OFFICIAL REPORT
AITHISG OIFIGEIL

Health, Social Care and Sport Committee

Tuesday 18 June 2024

Session 6

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 18 June 2024

CONTENTS

HEALTH, SOCIAL CARE AND SPORT COMMITTEE

20th Meeting 2024, Session 6

CONVENER

*Clare Haughey (Rutherglen) (SNP)

DEPUTY CONVENER

Paul Sweeney (Glasgow) (Lab)

COMMITTEE MEMBERS

*Sandesh Gulhane (Glasgow) (Con)
*Emma Harper (South Scotland) (SNP)
*Gillian Mackay (Central Scotland) (Green)
*Ruth Maguire (Cunninghame South) (SNP)
*Carol Mochan (South Scotland) (Lab)
David Torrance (Kirkcaldy) (SNP)
*Tess White (North East Scotland) (Con)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Dr Richard Brunner (University of Glasgow)
James Dornan (Glasgow Cathcart) (SNP) (Committee Substitute)
Rob Gowans (Health and Social Care Alliance Scotland)
James Mahon (York Health Economics Consortium)
Des McCart (Healthcare Improvement Scotland)

CLERK TO THE COMMITTEE

Alex Bruce

LOCATION

The Sir Alexander Fleming Room (CR3)

Scottish Parliament

Health, Social Care and Sport Committee

Tuesday 18 June 2024

[The Convener opened the meeting at 09:15]

Decision on Taking Business in Private

The Convener (Clare Haughey): Good morning and welcome to the 20th meeting of the Health, Social Care and Sport Committee in 2024. I have received apologies from Paul Sweeney.

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

Members *indicated agreement.*

Social Care (Self-directed Support) (Scotland) Act 2013 (Post-legislative Scrutiny)

The Convener: The next item on our agenda is an evidence session on monitoring and evaluation as part of phase 2 of our post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013. I welcome Dr Richard Brunner, who is a research associate at the University of Glasgow; Rob Gowans, who is policy and public affairs manager at the Health and Social Care Alliance Scotland; James Mahon, who is an economist at the York Health Economics Consortium; and Des McCart, who is senior programme manager for strategic commissioning at Healthcare Improvement Scotland. We will move straight to questions.

Emma Harper (South Scotland) (SNP): Thank you, convener, and good morning, witnesses.

I have a couple of questions about monitoring and evaluation of self-directed support. It is not really part of the development of the Social Care (Self-directed Support) (Scotland) Act 2013, but we seem to be adding more requirements for monitoring, evaluation and reporting into much legislation that is passed these days. I am interested to hear why monitoring and evaluation of policy are important.

Rob Gowans (Health and Social Care Alliance Scotland): The purpose of monitoring and evaluation of policy is to make sure that it is working as intended and that it is having the desired effect and the intended outcome. One of the reasons why the ALLIANCE has worked on self-directed support over the years is that people have told us that, although the legislation is good and well-intentioned, there is an implementation gap in terms of what is happening on the ground. People do not necessarily have the choice and control that they should have in the support that they receive, or they are not aware of what their options are for self-directed support.

In the research and engagement work that we have done—in particular, the research report “My Support My Choice: People’s Experiences of Self-directed Support and Social Care in Scotland”, which I would be happy to talk about—we have seen that when SDS is implemented correctly it improves people’s experiences of social care. However, in too many cases, people do not have full choice and control, so their experience falls short. The committee’s inquiry is a welcome contribution in trying to tease out some of the issues with the implementation gap.

Dr Richard Brunner (University of Glasgow): Many thanks for the invitation to attend the committee meeting.

In the main, I am here to talk about unmet need in social care. There is a data gap in that regard, which is a great opportunity for the committee and for Scotland to make choices about what we want to monitor and evaluate. The key to successful monitoring and evaluation is the vision: we need to ask, "What is the vision for the policy? What do we want to achieve and what do we want to see in five years?" We would then monitor based on those aims. We know that the aim of self-directed support, among other policies, is that it supports people to live independently. I would like to talk more about that today, as well as about potential steps for monitoring what we mean by "independent living".

Des McCart (Healthcare Improvement Scotland): The purpose of Healthcare Improvement Scotland is improvement. How we know whether we are improving is a key part of that, so monitoring and evaluation are essential.

It is interesting that Ms Harper said that that requirement has not necessarily existed from the beginning: that might be one of the reasons why we are still trying to embed self-directed support in Scotland. We have not necessarily understood what has made it possible or what has made it difficult.

Emma Harper has said that self-directed support is increasing the amount of monitoring and evaluation and, as colleagues have said, one of the challenges has been in getting right what we monitor and evaluate. There must be a learning-based approach at the heart of improvement. Something that is only about performance does not really help us to learn what we need to change.

Self-directed support landed in the environment of care management and a particular system for delivery of health and social care. We really needed SDS to change that—that is what it was about, as is seen in the independent review that Derek Feeley did recently. In order that we see change happening, we need monitoring and evaluation that informs it. That has to happen through a learning-based approach being taken rather than just through performance. Performance is helpful, but we need a learning focus at the heart of it to inform the changes that we need to make.

Emma Harper: Does James Mahon have anything to add?

James Mahon (York Health Economics Consortium): No—I have nothing to add.

Emma Harper: Okay. Should that monitoring and evaluation have been built in up front, so that we started assessing, monitoring and evaluating as soon as SDS was implemented? Is that part of the process of assessing 10 years since the Feeley report? I know that Public Health Scotland has good dashboard information about options 1, 2, 3 and 4 and uptake of them. What are your thoughts about monitoring and evaluating from the get-go? What do we need to evaluate when it comes to implementation of self-directed support?

Des McCart: Yes, monitoring and evaluating should have been in from the beginning and should develop over time. It should not be a case of setting a goal at the beginning then saying only whether we have achieved it—especially with a 10-year strategy. As I said, the focus has to be on a learning-based approach, which means asking what we are observing, what we are learning through discussion and what we should, therefore, be changing. That was always the idea of SDS. If we align it to things such as realistic medicine and community empowerment, we see that there is a lot of legislation putting power in the hands of people, but our system was not built that way previously, which is why we brought in the legislation.

