with lived experience? My contention is that people want detail, and they want to help to co-design that detail through the legislative process rather than after the fact. It feels like a structural bill rather than a bill about culture.

Derek Feeley: It is very difficult to capture culture in a bill. Whenever anybody talks to me about culture I refer to the work of Edgar Schein, who says that the only way to change culture is to solve problems differently.

We need to get outside of the bill and into what a national care service will do, how it will do it, how people with lived experience will be listened to in that process, how we are going to remove some of the variations that exist and how we will ensure that we in Scotland can scale up and spread promising things—of which there are many. That is how we will change the culture. I do not think that the bill is a good vehicle for changing culture, and although I cannot speak for the authors of the bill I am pretty sure that that was never their intent.

The bill has to create some kind of structure around which we can hang the creation of a national care service. The real work will start when we have a national care service that has to completely change the narrative around social care and ensure that all of the good things that exist in Scotland—such as self-directed support—are properly implemented and that promising practice is available to everybody in Scotland and not just to people in pockets of the country. That is how we will change the culture.

Tess White: The convener of the Finance and Public Administration Committee, Kenneth Gibson, said that, with the bill, it seems that the Government is

"using a sledgehammer to crack a nut."—[*Official Report, Finance and Public Administration Committee*, 25 October 2022; c 24.]

Will you comment on that, please?

Derek Feeley: To be honest, I am not sure that I am well enough qualified to comment on that. A bill is required in order to establish a national care service, and we ought to establish whether the bill is fit for purpose through the combined wisdom of the bill's architects and the parliamentary process. I do not feel well enough qualified to make that judgment.

Tess White: The Finance and Public Administration Committee had serious concerns about the financial memorandum that accompanies the bill. What is your view of that?

Derek Feeley: When we created our report, we made the deliberate decision to deal with financing as a third-order issue. The first thing that was important to us—I think that this is also the case with the bill—was what people who rely on social care support need and want. For me, that is the most important thing. We need to get as deep an understanding as we can about what people really need and want and how they would prefer to receive it.

The second-order question was what kind of system we need to build to meet those people's aspirations. That is what the bill, at least in part, is trying to do.

The third-order question was how we would pay for that. Until the work is done on getting a deeper understanding and acquiring the ability to describe the system architecture that will get what is wanted, it will probably be too early to say anything definitive about the finances. The finances will need to be sufficient to do those two things.

I would be the first to admit that the job that we did on financing in the independent review was incomplete. We did the best that we could do in the time that we had available to identify things such as unmet need and what it would take to rebuild some of what had been lost through the pandemic. However, it was difficult for us to deal with fair pay, for example. Again, I am not sure whether the financial memorandum to the bill is a great vehicle for an assessment of what it would take to pay everyone in social care a fair wage.

I guess that that is a roundabout way of saying that creating a financial memorandum is difficult until we have some definitive answers, including to some of Mr O'Kane's questions.

The Convener: Thank you. Stephanie Callaghan will now lead questions on the human rights-based approach.

Stephanie Callaghan: Thank you, Mr Feeley, for all your work so far and your on-going work.

I have heard some criticism that the bill is not sufficiently focused on prevention and early intervention. There is not much mention of that in the bill or in the memorandum. Is that an issue, or is that part of the human rights-based approach to the bill? Is there something else that we should do to put prevention and intervention more at the centre of the framework bill?

Derek Feeley: The human rights-based approach should be central to everything that we do on the creation of a national care service and the on-going improvement of social care support in Scotland. That is absolutely essential. There is something in the principles that are outlined in the bill and, again, there is something in the creation of a charter. Those things can always be strengthened, and human rights is one of those issues in respect of which, unless we are absolutely explicit about what we mean and what we want, there will be opportunities for it to be deprioritised. Therefore, anything that the committee and the Parliament can do to strengthen the explicit nature of the human rights requirements would be welcome.

Stephanie Callaghan: Human rights are absolutely at the centre of the bill and the approach to the delivery of social care. For some people, those rights often seem to be at odds with the constraints that are imposed by finite resources. Is that always true? Is that your experience, or does investment in that approach mean that people do not reach the point of crisis? You said that the shift in focus to prevention and early intervention really strengthened the human rights-based approach to social care. Informal community initiatives also often mean that small issues do not grow into much bigger issues because that support is provided locally.

