OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 18 September 2018

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 18 September 2018

CONTENTS

HEALTH AND SPORT COMMITTEE
23rd Meeting 2018, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

*Miles Briggs (Lothian) (Con)
*Keith Brown (Clackmannanshire and Dunblane) (SNP)
Alex Cole-Hamilton (Edinburgh Western) (LD)
*David Stewart (Highlands and Islands) (Lab)
*David Torrance (Kirkcaldy) (SNP)
*Sandra White (Glasgow Kelvin) (SNP)
*Brian Whittle (South Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Stuart Bain (Society of Personnel and Development Scotland)
Alison Christie (Coalition of Care and Support Providers in Scotland)
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
Eddie Fraser (East Ayrshire Health and Social Care Partnership)
Jeane Freeman (Cabinet Secretary for Health and Sport)
Mark Hazelwood (Scottish Partnership for Palliative Care)
Karen Hedge (Scottish Care)
Dr Jane Kellock (Social Work Scotland)
Andrew Strong (Health and Social Care Alliance Scotland)
Katherine Wainwright (Scottish Council for Voluntary Organisations)
David Williams (Glasgow City Health and Social Care Partnership)
John Wood (Convention of Scottish Local Authorities)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 18 September 2018

[The Convener opened the meeting at 10:01]

Interests

The Convener (Lewis Macdonald): Good morning and welcome to the 23rd meeting in 2018 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are switched to silent mode. Mobile devices may be used for social media purposes, but they should not be used to film or record the meeting.

We have received apologies from Emma Harper and Alex Cole-Hamilton.

Agenda item 1 is a declaration of interests. In accordance with section 3 of the "Code of Conduct for Members of the Scottish Parliament", I invite David Torrance to declare any interests that are relevant to the committee's remit.

David Torrance (Kirkcaldy) (SNP): I have nothing to declare, convener.

The Convener: Thank you. I also invite Bob Doris, who is attending this morning's meeting as Emma Harper's substitute, to declare any interests that are relevant to the committee's remit.

Bob Doris (Glasgow Maryhill and Springburn) (SNP): I have nothing to declare.

The Convener: Thank you very much. I welcome David Torrance as a new committee member and Bob Doris as a substitute member.

Health and Care (Staffing) (Scotland) Bill: Stage 1

10:02

The Convener: We move on swiftly to agenda item 2, which is two evidence-taking sessions on the Health and Care (Staffing) (Scotland) Bill. The sessions will focus on the bill's impact on the social care sector.

I welcome to the committee Karen Hedge, who is the national director of Scottish Care; Alison Christie, who is the policy and development officer for workforce at the Coalition of Care and Support Providers in Scotland; Andrew Strong, who is assistant director for policy and communications with the Health and Social Care Alliance Scotland; Mark Hazelwood, who is the chief executive of the Scottish Partnership for Palliative Care; and Katherine Wainwright, who is the head of human resources at Turning Point Scotland, and is here representing the Scottish Council for Voluntary Organisations. I thank you all very much for joining us this morning.

I am sure that you are all familiar with the procedure: I will kick off the questions, then colleagues will ask their questions. All questions and answers should go through the chair.

I will start by asking all of you a general question about the bill's provisions and the issues that the bill might be intended to address. Do you believe that current staffing in the social care sector is adequately covered by the current regulation and inspection regimes? Who would like to start?

Karen Hedge (Scottish Care): We already have the policy and legislative context to support staffing in the social care sector. Social care in Scotland has come a long way and is beginning to create the conditions that are required for improvement and innovation, which can be seen in the health and social care standards that were introduced earlier this year in legislation—the Social Care (Self-directed Support) (Scotland) Act 2013—and, as far as our practice is concerned, in the inspection methods that the Care Inspectorate has recently brought in.

I am proud to represent an ever-evolving sector that retains at its heart an asset-based and individualised approach to providing care that is grounded in human rights. As human beings and as a society our wants, needs and wishes change, which means that we need to be able to meet the needs of our older citizens and of those who act as caring support, and we must be flexible in relation to those demands.

On top of that, the market is ever changing and people are living longer. With regard to austerity,

we need to be able to think differently about how care and support are delivered. The committee will know that the purpose of legislation is to freeze components. My concern is that the bill will enshrine use of tools and statute that could put at risk several things that I can outline later. At this time, however, the context fits what is required.

The Convener: I am keen to understand how far the current regimes operate and how adequate they are.