Core evaluation using something as simple as the number of people who have chosen options 1, 2, 3 or 4 has not really helped us to understand what has made any of the options possible or difficult. What is the quality of option 1, for example? Is there a choice, or is an option chosen because it is the only thing that is available in an area because of—excuse the language—market availability? What choices are available?

SDS was always about the choice and control agenda, as per the "My Support My Choice" report, so clarity from the outset about what we are trying to achieve is about focusing not on whether we are performing against a fixed matrix, but on whether we are taking a learning-based approach that allows us to adapt continuously over 10 years. It would have been helpful to have something there from the beginning, but we are where we are. How do we move forward? We should set a baseline at where we are and decide what we want to achieve from there. Does that help?

Rob Gowans: I agree with what Des McCart has said. There are still data gaps because data is not being collected, so we know about what options people have taken, but we do not necessarily know whether that was their choice or nothing else was available. Were they given full information or steered towards a particular option?

There is a gap in respect of intersectional data and good-quality data. The Scottish Government's health and social care data strategy is a helpful start on that, but there is on-going absence of some data. One of the reasons why we did the "My Support My Choice" research was so that we could find out a bit more about people's experiences on the ground; that is about issues to do with people not having full information or not having access to independent support or advocacy to help them to decide what would be best for them. Quite a bit more needs to be done on data to help us to understand users' experiences.

Dr Brunner: I want to follow up on the question about what we need to monitor and evaluate. The question is quite timely, to be honest. The Feeley review from 2021 advanced our thinking on care as an investment in society and a vehicle for independent living. Of course, the development of a national care service is running alongside that now.

What do we need to monitor and evaluate? The 2014 guidance on self-directed support makes it clear that self-directed support is

> "intended to support, promote and protect the human rights and independent living of care and support users in Scotland."

That begs the question what we mean by independent living. Feeley helped us to think about that. I quote "Independent Review of Adult Social Care in Scotland", which states:

> "Independent living means people of all ages having the same freedom, choice, dignity and control as other citizens at home, at work, and in the community. It does not mean living by yourself, or fending for yourself. It means having rights to practical assistance and support to participate in society and live a full life."

That definition of independent living has previously been adopted by the Scottish Government and the national health service in Scotland. It is consistent with article 19 of the United Nations Convention on the Rights of Persons with Disabilities and with Scotland's national performance outcomes. All our monitoring, evaluation and public policy need to work towards delivery of the national performance framework goals.

The question of how we enable disabled people and older people who use social care to achieve the independent living that Feeley has helped us to crystallise is the framework for our thinking about monitoring and evaluation.

Emma Harper: Okay, thank you.

Gillian Mackay (Central Scotland) (Green): Good morning, panel. I have a couple of questions for James Mahon first, then probably one for the whole panel. What benchmarking was available to you, as researchers, at the start of your evaluation of implementation of SDS? Was the data sufficient and, if not, what else would you have liked or needed at that point?

James Mahon: Am I on mute, by the way?

Gillian Mackay: No, we can hear you.

James Mahon: Good.

I will answer that by sort of quickly answering the last question. What data was available? Very little. Was it enough? No. Hearing the others speak made me think that the problem is the danger that, in evaluation, we collect what is easy rather than what we need to collect.

For example, we have data on how many people have taken each option, but that is meaningless. Who cares? It is interesting, but how useful is it, actually? What we are interested in is people's outcomes and whether those outcomes are the ones that we want. We also need to break down how the outcomes were achieved. If they were not achieved, why and what evidence do we have to show that?

The key data gaps are largely around service-user outcomes, but they also exist also for things such as the quality of the conversation that was had. The social worker element is key: how comfortable were social workers about talking about the various options? Were they leading people towards one option or another? How creative could they be in offering solutions? How did the local authority support that? Were resource allocation panels used? Was that done consistently across an authority? We need to understand all those things if we are to evaluate properly.

There is a complete lack of evidence from routinely collected data. A survey of—as I was just describing—the outcomes at however high a level, on how independent people feel in their living, is not, in itself, enough. You must understand how things happened and what changed and still needs to change in order to improve the system. You will almost certainly not get an answer if you look at outcomes that say, "Everybody's happy with how this is all going." You must understand at a deeper level what is going on.

Was your question to do with what data should be collected?

Gillian Mackay: Yes.

09:30

James Mahon: We propose several things. Data needs to be collected through some sort of survey of social workers. I have been evaluating for more than 20 years and I am loth to undertake data collections just for the purpose of undertaking data collections The exercise has to be focused and useful. My line is this: if it is interesting but not useful, do not do it—do it only if it is useful.

We came up with four or five questions that we thought were absolutely key to gaining an understanding of how social workers feel the system is working. That is one approach. Other suggestions include adaptations being made to existing surveys that could be undertaken, and wider roll-out of the self-directed support user experience survey.

You will have to forgive me, because the work was done six years ago, so I do not know where the committee now is on this, but we said that information must be routinely collected specifically from people who were using SDS, with very specific questions being asked about the outcomes that they were achieving through SDS and the challenges that they were facing.

There are data gaps everywhere, but that is what we thought would be useful from the service-user perspective and the social worker perspective, as well as—to a lesser extent—the local authority perspective. That is because we found not just that there are differences among local authorities in how the system is being implemented, but that there are differences among social workers within local authorities.

Gillian Mackay: Yes—that variation is regularly brought to the attention of MSPs.

Did most of your study's recommendations concern implementation? Were there conclusions around the need for the 2013 act to be amended? What are the top findings from your study that the committee should look at in order to bring about improvements?

James Mahon: Whether the 2013 act needs to be amended was beyond the remit of the study, so it would not be fair for me to comment on that.