Derek Feeley: It would be wrong to assume that a human rights-based approach is more costly. Let us think about some rights-based approaches, such as the panel approach. It does not really cost us anything to enable people to participate in such processes. No additional cost is involved in enabling people to feel that someone is accountable. Non-discrimination is likely to be less expensive than discriminating against people, and enabling people to do more for themselves and to live the independent lives that they—[*Inaudible*.]—is probably, on balance, more likely to be less expensive than more expensive. The point about enablement is connected to the part of your question that was about prevention.

11:45

During the independent review, there were a few things that really struck a chord with us and made us craft our recommendations in a particular way. First, a young man who was taking part in a conversation that we were having with a group of people who had learning disabilities said to me, "You know, you're thinking about this entirely the wrong way. Social care support should not be a safety net; it should be a springboard."

Secondly, I spoke to a senior executive from one of the voluntary sector organisations, who told me about a fantastic programme that the organisation had developed for early detection of dementia and early intervention for people who have it. The organisation had been able to demonstrate, through early intervention, that it could delay people's admission to care homes and that it could enable people to live where they wanted to live—for most of them, that was at home. The organisation could also do that in a less costly manner than if it were to admit those people to a care home earlier in the process. It was like a perfect trilogy. I said to him, "That's fantastic. How are we going to get that scaled up?" The organisation had managed to do that in two or three local authority areas. He said, "Well, I am going to have to go and sell it to 32 local authorities."

A national care service ought to be able to identify promising early interventions such as that and bring them to full scale in a much more effective and rapid way that would chime with people's expectations of their human rights.

There are huge opportunities, and it is incredibly encouraging that we are having a conversation about human rights in Scotland. I read some of the research that your parliamentary colleagues did and, as we were doing the review, we did a fair bit of international research ourselves. Very few places in the world are having such a conversation with a human rights focus. I commend the committee for doing that and encourage it to continue. I think that that is what the people who rely on social care support whom I have spoken to would want it to do.

Stephanie Callaghan: Will the bill as introduced create the conditions for innovation? Are co-design and co-production well enough and broadly enough understood across health and social care?

Derek Feeley: You would probably get as many definitions of innovation, co-design and co-production as the number of people whom you spoke to. Again, I am not absolutely sure that a bill is the right place to do this, but definitions of what we mean by co-design, co-production and innovation in the explanatory notes or the policy

memorandum would be no bad thing. However, I am not sure whether they could be defined in a bill.

For me, innovation is the bridge between an idea and its implementation. That is what we meant when we talked about innovation in our report. We do not really need a lot more creativity in Scotland; there are plenty of ideas. Our challenge is to turn those ideas into things that get implemented reliably.

Self-directed support is a great example of that. That is a fantastic idea—it is groundbreaking and world leading—but, according to a report that was done by Self Directed Support Scotland and the Health and Social Care Alliance Scotland during our independent review, it is implemented properly in about 50 per cent of cases.

The Convener: James Dornan has a question.

Derek Feeley: The question is: what are the innovations that could get us to 100 per cent?

The Convener: My apologies—I cut you off there. That is always the danger when there is a remote participant. Carry on.

Derek Feeley: I had finished. Stephanie Callaghan asked me a question about innovation, which I am really passionate about. I probably spoke for too long. I apologise for that.

James Dornan: I suggest that the example that you used in response to Stephanie Callaghan shows the benefits of centralisation. However, what are the potential risks associated with centralisation of accountability?

Derek Feeley: The main risks lie in a couple of areas. First, there is the risk that we separate the national structure and system of accountabilities too far away from individual needs, rights and preferences. In our report, we recommended that we should mitigate that risk by ensuring that people with lived experience get a voice at every level of the architecture of the system.

One of the things in the bill that I am somewhat nervous about is the idea that the national care service ought at the national level to be a part of Government. We recommended very specifically that some kind of arm's-length body ought to be set up to hold the national care service to account, and that it should have on it people with lived experience and unpaid carers in order to make sure that there is no separation of central national-level accountability from individual needs, rights and preferences. That is the first risk that would have to be managed, but I think that it is manageable.

The second risk relates to the fact that Scotland is quite a diverse country in terms of rurality and the social determinants of health and wellbeing. We would need to ensure that a centralised national-level entity paid due regard to such issues. That is why we recommended in our report that integration joint boards—or some form of them—ought to continue. I assume that that is the intent in the bill around the care boards—that they will be able to capture some of that local diversity and factor it in.