Alison Christie (Coalition of Care and Support Providers in Scotland): The CCPS's members believe that the current regulations provide for high-quality trained staff to support individuals to achieve their required outcomes. We are aware that the "National Health and Social Care Workforce Plan: Part 2—a framework for improving workforce planning for social care in Scotland" looks to address workforce planning and that the Convention of Scottish Local Authorities and the Scottish Government are progressing the recommendations to do just that.

We have worked quite closely, and had several discussions, with the bill team, but we have yet to get clarity on the benefits and added value that the bill will bring to social services or to the people who use social care.

Andrew Strong (Health and Social Care Alliance Scotland): Our perspective differs slightly from that of other members of the panel. Our response was written in conjunction with individual members of the Health and Social Care Alliance Scotland who use health and social care services regularly. We feel that their views have so far been missing in the debate about the bill.

I will go back to the question. It is important to see the bill as a means to an end, rather than as an end in itself. People told us that continuity of care is key and is critical to them. They want, as far as possible, staff whom they know. Greater consideration of staff input is likely to lead to a greater possibility of achieving that continuity, so many of those people are in favour of the bill.

However, in our member consultation, we heard about experiences of understaffing in health and social care settings. That situation could be improved by the introduction of appropriate and ambitious tools, and the resources that are required to make it possible to use those tools.

Mark Hazelwood (Scottish Partnership for Palliative Care): The health and social care sector obviously has major workforce issues, which we believe are primarily driven by factors including national workforce planning, affordability for commissioners and wider issues that affect recruitment and retention in the labour market. Those main issues are not primarily caused by deficiencies in workforce planning at local level or by inadequacies in legislative or regulatory frameworks.

Katherine Wainwright (Scottish Council for Voluntary Organisations): We believe that the plans, policies and legislation and the new health and social care standards and inspection approach are more than adequate, at the moment. We see no particular benefit coming from the bill; it has no focus on outcomes, which is how the sector thinks at the moment. In short, we do not believe that the bill is necessary or required.

The Convener: Thank you very much. I will go back to Andrew Strong's particular perspective on the users of services. Is it possible to describe the user perspective as it currently exists in relation to staffing issues, or is it so dispersed and varied as not to allow for such characterisation?

Andrew Strong: I am sorry. I am not sure about the question.

The Convener: Is it the alliance's view that there is a user perspective on staffing issues and how they are being addressed, and how they should be addressed?

Andrew Strong: People are clear that there has been a lot of consultation on the health and social care standards. There has been a lot going on in relation to workforce issues and the regulatory framework of the Care Inspectorate. People are clear about what they expect from social care services, but I would not say that there is complete understanding of that. There are different opinions on the bill among our membership.

David Stewart (Highlands and Islands) (Lab): I thank the witnesses for the evidence that they have given so far. I am interested in workforce planning, particularly in the care home sector, which has three aspects: the private sector, local authority care and third sector provision. Can the panel outline the tools—if any—that are used for workforce planning in the sector?

Karen Hedge: Those who currently use workforce planning tools often use something called the indicator of relative need, which is known as IoRN. There are two versions of that tool, one that was created about 15 years ago and a more recent version. The tool served a purpose as guidance. However, in current social care thinking, an asset-based approach does not meet the needs of society. That is exactly what some of my colleagues on the panel were talking about—the individualised and personalised approach to delivering health and social care. Do you want me to talk more about the tool?

David Stewart: Yes. Could you briefly explain the tool for those who are not familiar with it?

Karen Hedge: The tool asks questions and assesses dependency and need. However, it is

not fit for purpose. We need to think about capability, enablement and prevention. It is not able to take those into account. The tool also misses what happens overnight. That is why it is not fit for purpose.

If new tools were to be developed, there would need to be a two-stage process. The tools would have to be developed such that they would take into account all the concerns about the bill that my colleagues and I have. The first stage would be to develop an asset-based model that can assess the needs of and outcomes for a person, and which can assess what that person is able to do, rather than their dependency, as outlined in the Care Inspectorate's submission.

There is concern because the Care Inspectorate has lead responsibility for producing such tools. We need to think about how to work better so that the tools could be co-produced. The tools need to work for the people on the ground who will use them—otherwise, they will create an additional burden.

The second stage of the process would be to develop an algorithm. I have absolutely no idea how that would work, but I am sure that there are digital experts who would be able to think about that. We would take that staffing and skills mix and apply it to the asset-based model.

However, we need to think about all that very carefully. We do not want to risk enshrining something that would take away human judgment.

David Stewart: I presume that there is an issue of scale—that it must be much more difficult to use such technical tools in very small care homes.

Karen Hedge: The social care sector is very diverse. We have large corporate businesses to small individual-run providers. My panel colleagues also represent other providers, including those that deal with drug and alcohol abuse. That includes Scottish Care. We need to think about how to apply the tool in different settings and about whether different tools would be required. There would also be a requirement for training and development. There are so many different issues to think about, if that is the route that we choose to go down.