From looking through what we suggested, I would say that this is a very complex area, so simple surveys might be insufficient for giving you the answers that you really want. We suggested doing some proper longitudinal research that would follow people from the time of initial assessment through to their receiving support and onwards, because what we found when we spoke to individuals was that their views changed over time. They might have been happy when they first received the support, but they might have found difficulties with how flexible it was 12 months later, when something changed and they wanted to adapt the support that they were receiving. We found that when we stopped evidence gathering when a person received the service, they would say that everything was wonderful, that they had great choice and that they had got what they wanted. However, that is insufficient—you have to carry on the research. If I had to suggest only one area for you to focus on, I would ask you please, to do longitudinal research and follow people through.

Of course, other stuff can be done. It is important to expand the self-directed support user-experience survey, but the survey of social workers to find out what they are doing is also important. My understanding of why that is important might come from the fact that I used to be the lead economist at the Commission for Social Care Inspection in England and did a lot of work with social workers, who are the key cogs in the wheels of the system and are the people who monitor what is going on and who make sure that it is all working properly. You have to find out that is happening with them, how they are approaching the arrangements, what challenges they are facing and how consistent the support that they are able to offer is.

You should definitely do longitudinal research and definitely do a social work survey, and you should try to do an SDS user-experience survey in order to capture standardised information on outcomes. The adult social care outcomes toolkit—ASCOT—will help you to get some standardised outcomes. Doing all those things would help no end.

Gillian Mackay: My next question is for all the witnesses.

Local authorities collect data and all of you collect data—there are layers and layers of organisations collecting data from service users, and they are not always joining up across the piece in order to gain a wider overview. Should we be gathering additional data or evidence, or should we just join up all the information about the outcomes for individuals that is being gathered by various organisations in order to get that bigger picture?

Des McCart: I am not sure that it is necessarily a question of gathering additional data; in a way, it is more a matter of how we understand it. Local authorities and health and social care partnerships gather an enormous amount of data. The question is whether that just involves performance, and seeing whether the line on a graph is going up or down, or involves seeking an understanding of what is happening behind that.

We submitted an example in advance featuring some work that was done with Social Work Scotland and Self Directed Support Scotland—and I know that colleagues from those organisations have been giving you evidence. That self-evaluation speaks to what James Mahon was saying about staff: it is important to understand what it is taking to implement SDS, what is making it possible and what is making it hard.

That survey used appreciative inquiry—to get to the granular detail of what the data means—which is done collaboratively in a space that is shared between practitioners, people who are using services, the wider community and third sector organisations. That leads to multifaceted reviewing, which is self-evaluation, but it is open and transparent. The paper that was produced demonstrates that, in that sort of space, there has been much more honesty about what is working and what is not working. Putting that out there is quite difficult, especially when things are not working. Having the space to safely say "I'm finding this tough" or "I can't do this," and to self-evaluate, with openness and transparency with communities, especially through the place-based approach that was taken, provides an opportunity to develop a real improvement plan: something that works in situ in a place—in remote parts of the Highlands, in the east end of Glasgow or wherever.

It is a matter of having the right space for looking at the data in a collective way. That means developing an understanding from conversation, rather than just from observation, where we say, "We see this" and draw a conclusion. That speaks to the power of SDS: it is about giving people a central place, alongside those who are trying to provide support. That makes things much more even in that space.

Does that help?

Gillian Mackay: Yes—it does.

Rob Gowans: One thing that is missing is a bit of oversight—a joining up of what is being collected and ensuring that we are measuring the right things. The postcode lottery, or the "unwarranted local variation", as Feeley described it, is a huge issue, which people have reported. There are different things happening in different ways in different places. Some people are eligible for some things in some areas but not in others. We thought that the national care service might have a role in providing a level of national oversight. That could be done, but there is a need for joined-upness—I may have just invented that phrase—of the data that is collected, ensuring that we are measuring the right things, as James Mahon described.

Dr Brunner: In the evidence that Nafsika Zarkou and I produced last year on unmet needs in social care, we discovered evidence of a social gradient in what is collected on unmet needs. The evidence suggests that certain groups, such as people with dementia or people who face communication barriers, as well as those in greatest poverty and living in greatest isolation, are less likely to be represented in large surveys on social care use. We are concerned that there may be a large cohort of disabled adults in Scotland who have low support needs for social care that are still unmet, and who are not on the radar.

There is another huge potential problem with people who do not see that they have a need for social care, so they have an unmet need, but that is not recognised by them and they are not on the radar of social services. Progressive work needs to be done to reach out to groups who are particularly socially marginalised, among those who should be accessing social care, to support them to live independently and as well as the rest of Scotland is living. There is that cohort of people and a need for more reaching out through research and surveys.

Gillian Mackay: That is really useful—thank you.

Sandesh Gulhane (Glasgow) (Con): I declare an interest as a practicing NHS general practitioner.

I will put my first question to James Mahon. Could you summarise the findings of the 2018 study on the implementation of self-directed support and any recommendations that it made?

James Mahon: As far as the findings on implementation are concerned, we found that practice was variable. We found examples where self-directed support was working very well but, as I said before, we found variation within and between authorities.

Our work in looking at implementation was more of an evaluability assessment—I struggled to say "evaluability" six years ago, and I still struggle to say it. The paucity of data affected our ability to say anything concrete. If we are still in the same position five years after the report, as an evaluator, I find that somewhat disappointing. It is bad enough that we should have collected data from the start but did not. If we are still not collecting that information five years after the report, I do not know how we can evaluate it.

I will again put on my social care hat, as someone who worked for the Commission for Social Care Inspection. I remember going to a conference in 2005 or 2006, at which someone talked about direct payments, which there was a bit of a to-do about, albeit that that was in England. I remember that a lady stood up and said, "I just want good-quality services. I'm 80 years old. My husband's always managed the finances, and I don't want to manage my own care." That was her choice. She felt that direct payments had been foisted on her.

There is a danger in looking at the data on the four options and saying, "If everybody's taking option 2 or option 3, there must be lots of choice here." That is not the case if they had no choice about any of the options and were forced to go down a certain pathway. There is an inability to look deeply into what is really happening as regards the choices that people are properly able to exercise, because we do not have the data to support that.