There will be some risks with any kind of system design. The risk of the current design is that it gives us what we get, which is enormous variation and a real challenge in doing anything that works at the national level. We simply have to manage the risks.

James Dornan: In the process of your investigation for your report, did you come across a barrier to the idea of centralisation from vested interests? I do not mean that in a critical way—I mean the likes of people who are doing the job just now. Did you find that they are opposed to centralisation because they think that it might take away some of their influence and power, or think that it might damage the service?

Derek Feeley: For a large part of the work that we did on the review, it was difficult to have conversations because folk were unsure at that stage what a national care service was, and people had different senses of what it might be. Therefore, it was not until quite late in our review, when we started to pull our recommendations together and test some of the ideas, that we could have those conversations.

It was no surprise to us that our recommendations were not universally well received because we were recommending changes from the status quo, which is always difficult. The encouraging thing for us was how well supported the recommendations were by people who rely on social care support and folks who represent them. To be honest, Mr Dornan, they were my primary audience. They were the people whom I was most interested to hear from and whose requirements I was most interested in satisfying, so their support was encouraging for us.

A thing that amplifies that a little is that, in the consultation on the recommendations, the vast majority of people seemed to support a national care service as a direction of travel. Undoubtedly, some people will fear the changes from the status quo and what they mean for them, but our guiding principle should be that the proposals address the needs, rights and preferences of people who need social care support. What are they saying about what we are doing? For the most part, as I said in my initial response to the convener, they remain committed to the idea of a national care service and, by and large, to the other measures that we

recommended in our report. Some of them are getting impatient and want us to get on with it.

Gillian Mackay: Good morning, Mr Feeley. In your work on the independent review of adult social care, you took evidence from service users and people who work in social care. There will obviously be a lot of workstreams from within the bill and on co-designing services. How will we ensure that it is sustainable for people to maintain input and participation in co-design, given the number of workstreams? How will we ensure that the work is coherent across the piece and that it does not fatigue the voices of really important stakeholders who, perhaps, have only small teams working behind them?

Derek Feeley: That is a great question. We need to make it as easy as possible for people to engage.

What people told us during the review can be boiled down to four things. First, they asked us to hear their voices and to see them as partners. Too often, we construct something then ask people what they think of it. That is not what the folk whom we spoke to—[*Inaudible*.]—want. They want to be engaged as equal partners and to have their voices heard.

The second thing that is really important to people, and which we will need to take into account in the various workstreams that Gillian Mackay mentioned, is—as per the conversation that we had earlier—human rights. A basic human right is the right to participate. We need to give people that right and we need to honour their human rights in that way.

The third thing that people asked us was that we make it a bit easier for them and that we ease their way into the discussions. Anything that could be done to describe the changes in ways that are meaningful for people will help.

12:00

In an odd way, doing our review when we did it—in the heart of the pandemic during periods of lockdown—made it easier: it meant that we could talk to many more people than we ever could have, had we been meeting them face to face. That democratised the process a little bit. I suspect that a lot of people who might not have spoken up in a face-to-face meeting did speak up or put things in the chat. What I am suggesting is that people should be given multiple ways to engage.

The fourth and final thing, which I have already mentioned, is that people want to be seen as part of the solution and not as part of the problem. My experience is that folk will come up with fantastic ideas if they are given the chance to do that. The way in which we engage is really important.

Emma Harper: I have a quick question about the national care service charter that is part of the bill. Sections 11 and 12 mention the creation of a national care service charter that is "publicly available" and they state that the charter should be monitored and reviewed after five years.

I am interested in your thoughts about inclusion of the charter, specifically as it relates to the human rights-based approach and to supporting people—especially people who receive care. This is about embedding support for people with lived experience, as I understand it. Can you please tell us your thoughts on that?

Derek Feeley: I am very supportive of the charter being in the bill. As I said to one of your colleagues, it would be a good thing to make the charter even more explicit about the human rights-based approach.

There is also an opportunity to emphasise the new narrative that talks about social care as being preventative and anticipatory, about its being about relationships rather than transactions, and about its being a vehicle for independent living rather than a place for services.

I support the idea of a charter, and I invite the committee to think about making it as explicit as possible so that there is no wriggle room for people when we come to give life to what the charter says.

The Convener: Evelyn Tweed will ask about leadership and accountability.