Katherine Wainwright: As a provider, Turning Point's two registered care homes are specifically for substance abusing people. I point that out to highlight the fact that we should not assume that we are talking only about care of elderly people. The individual cases that Turning Point works with are really complex. The units that we run support 10 or 12 people, so their capacity is fairly small. They are supported by other services that we provide; they do not stand in isolation. There is some staff enrichment and movement of staff and skills between services. Care homes do not stand alone—they are part of a greater network within provider units.

10:15

David Stewart: Committee members visit care homes across our patches. On recent visits in the Highlands and Islands, one of the issues that has been drawn to my attention is the increase in dementia and the effect that that has on staffing. The hard reality that is thrown back to me whenever I have raised the issue—without naming any establishments—is the chronic shortage of staff. I cannot speak for the organisations that I have visited, but I know that having sophisticated tools is all fine and well and makes sense from a financial point of view, but the reality is that trying to fill the rota week in and week out is the main problem that many managers face. Is that Turning Point's experience?

Katherine Wainwright: Absolutely. At any point, we are running a staffing vacancy rate of between 7 per cent and 11 per cent—and we are pretty good at recruitment at Turning Point Scotland. There is a chronic requirement for staff, so it feels risky to make it more difficult for us to meet the base requirements.

Alison Christie: CCPS, along with the human resources voluntary sector forum, carries out an annual benchmarking survey that looks at a range of workforce issues. Questions are always asked about recruitment and retention. In the 2017-18 survey, 93 per cent of providers stated that recruitment is difficult or very difficult, which was an increase from 87.5 per cent in the previous year. That finding is also supported by the Scottish Government commissioned survey for 2016, which looked at the social services workforce in Scotland and stated that the majority of providers found recruitment challenging either regularly or occasionally.

Andrew Strong: I want to comment on the future threat to the social care sector from Brexit. BBC research that came out this morning says that there are 26,000 people from the European Union working in health, social care and public administration. We should see that wider context as being important in terms of the social care sector. A lot of those people work in the sector, so the ability to carry on business as usual beyond March next year could be threatened by that.

Karen Hedge: It is also worth having a look at the Scottish Social Services Council's "Scottish Social Service Sector: Report on 2017 Workforce Data", which was published last month. I draw members' attention to the fact that, with regard to the recruitment and retention crisis that the sector currently faces, the data report cites a stability index of 77.1 per cent. That means that about a

quarter of staff roles are changing in a year. Our research at Scottish Care also shows that more people leave within six months of entering the sector than stay. Put those two facts together with increased demand, and it is clear that we currently face a huge crisis.

Others have alluded to the vacancy rate in their services. I want to highlight the fact that, for nurses in particular, the vacancy rate is currently sitting at 32 per cent. That situation cannot continue. I do not know whether the committee is aware of last week's headline news that 19 care homes have closed this year because they cannot recruit nurses.

Brian Whittle (South Scotland) (Con): We have heard evidence and received written submissions suggesting that the national health service in the UK and in Scotland is actually very efficient but that that efficiency is in itself making the system more fragile. Does that apply in the care home sector as well? Are we starting to work right at the boundaries of what we would term safe staffing?

The Convener: That is a challenging question. How fragile is the care home sector or, to put it another way, how robust are staffing arrangements currently?

Karen Hedge: I would merely reiterate the statistics that we have just described. We are struggling to recruit staff, so when efficiencies are made, that is often where they are made, because we are already at the bottom line in terms of resource for providing the service. There is nowhere else that we can lose funds. In addition to the 32 per cent vacancy rate for nurses, you will see that there has been a growth in agency nurse provision of 18 per cent in the past year. The fact that there are more nursing agencies does not mean that there are more nurses. Actually, some of our providers have to spend up to £1,200 a night to get a nurse. "Efficiency" is not really the word that I would use in this context.

Katherine Wainwright: Providers are trying to be more creative and dynamic and use multidisciplinary teams—that is the counterbalance to the staffing crisis.

Mark Hazelwood: The bill's ambition is to create a framework that spans diverse settings, multiple professions, integrated services and teamworking. That is good, but I am not clear that we have evidence-based approaches in which to ground it at this stage. There is a risk that, in trying to create that framework, we create rigidities and end up with a tool that is not sufficiently flexible, which will potentially become an obstacle to the integration and innovation that Katherine Wainwright mentioned, which are the responses that the sector has when it faces the workforce pressures and recruitment issues that Karen Hedge has described. That is one of the risks and potential unintended consequences of the bill.