As an economist, I am quite unusual, because I am not that fixated on quantitative data. Quantitative data is all well and good and useful, but if you really want to understand what is happening, you have to speak to people and get some qualitative data. There was an absence of qualitative data at the time. The situation might have improved in the past five years, but because we are having this meeting, I am guessing that it has not improved hugely. There is an absence of qualitative data to enable us to understand the choices that people are able to make. Most of the recommendations that we made around data capture were about that. We need qualitative data in order to better understand the impact that the policy is having on people's lives and how well it has been implemented by local authorities.

Sandesh Gulhane: Thank you. One thing that frustrates me is that, when policy is created, it should surely be set out at the time what the outcome ought to be, how the outcome will be reviewed, what data we will use, how we will gather it and how we will measure it when it comes back. From what you have said, it seems that we do not really know how well things are working.

Therefore—this question is for any member of the panel—what would you like us to do in relation to the gathering of data? What information do we not have? James Mahon has mentioned the need for qualitative data. What else should we be trying to gather?

Dr Brunner: What needs attention is the vision of self-directed support and the outcomes in relation to that. As you said, when it comes to what we need to monitor, we should be tracking back from what the policy aims to do. We need to have a sense of the voices of disabled people, people who use social care and disabled people's organisations, because that is part of the Scottish approach to service design and the collaborative co-design principles, which I think we use very well. That conversation needs to be about what the vision for wellbeing is for people who are achieving self-directed support.

Jim Elder-Woodward has talked about that in a different context. People need a reason to get out of bed in the morning. It is not sufficient for social care just to help someone to get out of bed and sit in a chair all day. We need to provide independent living choices for people and to measure what people are able to do with their lives with the support of social care. Are people able to go to work, to go out, to have fun, to fall in love, to become members of the Scottish Parliament, to move house and to go on holiday—to do all the things that are open to everybody else in society? We need to fulfil our equal opportunities and non-discrimination obligations by thinking about the outcome that social care and self-directed support are intended to achieve, which is equality for disabled people and older people.

09:45

Sandesh Gulhane: James Mahon said that there are some good examples but that the paucity of data means that we do not know what is going on across the piece. Has any work on making improvements been undertaken with HSCPs or anyone else as a direct result of the projects that we are doing and the data that we have gathered? If great work is being done in one area, why are we not transferring across the country the lessons that have been learned?

Des McCart: That work is on-going, but I guess that the issue is about what we spread. We cannot spread a magic-bullet answer, because what works in the Isle of Eday, in Orkney, will not necessarily work in the same way in the east end of Glasgow. It comes back to the point that was made in one of the previous committee meetings and which Gillian Mackay made earlier about the variability of satisfaction and experience. Ultimately, we look at what we can see from the qualitative data that James Mahon talked about. What evidence do we see that people are getting satisfaction and are feeling that their life is better and that they have more control over it?

Work is being done. For example, Matter of Focus's OutNav work is beginning to capture outcome data systematically, which allows us to think about what we can learn from such data. How is that happening? What makes it possible? What makes it difficult?

There is no magic-bullet answer to spreading practice, because things do not translate—there are different assets in different communities. If this is about person-centred practice, we should build on individual assets and consider what people have or do not have by way of family and friends and community resources, which is different everywhere. If we truly want such practice to be at the heart of SDS and community empowerment, which is what those things are all about, we need to be cognisant of locality and respond to it in the right way. We need to say, "This works in the Isle of Eday because X, and this works in the east end of Glasgow because Y." We should be looking to get consistency in people's satisfaction levels and experience of choice and control, not in the model of care itself. Sometimes, we have been drawn to thinking about models of care instead of applying the values and principles consistently.

The Feeley report is about how we get collaboration, co-production and so on and how we ensure that we see those things manifest in each local community, rather than trying to find one answer and spread it. That work is about improvement within complexity, rather than within complicated, and it is about being able to understand what it is that you are spreading. Does that make sense?

Sandesh Gulhane: It does, but I will pick up on a number of issues. First, if something works well, we can learn some lessons from it and spread those from an island community to the east end of Glasgow. I do not see why you would not do that. That is a bit of a frustration. If something does not work, that is okay, but we can say, “This is what’s worked up here. What lessons can we learn in a different area?”

Secondly, we are five years on from the implementation study. Although I am hearing a load of things that witnesses would like to do, I would like to know what has happened in those five years. What can we point to where we are able to say, “There we go—that’s what we’re doing, and this is how it’s improving things”? Five years is a long time in people’s lives, and I am just not hearing that we are doing what we are supposed to be doing.

Dr Brunner: Last year, as part of my research, I collaborated with Glasgow Disability Alliance, which is a disabled people’s organisation. We were thinking about the very problem that you are pointing to—where are the good examples?

I wrote a small-scale study based on 10 in-depth qualitative interviews with people who had good experiences of self-directed support. What was particularly interesting was that those in the study lived in different local authority areas and were on different options for SDS, which immediately tells us both that it is not the case that some local authorities do everything well and others do everything badly and that different options for SDS suit different people.

We were able to draw out the principal things that people enjoyed when they had a subjective good experience of self-directed support. Those included being able to be spontaneous—such as being able to go out to a gig because they had flexible personal assistance—and being able to plan future activities because they had a reliable social care system and had a social worker on their side. We could see the principles of independent living that I spoke about earlier coming into play.

We could still see problems. Some people faced barriers because care packages were reviewed every year and they could not make long-term plans. People really struggled with being able to go on holiday and to do the very ordinary things that help us all with our wellbeing.

That is one example of recent research that focused on trying to understand what works in self-directed support. We have spoken once or twice to the Scottish Government civil service about the findings from that research. We have also presented on it publicly and there will be more to come.

The Convener: James Mahon is online and wants to come in.