Evelyn Tweed: The independent review highlighted that we should be moving toward accountability for social care lying with ministers instead of with local authorities. The Scottish public expect ministers to be accountable; that is a reasonable expectation, given the impact on national wellbeing. Can you outline the benefits that the move will have for Scottish people?

Derek Feeley: We considered a number of things when we made that recommendation. The first was that we should try to create parity between the national care service and the national health service, so that people would feel the same way about the national care service as they feel about the national health service. I think that we all appreciate how precious the NHS is to people; we want them to feel the same way about the national care service. Parity of esteem for healthcare and social care is really important to us.

The second consideration was the nature of the accountabilities to which Evelyn Tweed referred. Again, I point out that we were doing the work in the pandemic. Social care, and especially care homes, were on people's minds like almost never

before. The people who were being held to account for social care were, largely, Scottish ministers, but they did not have the powers and levers to truly exercise their abilities. They could not set direction and they could not be sure that what they thought were priorities for resource allocation were shared priorities.

It was challenging for us then to have the kind of parliamentary scrutiny that we will have in the future. As I suggested earlier, as accountable officer for the NHS I felt, and actually welcomed, that level of scrutiny, but such accountability does not currently exist for social care. It ought to. I do not have to tell committee members that you are doing this on behalf of the people. Parliamentary scrutiny of social care is another way in which the social care system will strengthen the direct accountability of elected representatives in the Scottish Parliament to members of the public. It will also give social care a profile that it has not had.

The third thing that we wanted was a truly national strategy for social care—a proper plan for social care that is informed by what the public have told us they need. Again, that presents an opportunity that we have not had previously. I am encouraged by what is said in the bill about the need to produce both national and local strategies.

Evelyn Tweed: Thank you. You said earlier that Scotland's developing a national care service is a "groundbreaking and world-leading" approach. Can you expand on that and tell us why that is the case?

Derek Feeley: Actually, I think that much of what is groundbreaking already exists. Self-directed support as a vehicle for social care support is as ambitious a thing as you will see anywhere. Scotland made a commitment to an independent living fund when other countries in the UK were abandoning theirs. Much in the existing system is already groundbreaking.

The problem that we have is implementation. We have not been able, historically, to turn groundbreaking ideas into things that every single citizen in Scotland can count on every time they need social care support. That is the missing ingredient that a national care service could provide. If we could get some of the groundbreaking initiatives implemented at full national scale, Scotland would be way beyond what other countries aspire to.

Paul O'Kane: I will pick up on your response to Evelyn Tweed on accountability to the Parliament and the minister being held accountable for social care. Is it your view that social care is not currently being held to account by elected council members and health board appointees—who are appointed by the Scottish ministers—who sit on IJBs? The Convention of Scottish Local Authorities would take exception to that because of how councillors are connected to their communities and hold social care accountable. Is the principle of local accountability not at stake, to some degree, if we focus everything on the Parliament?

Derek Feeley: The question is in part what the right balance is between local and national accountability. It is important to recognise that, in our report, we envisaged a continued and important role for local authorities as providers of care services; as partners in integration joint boards and care boards; and as the places where we expect a lot of innovation to happen on residential care and prevention. We envisaged a really important continued role for local government and, therefore, a continued need for local accountability.

As I said in my answer to Evelyn Tweed, we also recommend that social care, like healthcare, have national accountabilities. We wanted to be as clear as possible about how accountability would work. We feel that social care is important enough for our Scottish Parliament to be the primary place where those accountabilities would be exercised.

Tess White: One of the questions that remains unanswered comes from Reform Scotland, which feels that there has been inadequate

"explanation about why simply removing local government from social care will lead to an improvement in delivery."

It also pointed out that

"The loss of local understanding and accountability, especially in more rural areas, were highlighted as risks of the proposals during the consultation".

Will you comment on that?

Derek Feeley: Part of the responsibility of care boards, however they are constituted, will be to provide understanding of particular local needs. As Paul O'Kane alluded to and as I attempted to respond on, there will always be some kind of balance to be struck between the local and the national. We need to find the right point of balance, which might require rethinking of how we constitute the relationship between national Government and local government.

The main things that we saw in local delivery that we wanted a national care service to resolve concern variation. There is a lot of variation in relation to folks' eligibility for care and whether they can get into the system. There is quite a lot of variation in whether they are charged for services and in the nature of the provider organisations in particular localities. We saw an opportunity for a national approach to deal with some of that variation.