Brian Whittle: With that in mind, will the bill support the sustainability of the sector in terms of quality and safety? My colleague Dave Stewart alluded to the different sizes of care homes. Can tools be applicable across the whole sector?

In relation to the tension between numbers and service, are we talking about the wrong thing? Are we talking about numbers when we should be talking about service?

Karen Hedge: Actually, we should be talking about the people who access care and support and making sure that we deliver care that is responsive to them and led by them. When we start to use tools, we apply a prescriptive set of skills to the person, which does not necessarily take into account their individuality.

Sorry, but I have forgotten the other aspect of your question.

Brian Whittle: It was about whether tools are applicable across the sector, and it followed on from Dave Stewart's line of questioning. Does that in itself create tension?

Karen Hedge: To go back to the question about multidisciplinary teams and innovation, in our current setting, the tools do not apply across the sector, and that will need to be taken into account.

Alison Christie: One of our concerns was whether there could be a standardised tool that would suffice across the diverse range of services. On speaking to the bill team, we found that that was unlikely and that multiple tools will probably have to be developed, which brings its own challenges. Someone asked how many people do workforce planning. Our benchmarking survey found that only 23 per cent of respondents use workforce planning tools. When the tools are developed, we will have the issues and challenges of people having to be trained in their use, and that will be perhaps not just for single tools but for the multiple tools that one organisation will have to use. That brings me on to the point that there is no clear indication of how any training will be resourced.

Bob Doris: It is helpful to understand the concerns around the bill. At the outset, Karen Hedge said that there are concerns about the current tool, which is the IoRN tool—I will be dashed if I can explain the acronym. I have listened carefully to all the challenges. Any tool or tools that are developed will have to be suitably flexible and take into account the varying needs and the diversity of the sector. However, with all those caveats, if we can get it right, will it be positive for the sector?

The Convener: That is about workforce planning tools in principle, assuming that they are the right ones.

Karen Hedge: There are positivities in having these tools, such as transparency and the offering of guidance, and for those reasons, Scottish Care would support having them. However, they cannot be the be-all and end-all; human judgment still needs to be a significant factor that can override them.

We need to bear in mind the fact that the landscape is changing. We have not yet discussed—and I am not sure whether the committee discussed it last week either—the opportunities that changes in technology offer; they allow our staff to just be. Care homes are not clinical settings—they are, by definition, someone's home—and if you try to apply something that has been created for a clinical setting to somebody's personal place, you start to enter what is quite a grey area.

Bob Doris: It might be helpful if I reword things slightly just before Mr Hazelwood comes in. Karen Hedge talked about constraints and the fact that, even when you use these diagnostic tools to work out the skills mix and the workload in any one place, there must be on-the-ground judgment. Would it be helpful to have these diagnostic tools for what the head count, the skills mix and the workload should look like, as long as you have a degree of flexibility on the ground and the ability to make the final judgment, given that you know your local care home setting best?

Mark Hazelwood: I will come back to that but, even if we assume that we have a series of perfect tools, I think that there are still issues to address. In any well-managed service, there must be consideration of how to match the workforce to the service's needs and, as we have heard, there is an increasing need to personalise that process in order to achieve individual outcomes for individual people. That must be part of the process of running a good service.

The question is whether that is best done through making it a statutory requirement. There are issues about the statutory context into which such a tool is placed. As we have pointed out in our submission, there is a lack of clarity about how the duty on authorities that commission services to have regard to the duties and principles placed on care service providers will play out in practice when commissioners are trying to balance quality, safety and affordability.

That brings us back to the wider pressures on the sector that we have already talked about. The IJBs are, as commissioners, under great financial pressure, but the fact is that, even when service providers have a financial envelope sufficient to fund the workforce levels that are required to deliver the service, the labour market that they are going out into simply does not have sufficient people to meet those needs. There are significant concerns that, if Brexit proceeds, which in all likelihood it will, those pressures will be severely exacerbated.

The Convener: Does anyone else have an opinion on those points or, indeed, on Bob Doris's question whether tools are, in and of themselves, potentially useful or simply the wrong way to approach the issues that you face?

Katherine Wainwright: I find it hard to imagine them being particularly helpful in this context. I do not see them fitting particularly well and, until we have reached a position where the resourcing and the availability of nurses and social care workers are much improved, I cannot see how useful they might be.

Bob Doris: Finally, convener, I think that it is important to point out that, given the concerns that have been raised, the power in part 3 is for the Care Inspectorate to develop rather than implement a tool. That is an important distinction, because it might not be able to get it right.