James Mahon: There is an issue with the inability to disseminate information about the problems that are there and the good ways of doing things. It is okay to say that a particular package of support that someone in Shetland wants might not be transferable to Glasgow. I will buy that, but I will not buy the fact that some authorities are doing things such as having resource allocation panels meet to discuss the different requests people have made under option 2 or option 3—forgive me, I forget which way round they go—and the local authority basically sorts that out for them.

Not everybody does that. Are resource allocation panels a good or a bad idea? If they are a good idea, they will be as good in Shetland as they are in Edinburgh, because they are just a means of making a decision. If I find that an area is using a resource allocation panel and that that is working excellently, how can they disseminate that around Scotland so that someone else can see that that is the way to do it? If someone has a better way of doing it, they should tell us, so that we can disseminate that.

I can think of one particular example. We spoke to an former service user who wanted to go on holiday and take their carer with them, to care for them while they were on holiday. The resource allocation panel met and said that it was too risky to do that. The panel thought that it was risky politically, because it did not know how that would look or what people would think about it, and there was also a risk in managing the insurance. How we manage risk in such situations would be exactly the same in Glasgow, Shetland or anywhere else.

I am all for localisation and I think that it is great. I live in Berwick-upon-Tweed and when I go into Tesco there are two types of haggis; although there might be six types of haggis in Glasgow, 90 per cent of what Tesco does in Berwick is exactly the same in Glasgow, Shetland or down here. Localise where you really have to, but if there is something good that works you should disseminate that to ensure that everyone is doing that, or something better than that. I do not know what systems are in place to make that happen.

Emma Harper: Sandesh Gulhane said that five years is a long time to make a change. I am a former nurse clinical educator and we used to try to implement change on a massive scale across NHS Dumfries and Galloway, which takes time.

I was interested to hear Des McCart mention how we can use appreciative inquiry to empower social workers and to help them innovate and make changes that matter to people who are in receipt of self-directed support. I am interested in exploring change management. Is five years too long? How do we empower social workers through their skills training? Nine universities in Scotland teach courses and bachelor's degrees in social work. Do they include in their curriculum appreciative inquiry and self-directed support to empower social workers to implement self-directed support in the most effective and efficient way?

Des McCart: I am not sure that the approach is consistent. One issue, which has been mentioned in previous evidence, is about training on SDS. Inconsistencies were identified, so there is something there. I am absolutely not saying that the approach has to be entirely consistent across localities, but how does it work? Is there a key theme? Is there absolute consistency around risk and all those things? There is inherent good practice there, but it is about adaptability at a local level. It is not an either/or situation in that respect.

The work that we have just done with Social Work Scotland and SDS Scotland was about using models such as appreciative inquiry. The three test sites used different models of self-evaluation, and one used OutNav. Awareness of how we use that data is increasing. People are beginning to do such work. Bringing that together at the national level is key; it is not just about each locality doing that. Sharing that across the three areas and having peer learning allows practitioners and people using services in the third sector to directly learn from each other about what works. That is about transferring knowledge from, for example, Highland to East Ayrshire.

We are creating such spaces for people to come together and say, "This is how we have implemented it in this area, and this is why it worked," and, "We might need to tweak that in our area." We are beginning to create the spaces for that conversation and that learning to happen in situ.

Over the past five years, working has been more online and virtual, and that has had an impact on new staff coming in and people applying learning. The issue is about how we create spaces for people to come together. Some of that passing on of experience has been much harder for staff to do, given that there has been significant turnover—people left during and after Covid. Covid is not to blame in that respect, but those circumstances have had knock-on effects, so we have a different set of environments in which we are trying to apply things.

My point is that simply transferring learning is very hard. Using models such as appreciative inquiry and tools such as OutNav gives people the toolkits for the shared-learning space.

Carol Mochan (South Scotland) (Lab): I was asked to talk a wee bit about unmet need—that has been raised in the discussion, which has been interesting. My question is about unmet need and eligibility, which involves a conflict in terms of how people live their best lives. Have any studies looked at the interplay between what someone is assessed to need and what the unmet need in the wider context is?

Dr Brunner: I am happy to talk about the unmet need side and then move on to eligibility. To address the question head on, in order to assess unmet needs accurately—that is, to think about the vision of independent living—social workers and others who are making assessments of unmet needs outcomes need to do so without the fear that they will immediately be liable for delivering on all those unmet needs instantly. We need a measure of unmet need that is accurate about achieving independent living for people who need social care. The eligibility question is separate, and the resource allocation question is separate from that.

10:00

In the first instance, what we need in order to understand the degree of unmet need in social care in Scotland is the freedom to really go for it and understand what the vision is. In the review of unmet needs that we at the University of Glasgow undertook last year, Nafsika Zarkou and I looked at more than 100 papers, and from that evidence, we developed a new definition of unmet needs in adult social care that ties those needs to independent living. If it is okay, I will read that definition out—it is very short. It is this:

> "'Unmet need in adult social care in Scotland' should therefore be defined as: (a) the number of adults in Scotland that need any, more, or amended, social care to enable them to achieve and sustain independent living, and (b) the range of those unsatisfied care and support needs."

In other words, it seeks to cover the number of adults who need some, more or different social care to be able to live life in all its fullness—as Fiona McQueen, the former chief nursing officer, put it—and the range of those unsatisfied care and support needs. We therefore need the outcomes vision to be set and clear; resource allocation or eligibility is, for me, a separate question.

Carol Mochan: The legislation has been acknowledged as being very good, but does anything else need to be in it to help us take things forward? Does anyone have a view on that?

Rob Gowans: We are happy that the 2013 act does not need any major amendment—it is really good legislation. The issue is how it is being implemented. One opportunity that we might have with the National Care Service (Scotland) Bill, which will shortly be coming back to the committee, is to look at where some national oversight and consistency can be provided. I am thinking of things such as data and, as has been mentioned, the sharing of good practice. The fact is that self-directed support can be used in all parts of Scotland, and I know that some sharing of practice is going on between practitioners—for instance, through the national SDS collaboration. Those are a couple of things that could provide a bit of national consistency, particularly in areas such as unmet need, eligibility and the postcode lottery.