The second thing about which people asked us was portability: they asked why care packages are

not portable when people have to move. People have to start the whole process again in a new locality, so they asked us whether we could do something about that. Again, it seems that a national approach is more likely than a local one to resolve that issue.

12:15

Thirdly, there was a question about whether we would be better to scale up and spread promising practice to national level, or to do it with 32 delivery organisations. Again, our view is that we are more likely to get application of promising practice through a national approach than through a localised one.

There is always a balance to be struck in such matters, and the challenge is to find the right balance.

Sandesh Gulhane: Good afternoon. One of the interesting things that you said was about the setting up of an arm's-length body. Having spoken to the unit that is working on the bill, it is clear to me that that is not going to happen. Audit Scotland suggests that setting up a national care service could cost more than £1.3 billion. Given that that money would be taken away from health boards and local government, do you feel that it is worth it? It could, for instance, remove the potential for local government to do certain things. We were told that one council might lose its lawyer unit because work would be taken away from it.

Derek Feeley: The main reason why we recommended that the national care service have its own board of governance is to ensure that the voices of service users and unpaid carers are heard around its topmost decision-making table. People should consider whether there are other ways to achieve that, but, as I said, the underlying rationale is to ensure that the voice of lived experience is represented in discussions about allocation of resources in the national care service.

In setting up any new organisation, there will inevitably be some changes to people's roles and functions. It strikes me that there must be at least an opportunity for greater efficiency if we do once at national level the things that ought to be done in that way and at that level. As I said earlier, there is a balance to be struck; things that are best done locally should continue to be done locally. However, a proper and detailed analysis of what we should do once for Scotland and what we should continue to do at health board or local authority level would probably be useful, at this stage.

Emma Harper: I have questions about the workforce and fair work. Section 1 of the bill says that

"the National Care Service is to be an exemplar in its approach to fair work for the people who work for it and on its behalf, ensuring that they are recognised and valued for the critically important work that they do."

In the previous evidence session, Nick Morris said that a national care service should allow for greater awareness of the work that social care staff and social workers do.

Can you comment on the fair work principles in the bill and say whether anything still needs to be added? Are there any gaps?

Derek Feeley: Again, that is an important issue. In the course of our review, people said to us that, if we are going to invest in anything, we should invest in the workforce. That message came from service users and organisations that represent them as much as it came from the trade unions and others who have an interest. There is definitely a need to invest in the social care workforce.

We identified a potential vehicle for fair work in the rethinking of the commissioning and procurement process and in the introduction of the idea of ethical commissioning, which came from one of the trade unions.

The bill refers to fair pay and ethical commissioning. We need to ensure that we keep on the table the connection between those two things. We ought to use the redesigned commissioning and procuring process as a vehicle for fair pay. Essentially, we would be saying to care providers that, if they are going to receive public money, they will have to follow a set of expectations that we have of them. One of them is that they should pay a fair wage, and a second might be that they are transparent about their profits. Our report sets out a set of potential conditions for ethical commissioning and procurement.

If the bill is explicit about the commitment to fairness and sees the ethical commissioning and procurement process as a viable route for securing fair pay for social care staff, that will be satisfactory.

Emma Harper: As a former clinical educator, I like the national pathways model of skills development and the ability to look at how we measure the quality of care that is delivered so that we can ensure that it is the same whether the person is in Stranraer or Stornoway. I am interested in your thoughts on establishing recognised national career pathways so that we can focus on recruitment and retention and ensure that the career development process helps us to focus on valuing the staff and the care that they are providing. Can you give us your thoughts on that?

Derek Feeley: It is important that people begin to see social care as a viable career. We also need greater certainty for staff that they can and will be released for continuing professional development, which we heard can be a bit of a challenge for some people.

We also need to think now about new roles. One of the ways in which we could give effect to the underlying case for integration, which is in the independent review and the bill, is by ensuring that such roles are present at the point of service. We need to think, from the end user's point of view, about who they need to see—it might be someone from healthcare or someone from social care, but it might also be the case that it would be better if they could see someone who had some kind of hybrid integrated role. That might well open up some of the development opportunities to which you referred.

Carol Mochan: I think that we all agree that carers have traditionally been undervalued, but we are now recognising the great contribution that they make. How will the bill support carers? Is there sufficient information about how carers can help to co-design the national care service and how they can go on to become full partners in it?