Going back to the point that Mark Hazelwood made about the recruitment and retention of staff—and Karen Hedge said something similar—I note that one power that the Government is not taking in part 3 is the power to report on staffing levels. Does that seem a bit odd to you? Should there be, as part of this, national reporting of staffing levels so that we get a national picture and can see what is happening across the sector and the country? Would that be helpful, or would it just cause administrative difficulties for individual care homes in the sector?

Andrew Strong: We would like to see something like that. Whether that works for providers is another question. The people we have spoken to would like more transparency about the pressures that social care and health services are facing.

10:30

Karen Hedge: I want to come in on that point. The SSSC already collates some workforce data, as do Scottish Care and the CCPS. There are other means of getting hold of the data, although a national picture might well be helpful in planning for the future.

Sandra White (Glasgow Kelvin) (SNP): I want to go back to the basics of why we are here. We have had evidence from other professionals and we are taking evidence today from you and others. The point is to look at both health and care—that is important; this is the Health and Care (Staffing)

(Scotland) Bill. What I am hearing from the panel and others is that there are so many different aspects to the bill. It seems to be based on nursing at the top and then it works its way down. The panel may not think that, but it is certainly what has been fed back to me.

The complication is that there are so many different sectors. There is the private sector, the council sector, care homes and so on. Panel members can answer me honestly about whether they have been involved enough in the bill. The bill applies the same general duties on all providers, yet they not only provide different levels of care but are completely different organisations. Will the bill succeed in creating coherence by integrating legislation and practice between health and social care?

Mark Hazelwood: Even if we stay close to the core, as Sandra White has described it, of the consistent application of nurse workforce planning tools, there are some challenges and complexities that are not reflected in the bill.

For example, the voluntary hospice sector is a major provider of in-patient specialist palliative care provision in Scotland. Most of the care that hospices provide is in people's homes. Among the broad range of services that hospices provide, however, are in-patient services and several of the healthcare services that are listed in new section 12IC of the National Health Service (Scotland) Act 1978 as inserted by the bill, which proposes the application of a common method. The locations listed in the table in that section do not clearly equate to hospices. They seem to be predicated entirely on NHS settings.

We need to understand that complexity better, even before we get into the wider orbit of the huge diversity of health and care settings that other colleagues have spoken about. There should not be a blanket assumption that tools that have been developed primarily in and for the NHS can necessarily be applied without adaptation to other healthcare settings, such as voluntary hospices.

Karen Hedge: The bill in itself does not add anything to integration. There is already work to develop new models of care. The chief nursing officer's directorate recently had a meeting that drew on examples of local changes in looking at how nurses can potentially work peripatetically and at things such as enablement programmes.

If anything, the bill might create a barrier between the two sectors, because of the potential for nursing staff in particular to move into the NHS from the independent and third sectors without terms and conditions being a difficulty. Where we already have a workforce in crisis, that is a problem.

We need to focus on new models of care and linked career pathways, looking at multidisciplinary teams and other opportunities that we are already considering.

Keith Brown (Clackmannanshire and Dunblane) (SNP): I am aware that four panel members have mentioned the impact of Brexit, especially in relation to recruitment and retention. Vacancy rates of 32 per cent were mentioned and there has been a substantial increase in vacancies in the past year. I was stunned to hear that the cost for an agency nurse is £1,200 a night—I wonder how much of that goes to the nurse.

I know that it is not as simple as considering only the impact of those staff who are from the EU potentially leaving because of Brexit; there will be other issues to consider as well. However, can any of the panel members give us an idea of the impact on the vacancy rate of EU staff leaving over the past year or even the past two years?

The Convener: This is in the context of what is in the bill and the workforce planning proposals.

Mark Hazelwood: I do not have the statistics in front of me, but I will happily submit something after the meeting, because I know that there is a growing body of evidence about the impact of the prospect of Brexit. Also, some of the evidence that has been published by the Government in Westminster on economic projections raises concerns as well.

The Convener: Thank you. That is helpful.

Keith Brown: Whether the situation is due to Brexit or other recruitment and retention issues, bearing in mind what has been said about being able to apply professional judgment, which it is possible to do with the current tools that are used by nurses, could one of the benefits be that you could point to an objective, evidence-based statutory process and say to commissioners, "This is what we require in terms of staff"? That might help in relation to Mark Hazelwood's point about commissioners being aware of their obligations as well. You could point to these tools and say, "We need to have this," and everyone would be in the same boat; you could take that back to commissioners.

Karen Hedge: That is one of the reasons why we have been looking at this as part of the national care home contract negotiations. Scottish Care, COSLA—which will be appearing in the second evidence session today—and Scotland Excel are involved in the conversation, with the proviso that the tools act as a guide and not as a prescribed formula.