Carol Mochan: I have one final question. Are people with self-directed support seen as having lower or moderate levels of needs? Can they dip in for things that might be seen as additional, such as a holiday? How does that sort of thing happen practically on the ground? Does it happen at all?

Des McCart: I suppose so. A number of areas have adopted more general community-led models of social care, although maybe not to the extent that you are talking about with regard to holidays. Instead, they are about being able to connect into the community to find such things. I guess that the hard part is that it probably goes nowhere near formal assessment or options 1, 2, 3 and 4, so the question, again, is: how do we know that this is happening?

The Heart of Hawick is an example of an environment where the public and third sectors are brought together, and people can have a good conversation. Such an approach can, first and foremost, be linked with community resources, and what has been found is that it gives people what they need there and then and quickly, especially around carer support. People there are able to find solutions.

The harder part is how to track that. Of course, there is the question whether you want to track it but, in any case, it all comes back to people being able to say, “That’s great. I’ve been able to go there today and I know that I can go back tomorrow if I need this or that.”

That gives people a real feeling of confidence, and we have seen communities saying that they do not feel that they need as many of these hubs as we might have thought, because they are much more confident about things and know where to go. Empowering people means creating the kind of space where people can come in and get knowledge and independent advice on issues such as community brokerage support, which my colleague Anne-Marie Monaghan would have talked about if she was here today.

It is important to connect people to what helps them to live well in their community. Resources around independent advice and advocacy are not assessed and provided for as funded services in one sense, so the provision of those services, which create good, strong community resources, requires public bodies to find the right kind of grant funding. There are good examples of that work being done in East Ayrshire, the Scottish Borders and across the country. The challenge is to make the success of that approach more visible in a way that gives comfort at the kind of level that we are talking about.

Ruth Maguire (Cunninghame South) (SNP): Good morning, and thanks for your contributions so far.

Most of my questions are for you, Mr McCart, and are around the national collaboration and the learning-based approach to improvement. We have heard a bit about that this morning, but could you define what a learning-based approach to improvement is?

Des McCart: I should be clear that I am here with my Healthcare Improvement Scotland hat on, but we are members of the national collaboration, along with the ALLIANCE and others, and I have a focus on evaluation.

A learning-based approach acknowledges that learning is at the heart of any improvement structure—Healthcare Improvement Scotland’s quality management system has a learning focus at the centre of it. It involves an understanding of what it is that we are observing—it is not simply the observation that is important, but what we are learning from it—and that comes from dialogue, which is why things such as the appreciative inquiry approach are particularly useful tools.

Our focus over the past few years has been on what continuous improvement looks like in a complex—rather than complicated—system. Obviously, medical models are complicated, but the landscape is more linear, so you can follow things through. In complex areas, you have much more of a kind of butterfly effect, where a change in one place creates wider variability. In that space, we have been engaging with the human learning system model—I think that one of your previous witnesses talked about that. That is about shifting the balance in relation to how a system is accessed.

At the moment, the balance is towards humans having to learn how to get into a system, which results in people presenting at GP surgeries and accident and emergency departments because they do not know where else to get into the system. The assumption is that the system is right, or fairly right, and people have to find the best way to get support from it. However, the point of the human learning system model is to think about how the system can learn from human beings and begin to evolve and change. In that respect, improvement is not just about doing things better but about doing better things.

Shifting the focus towards that is what we are concentrating on. It involves a consideration of what works, why it works and what mechanism makes that possible. That requires conversation rather than simply an examination of performance data, and it gets into a much more of a qualitative space. Does that answer the question?

Ruth Maguire: Kind of. When my colleagues and I talk about these systems, it is not an abstract thing for us, as we will often have in mind specific constituents who have perhaps been failed, sometimes with tragic consequences. For me, the most important question is: when will citizens who are in receipt of or in need of this support see changes as a result of that improvement work? What is the timeframe?

Des McCart: I think that we are seeing improvement now. It goes back to your point about the fact that things take time. I know that that is not an easy thing to accept, but a lot of examples of improvement are beginning to come through. The Highland example that we mentioned is one in which you can see improvements being experienced by people in communities who are receiving care and the staff who are providing care.

The intention is to further roll out the SDS framework of standards and the self-evaluation process over the next 12 months. Again, that work will involve the three organisations that are supporting it, and the work should bring forward more evidence of how things look in each area, what is being learned and, therefore, what the improvement plan is to make the approach more real.

Ruth Maguire: To what extent can the committee be assured that health and social care partnerships and local authorities have access to support for improvement work?

Des McCart: There are a number of improvement bodies apart from ourselves. For example, in social care there are organisations such as Inspiring Scotland, which has given evidence to the committee, In Control Scotland and Iriss—the Institute for Research and Innovation in Social Services.

It is important to say that we work collaboratively. We recognise that although any one of us might have limited resources, we are stronger when we pull together. That means that a local area can receive aligned support rather than assistance that might be pulled in different directions if each organisation was saying, “This is our model”. We do not want to work in that way; we want to bring a different approach.

Not being part of the work in the first round of improvement can be useful for a local authority. Rather than saying that something should be done in this way or that way, it can ask, “How does that tool affect this?” and “How can we bring a sense of inquiry to this?”

As national bodies, we also share space. In our work, we have regularly met people from Social Work Scotland and SDS Scotland to share what we have learned about providing improvement support, so that we have begun to adjust ourselves and ensure that we are aligned rather than pulling people in different directions.

Ruth Maguire: Is that work accessible to people who are delivering services on the ground?

Des McCart: Our focus for the SDS work has been the staff. That work is accessible to staff and we support them at all levels. The aim is to support management so that it can then support people, but some of the work is directed at building the confidence of staff. For example, In Control Scotland hosted and led appreciative inquiry work, which involved a mixture of facilitation and coaching skills.

Ruth Maguire: It might be helpful to say what appreciative inquiry is.