Derek Feeley: I welcome what is in the bill about that, which is one of the things that unpaid carers asked for. We need a different term: "unpaid carer" does not do justice to what those people contribute to our system of social care support. However, that is what people call them, so maybe we should park the issue and return to it in the future.

Unpaid carers are foundational to how social care support works. It is no exaggeration to say that the system would be swamped without them. Therefore, anything that we can do to make it easier for them to continue to do the kind of stuff that they choose to do ought to be encouraged. Respite is one of those things.

In the numerous conversations that we had with unpaid carers and their representative bodies during the review, they asked to be heard. At the moment, we are in the somewhat daft situation in which unpaid carers can be members of integration joint boards but do not have voting rights. We should change that. Why should an unpaid carer not be able to vote when everyone else around the board table can?

We should make it as easy as we can for people to continue to do the things that they want to do. A lot of really good stuff is already available. The introduction of carer plans was a massive step forward; the challenge is in implementation. Not every carer has a carer plan, although they should. We need to get those plans fully implemented at national level and we need to remove the variation that currently exists. Whether a carer has a proper plan and support package is somewhat dependent on where they live.

Carol Mochan: Thank you for that information.

Does anything need to be added to the bill to ensure that there is a statutory responsibility to enable carers to get breaks and support with breaks?

Derek Feeley: I would need to look again at the bill; I cannot remember how explicit the current draft is on that. The sort of approach that I said was necessary in relation to human rights might apply here. I think that the unpaid carer community would welcome anything that can be done during the passage of the bill to make that as explicit as possible.

The Convener: Stephanie Callaghan has questions on ethical commissioning, which we have spoken about a little.

Stephanie Callaghan: We have discussed ethical commissioning and procurement. Could the review's recommendations in that regard be met within the current model? Why did you not consider alternatives such as public-social partnerships and alliancing? Is such a radical redesign of social care commissioning absolutely necessary?

Derek Feeley: Redesign of commissioning is absolutely necessary. There were very few things that everybody we spoke to absolutely agreed on: they all agreed that the existing system of commissioning and procurement is not working for anybody.

12:30

Some things can be done outwith the bill, and there might well be some things that will need statutory underpinning to give them effect. We made reference to other potential reforms that are similar to alliancing and public-social partnerships, and we drew on a fantastic publication from a voluntary organisation called the Coalition of Care and Support Providers in Scotland that outlined a range of possibilities for ways to commission. If you have not read it, I recommend that you do. We drew heavily on it for our report.

The short and straightforward answer to the question whether I believe that radical redesign of commissioning is necessary is yes.

Stephanie Callaghan: I noted that COSLA's submission talked about the bill failing to

"address the difficult issue set out in the Independent Review of Adult Social Care, that of profit within the sector."

Its submission also said that

"Private sector provision ... accounts for 76 per cent of care home provision."

So, it is really about profiteering rather than reinvestment. Should reform of non-residential and residential care funding be included in the national care service bill?

Derek Feeley: When I relooked at the bill today, one of the things that I was looking for was something specific about the market oversight function that we recommended for the Care Inspectorate. In our report, we recommended that the Care Inspectorate's duties ought to be extended to enable it to conduct financial oversight of the market. I feel bad talking about social care as a market, because it should not be that way. However, I could not find that in the bill. It might well exist and I have just not found it, or it might be that it has been determined that such a statutory change is not needed and it can be done administratively. I do not know, but I still think that it would be useful to strengthen the powers of the Care Inspectorate to allow it to examine finances and the financial viability and conduct of care providers.

We also recommended that ethical commissioning and procurement be the vehicle that we use to get greater transparency about profits, because it is currently very difficult to get any kind of handle on exactly how much profit is being made and where it is going. Given that it is largely public money, we ought to be able to get that sort of information. That was part of the new deal that we tried to set out in the report; in return for receipt of that public money, people would sign up to greater transparency—[*Inaudible*.]—as well as fair pay.

The Convener: Those were all the questions that we had. I thank Derek Feeley very much for the time that he has spent with us this morning and for tying the intentions of the report and those of the bill together. It has been very helpful.

That concludes the public part of today's meeting. At our next meeting, the committee will continue its scrutiny of the National Care Service (Scotland) Bill. There will be two more evidence sessions.

12:34

Meeting continued in private until 12:38.

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