There are advantages but, as Mark Hazelwood mentioned earlier, the fact that commissioners are not included in the bill is a huge oversight. We can

see what happened with the Scottish living wage. There is a requirement to pay it—quite rightly, because we should be paying our staff and valuing them—but if that funding does not come down to the providers, they are put in quite a sticky position when it comes to being able to pay that money out. I would hate it if the bill created that same potential drain on resource.

Mark Hazelwood: This is a related point—it will be very important as the bill proceeds that there is some clear linkage between the development of the models and the regulatory framework. That is also where the relationship with the commissioners comes in, because it ends up being very difficult if there is an expectation on the part of the regulator that the provider will meet a certain set of workforce requirements but there is not adequate resource to meet that in the commissioning process. The comeback in that position is often at the level of the provider, who may suffer because of poor ratings from the regulator. That is what I was talking about when I mentioned the question of which duties are placed on the commissioning authorities in those circumstances.

The Convener: That is understood.

Alison Christie: On average, 77 per cent of the income of CCPS members relates to publicly funded services, so it is a huge concern for CCPS members that there is no duty placed on commissioners.

The Convener: That is an important point—thank you.

Miles Briggs (Lothian) (Con): To follow on from Keith Brown's question, I want to look at workforce planning and training. The national workforce plan is now in three parts. What feedback have you had with regard to future training and the college sector? It is quite clear that the care crisis and the staff crisis did not start with Brexit; they have been building up over many years now. What future projections on staff recruitment are you looking to meet? Are you concerned that an unintended consequence of the bill having two speeds, with the care sector very much in the slow lane, is that staff might be poached to address problems in the acute sector?

Karen Hedge: My answer to your final question is yes, absolutely. One of the risks of the bill is the unintended consequence of the sector being resource driven. If you are trying to address staffing numbers, that is where you put all your resource. If the health aspect of the bill is implemented first, resource will go first into getting people employed in that sector. That means that we are likely to lose staff and, given the figures that were quoted earlier, that is a real concern.

Alison Christie: A further concern for CCPS members is that, as a very small proportion of members have care homes, we are third in line for any resources. If resources initially go to health and then to care homes, services that deliver community support will be underresourced.

Katherine Wainwright: We are concerned that we would have to divert staff from one service to another to focus on care homes.

Miles Briggs: Is it fair to say that the college sector is not meeting demand? The Scottish Government is trying to fulfil its childcare policy, and I know from conversations that I have had in Edinburgh, which has half of all delayed discharges, that many potential students are being encouraged to go into childcare. My concern is that it will not be possible to meet future demand for adult care and that by encouraging people to choose different pathways that will never take them into a career in adult care, we are actively creating unintended consequences. Does the panel have any views on that?

Alison Christie: There are long-standing difficulties in getting people into careers in adult social care. We are quite optimistic that the national health and social care workforce plan and the national marketing campaign will address some of those challenges, but there is a long way to go to make adult social care attractive to people. CCPS and the voluntary sector have a recruitment working group, and since May we have been trying to get 10 people into an employability programme. We are targeting long-term unemployed people who face multiple barriers to employment, who do not see care as an attractive career prospect. There are many challenges to be addressed beyond the bill.

Katherine Wainwright: It is about long-term education about careers in social care. Such an approach, which does not exist at the moment, should start at the very beginning, at school, with young people seeing a career in social care as an option. Work by the joint voluntary sector working group on recruitment has shown that, despite being offered enticements, folk are not choosing social care as a career. It is really difficult.

Karen Hedge: My colleagues Katharine Ross and Paul O'Reilly can put something in writing for the committee about the issue. However, I can tell you that there are concerns about the way in which training is put in place, whether that is through Scottish vocational qualification models or apprenticeships. Part of the problem is that the median age of the workforce is 48. There have been regulatory changes leading to an increased requirement for more qualifications. People often come into the sector without qualifications and with dual caring commitments, and we know that they access training between 10 pm and 1 am.

There is a whole host of concerns about that. If it would be helpful, Katharine Ross or Paul O'Reilly could put something in writing.

The Convener: That would be helpful. Thank you.

A number of the panel members have commented on the potential for the bill to skew attention towards resources. Let us look at the other side of the coin. Does the bill assist in increasing a focus on outcomes for individuals? If not, perhaps we should hear about that as well. What is the view of panel members on the outcomes focus in the bill?

10:45

Katherine Wainwright: I do not see an outcomes focus in the bill as it stands.

Mark Hazelwood: We already have the health and social care standards, which provide a nice framework for a focus on outcomes.