Des McCart: Appreciative inquiry is a specific model of reflective practice. Forgive me—I have forgotten the names of the steps called the four Ds that the model involves, but I can certainly send that information to the committee later. I can say that it is a well-established reflective practice model, in which we ask stakeholders, “What is working?”, “How does that work for you?” and so on. It is a fairly simple model, but it allows space for reflection. We can share the information about what the appreciative inquiry model is. I reiterate that it is well established.

James Dornan (Glasgow Cathcart) (SNP): Good morning. I want to ask about SDS in the wider context of social care. To what extent do your studies take account of wider policy and the legislative context for SDS, such as the integration of health and social care? What needs to be prioritised in the wider social care context to ensure the embedding of choice, control and collaboration?

Rob Gowans: We are always struck by the fact that self-directed support seems to be separated from social care in people’s minds. It is often described as a model for delivering social care when, in reality, it is the model for delivering social care in Scotland. Sometimes we feel like enthusiasts for a good practice model rather than a team that is encouraging people to comply with the existing legislation. The recommendations of the independent review of adult social care and many of the areas that we identified in the "My Support My Choice" research would be addressed by fully implementing the Feeley review. We consider that the issues are about the national care service, how we could make improvements to the social care that people receive to ensure that their experiences are better, and how we can support self-directed support finally being implemented as it should be across the country.

10:15

There is also a role for leadership from the Scottish Government and from local government on self-directed support. There is a frustration that, more than 10 years on from the act being passed, we are still talking about implementing it and rolling it out into practice. That takes leadership, and it takes resources. A lot of the issues have been driven by a lack of financial resources, but leadership is needed, and there is a role for national consistency and support.

James Dornan: Does anybody else what to come in on that point? I have one or two other questions.

What impact, if any, would changes proposed by the National Care Service (Scotland) Bill have on SDS? Does the passage of that bill offer an opportunity to reconsider how relevant legislation ensures the best outcomes for people seeking care and support?

Do you want to come back in on that, Rob, or does somebody else want to take this up?

Rob Gowans: I am happy to come back on that point.

The ALLIANCE has supported the introduction of a national care service if it is done in a way that responds to the concerns of people receiving social care and self-directed support and those of the workforce who work with them. If the recommendations of the independent review of adult social care were implemented as part of the proposals, that would go a long way towards addressing those concerns. Some things in the national care service proposals could be important in that respect. For instance, there could be a better complaints process. Some of the national structures could help to ensure that good practice is shared across the country and could provide greater consistency.

That said, there are a number of areas where the bill could be improved, and we would be keen to work with the committee in discussing what those are, once the Scottish Government's next amendments to the bill are published.

James Dornan: Could the National Care Service (Scotland) Bill present you with an opportunity to allay some of your frustrations about the importance of SDS? If the importance of SDS as being the only delivery model is highlighted during the passage of the bill, would that be useful?

Rob Gowans: Perhaps. The legislation as it stands would probably do that already; it is a question of how it has been seeded and implemented in practice. There is an issue around support for practice implementation and the resource for that.

James Dornan: I have one last question for the panel. Does anybody think that changes to legislation are—

The Convener: I am sorry, James, but I think that both Des McCart and Richard Brunner wish to respond to that last question.

James Dornan: I apologise.

Des McCart: I will just make a short point. The bill contains a focus on ethical commissioning, and getting that right is a key aspect. That should be fully ethical and put people at the centre of decision making around how we commission. That alignment of ethical commissioning would really help, if we can get it right.

Dr Brunner: Through my work with Glasgow Disability Alliance on future visions for social care, which is funded by the Scottish Government, a community navigator has been funded. Their role is to support disabled people who are marginalised from social care.

It is really striking how regularly we see the gap between health and social care leading to significant health and wellbeing problems for individuals and problems for professionals. The services are just not working together well enough. Last year, we produced a report on that called "Navigating social care, independent living and human rights", which was authored by Marianne Scobie, me and Fiona McAloon, and we are producing another report on the community navigator work in the next month.

I think that everybody is aware that, with the national care service bill, significantly more work needs to be done to bring social care into the conversation so that we can maximize the integration between health and social care. Fewer people will then be lacking self-directed support at home, so they will be less likely to enter hospital. Also, if people have self-directed support in place to go back to, they will be discharged from hospital much more quickly, all other things being equal.

We all know that, so there needs to be more prominence for social care in the national care service bill.

James Dornan: Okay. Thank you, convener.

The Convener: Is that you finished, James?

James Dornan: Yes.

The Convener: Okay. Tess White has a supplementary.

Tess White (North East Scotland) (Con): Thank you, convener. In relation to whether the 2013 act is sufficient and appropriate to achieve independent living, as Feeley outlined, I would like to ask two questions. The first one is about resourcing. Des McCart made a point earlier in relation to social workers being

“key cogs in the wheels”.

However, at a previous session, the committee heard that there is a high staff turnover for social workers and that morale is low, so if they are the key cogs in the wheels, how are we going to improve self-directed support?

Des McCart: One of the key learnings from the Highland work was about staff feeling empowered. If SDS is about returning power to people, those closest to them in that arrangement also need to be empowered, so you need front-line staff who are confident and able to make decisions. That is one of the key things to come out of that work—staff feeling that their job is not just to administer the system as they are told. Instead, they feel able to bring back information and to say, “When we are doing this, we are learning that this is tough and this is doable but there is a way that you can improve it,” and they are being listened to.

One of the key things is that that model gives staff the opportunity to start to influence and to say, “We know stuff and we have got useful information to bring into the system, to change the system.” One way to improve things is to empower front-line staff so that they get that joy back into their work.

Tess White: Okay, so work needs to be done there for SDS to be successful—as you sad, they are the key cogs in the wheel.

My second question is about geography. Resources are under pressure, in relation to both people and finances, but there is a huge disparity between rural and urban areas. I am particularly bearing in mind two of the support options. It is very difficult to get carers out to rural areas. There is a disparity in mileage rates, sometimes people need to source their own carers and the rates that the councils offer are more centred on the cities. It is a difficult challenge, but for SDS to work, the challenge needs to be gripped. Do panel members have any comments on that?