Andrew Strong: I agree. I would like to see more reference in the bill to how people who use health and social care regularly can be involved in and consulted on the issues. The bill refers to who is to be consulted in the development of the tools, but it would be legitimate to extend that to people with long-term conditions or disabilities.

Alison Christie: I agree with what everyone has said. The bill is not outcomes focused.

Karen Hedge: I echo that.

The Convener: Thank you—that is clear.

David Torrance: With the Care Inspectorate being both the regulator of registered care services in Scotland and the scrutiny and improvement body for social work, is it the appropriate body to lead on the development of staffing methodologies for the care home sector?

Karen Hedge: The Care Inspectorate is very experienced in this area, and I believe that it should be involved. We have a close working relationship with the Care Inspectorate, as we need to have. That has resulted in the majority of care homes in Scotland having a "good" or "very good" rating.

However, I do not think that it should develop staffing methodologies in isolation. Collaboration is not the same as co-production. The tools need to be fit for purpose and easy to use. If our staff are running from place to place—and the future projections on staffing shortages suggest that that is highly likely to happen—they need to be able to use the tools quickly and easily. If tools are to be produced, the Care Inspectorate can lead, but they must be co-produced.

Andrew Strong: The national care standards were developed in co-production with providers, people who use the services and other bodies. The Care Inspectorate should see the value of doing that and are likely to take development forward in that way. We would be supportive of that, but with the caveat, as Karen Hedge said, that it is done in co-production, particularly with people who receive support and use services and with providers.

David Torrance: Will the bill change the relationships between the Care Inspectorate, commissioners and providers? Will there be any conflict of interest?

The Convener: Does anyone have a view? What is the potential impact?

Karen Hedge: I alluded to our relationship with the Care Inspectorate, which I would like to continue. Although there are concerns about the risk of creating a resource-driven service in which all the resources have to go into staffing as opposed to outcomes, I do not see the relationship changing in any great way, because we already co-produce things and work together in a way that is based on outcomes. On reviewing the submissions to the committee, my only concern was that we in Scottish Care have an asset-based model but the Care Commission refers to dependency tools. That is an area that we could explore; it is the only area where I could see us coming up against each other.

Alison Christie: I do not think that relationships will change, but I can see the potential for conflict. If the Care Inspectorate develops the tools and regulates against them but there is no duty on commissioners to meet the requirements that the tools evidence, conflict could arise between the Care Inspectorate, the provider and the commissioner.

Mark Hazelwood: This is not a direct answer to the question, but some voluntary sector hospices have dual regulation at present, in that some of their services are regulated by the Care Inspectorate but the bulk are inspected and regulated by Healthcare Improvement Scotland. There is a degree of complexity in the area. HIS does not have the same inspection and regulatory relationship with NHS services that it has with independent healthcare providers such as hospices.

When we come to the detail of how it is all going to work, we would need to ensure that there is an appropriate way of taking up whatever models are developed—some of that is specified in the bill in terms of types of healthcare service and types of setting—so that that does not feed into Healthcare Improvement Scotland's regulatory processes in a

way that hinders or has negative outcomes for the provision of services by independent hospices.

David Torrance: My next question is about recruitment, especially of nurses. As was mentioned earlier, there is a 32 per cent vacancy rate and an 18 per cent growth in the use of agency nurses. Can the bill in any way affect the recruitment and retention of nursing staff in the sector?

Karen Hedge: It very much will, because things will happen in a progressive manner from one sector to the next—from health to social care—so there is the potential consequence that social care will lose staff to the health sector. Other than that, the bill in itself cannot magically create nurses, as I keep saying. Although a lot of work is going on around that, such as increasing the number of student nursing places and introducing new models of care, the bill itself will not create more nurses.

Alison Christie: There is another unintended consequence. If a service cannot find the staff that the tools require it to have, what happens to that service? The risk is that it will have to close.

The Convener: Is there a risk that the Care Inspectorate might report that a particular provider is not delivering against the workforce levels that are set out in or deduced from the tool, although it could be doing a good job in every other respect? That service is at risk of attracting a negative inspection report, with potentially serious consequences.

Mark Hazelwood: That might be a risk. I can imagine a circumstance in which that happens despite the fact that the provider is delivering on outcomes that are important for its clients.

The Convener: The bill, having no outcomes focus, will potentially be in conflict with a provider's outcomes-focused practices or policies. Is that essentially the point?

Katherine Wainwright: Yes, that is the point.

Karen Hedge: We are in a positive position because of the recent changes to the Care Inspectorate's methodology, and it would be good to see where that takes us. That outcomes-focused approach is creating conditions for innovation and improvement, so to bring in what the bill proposes alongside that seems completely contradictory.