Des McCart: I am happy to come back in on that. Through getting the ethical commissioning part right, we are getting models where we are realising community assets in a different way, rather than having to employ whole-time staff. For example, if we go back to places such as Boleskine and Braemar, we see that they are using what we would call microproviders. We are also seeing that a lot now in South Ayrshire, which had a particular problem around recruitment and retention of care staff. Through working alongside third sector organisations, it has been able to add microproviders.

It is not a self-employed personal assistant model, although, very often, a microprovider is one person. The person can offer two or three hours at a time. It is being able to work the system around those individuals that allows that to be useful. You are either a full-time or part-time member of staff, with all that that entails, and that is a much more flexible approach to the workforce.

In those models, we have used things such as the open-badge system from the Scottish Social Services Council, so that if people require something from dementia support, they can use the open-badge system to get the proportionate and right training. That is the ethical commissioning part of it. We have mechanisms that allow that to happen, because people can give that.

What we have seen in South Ayrshire is that people such as retired nurses and teachers, especially nursing and care staff, are saying that they do not want to be in full-time employment but are able to offer some of their time in their local community. What are the mechanisms for that? That is where ethical commissioning comes in. We need the right kind of mechanisms that make that happen, and make it happen safely, so that we still have the same standards in care and quality, but are doing things in a good way. It is about getting some of the dull stuff right, such as the commissioning or the mechanistic parts, so that that can happen.

Rannoch and a number of other areas across Scotland are beginning to move into realising community assets and community capacity in a different way, so that people are paid. Those areas are not saying, “This is about volunteering,” but are having paid staff—although that might be alongside volunteering.

That tends to align with something more than just health and social care. It includes things such as handyperson services and transport, so it is aligned with community living. That is important because, for it to be sustainable, it has to be about not just a health-based or a social care-based service delivery model, but sustainable community living. That means that people may have two or three jobs, but if 10 people in local rural communities are doing two or three hours, that begins to make a significant difference. Again, we are seeing those models coming through more and more at the moment.

The Convener: Are you finished with your questions, Tess?

Tess White: Yes, thank you.

The Convener: I thank the panel for your attendance today and for the information that you shared with the committee.

Subordinate Legislation

Food Additives and Novel Foods (Authorisations and Miscellaneous Amendments) and Food Flavourings (Removal of Authorisations) (Scotland) Regulations 2024 (SSI 2024/156)

10:27

The Convener: The next item on our agenda is consideration of one negative instrument, which is the Food Additives and Novel Foods (Authorisations and Miscellaneous Amendments) and Food Flavourings (Removal of Authorisations) (Scotland) Regulations 2024. The purpose of the regulations is to implement the decision that was made by the Minister for Public Health and Women’s Health on eight regulated food product applications. It authorises the placing on the market in Scotland of four new novel foods, authorises a new production method for two food additives and a new use for one other food additive, and authorises the removal of 22 food-flavouring substances.

The regulations also set a maximum limit for residues of ethylene oxide in all food additives, and they correct minor technical errors and omissions in two existing novel foods authorisations and two existing food additive authorisations.

The Delegated Powers and Law Reform Committee considered the regulations at its meeting on 11 June 2024 and made no recommendations. No motion to annul has been lodged.

I believe that Emma Harper has a comment.

Emma Harper: I do—thank you, convener. I hear what you are saying about the removal of 22 products and the changes to other foods coming on to the market. I want to raise again my concerns about the colours, flavours, emulsifiers and stabilisers and the chemicals that are added into our food supply chain. Stevia, for instance, interrupts the gut biome and can affect people’s hormone levels. I also read that it can cause depression. There are other issues with ethylene oxide. It is carcinogenic and mutagenic. Ethylene oxide residue is used to sterilise surgical instruments and medical devices; that is where I learned about it. It is now used as a pesticide and a sterilising agent for food, so there must be some standards required for a minimal amount of ethylene oxide residue when it comes to food supply.

Our documents show that Food Standards Scotland and the Food Standards Agency have reviewed the European Food Safety Authority's opinions, along with all the documentation on what we are discussing today. I am interested in the issue of everything that is coming on to the market with novel foods.

There is also the issue of the novel food cetylated fatty acids, which has a maximum level of 1.6g per day in the European Union, whereas Great Britain's maximum level is 2.1g per day. Cetylated fatty acids are not naturally occurring, except for in some dairy products. Now they are added to our food. I would be interested to hear why it is 2.1g per day in GB, but 1.6g per day in the EU. I assume that it is to do with safety margins.

I just wanted to raise my concerns about the continuing issue of chemicals that are coming into our food supply.

The Convener: Would you be content for the committee to write to the minister and ask about the concerns that you have raised?

Emma Harper: I think that members of the committee would find that agreeable. I am just seeking some affirmation about the safety aspects of the regulations and the discrepancy between 1.6g per day being allowed in the EU and 2.1g being allowed in Great Britain.

The Convener: I am looking around the committee members and it looks as though they are content for us to do that. I am certainly happy to do it.

The proposal is that the committee does not make any recommendations on the regulations. Does any member disagree with that?

Members: No.

The Convener: Next week, the committee will hear from the Minister for Social Care, Mental Wellbeing and Sport in the concluding oral evidence of phase 2 of its post-legislative scrutiny of the Social Care (Self-directed Support) (Scotland) Act 2013.

That concludes the public part of our meeting.

10:31

Meeting continued in private until 10:49.

Published in Edinburgh by the Scottish Parliamentary Corporate Body, the Scottish Parliament, Edinburgh, EH99 1SP

All documents are available on
the Scottish Parliament website at:

www.parliament.scot

Information on non-endorsed print suppliers
is available here:

www.parliament.scot/documents

For information on the Scottish Parliament contact
Public Information on:

Telephone: 0131 348 5000
Textphone: 0800 092 7100
Email: sp.info@parliament.scot

The Scottish Parliament
Pàrlamaid na h-Alba