The Convener: Are you saying that this is the wrong time?

Karen Hedge: Maybe, yes. The bill is fixing things in statute and freezing them in time, as opposed to offering an opportunity for innovation and change.

The Convener: The bill's financial and policy memorandums say that it does not inevitably follow that tools will be devised for care homes, hospices and other settings that are not specifically identified in the bill. Do the witnesses feel that there is a logic to the bill that will drive the development of those tools? Is there a risk there? If we create the mechanism to devise tools, does it follow that tools will be devised?

Karen Hedge: We were already looking at developing some sort of tool under the national care home contract, but that will be used very much as a guide and a way of offering transparency in commissioning. It has to be flexible, opt-in and not burdensome. Legislation is not needed to make that happen, and could limit where we go with it.

The Convener: If legislation comes forward, would you want to see the tool that you are developing put in place, rather than something borrowed from the NHS?

Karen Hedge: It would need to be developed for the sector and co-produced by those of us who work in the sector.

Brian Whittle: Should or could the bill cover all care homes? It seems to me that we are talking about only the part of the sector that cares for the elderly but, as has already been indicated, there is much more to the sector than that. Can we develop tools that deliver to the sector?

Katherine Wainwright: We would need to look at having multiple tools; we would certainly need a range of options, not just one, and they would have to be quite flexible. I cannot see how one tool will be able to deal with the dynamic of the sector or the range of services that are being delivered.

Brian Whittle: Is there scope or room in the bill to set out the training that is required to deliver those tools on the ground? Surely that knowledge will have to be applied to—or cascaded down to—the care sector.

Katherine Wainwright: I do not see that provided for in the bill. Any training in a tool would have to be cascaded down through organisations. In any case, the tool would have to be applied correctly for it to work, and it would be quite dangerous if it were applied without training. Training would certainly be required, and we would need to ensure that all our services had capacity in that respect.

The Convener: Bob Doris has a final question.

Bob Doris: Given the evidence that we have heard, it is evident that, if the tool is to be brought in, there will have to be a huge amount of reassurance, a lot of co-production and flexibility to allow for justifiable variation on the ground. However, a really interesting issue raised in our

discussion has been the training of nurses and social care staff. If this—perhaps imperfect—tool comes in, should there be an automatic triggering of an annual review of nursing training places in the further and higher education sectors, based on the data that comes out? It is not enough to say, "Here's a diagnostic tool that indicates how you might deliver the workforce and the skills mix on the ground." Is the next step for the Scottish Government to use that data annually to tweak and develop nursing training places in FE and university provision? I know that there are issues with getting people to fill posts in the first place, but once we get them, do we then have to look at how we might have an impact on training?

Katherine Wainwright: Absolutely. If the tool comes in and it produces valuable data, we should definitely use that for national workforce planning as well as workforce planning on an individual, service and regional basis. We need to look at the whole picture.

However, I should point out that things do not move that quickly. For example, although we might see a need for nurses in the sector very quickly and although more nurses might be trained, the nurses who are used in our settings are usually quite experienced and do not usually come straight out of university. It is a very responsible job, with two nurses perhaps working together, or a nurse working solo. There will therefore be a timescale delay in that respect, and we need to think about those timescales as well as using any data that is produced.

The Convener: As members have no more questions, I thank our witnesses for what has been a very helpful evidence session. We have certainly gleaned some useful information from it.

We will briefly adjourn before resuming with our next panel.

10:58

Meeting suspended.

11:04

On resuming—

The Convener: We resume the meeting with our second panel of witnesses. I welcome to the committee John Wood, the chief officer for health and social care at COSLA; Stuart Bain, HR business partner for the Fife health and social care partnership, representing the Society of Personnel and Development Scotland; Dr Jane Kellock, head of social work strategy and development at Social Work Scotland; David Williams, chief officer of Glasgow city health and social care partnership; and Eddie Fraser, director of East Ayrshire health and social care partnership. Thank you for attending this morning. We have about an hour for this evidence session.

I start with a question that I asked the witnesses on the previous panel. How far do you believe that this bill is focused on outcomes for users of services?

John Wood (Convention of Scottish Local Authorities): As I hope is clear from our evidence, COSLA does not support the bill as it stands. One reason for that is that we see the bill as focusing on inputs rather than outcomes. Although the bill does not specify staffing numbers, it appears that the bill and the tools are heading in that direction.

Reflecting on the previous session, there is nothing in the bill or the supporting policy memorandum that demonstrates that outcomes are at the heart of the intention of the bill.

Stuart Bain (Society of Personnel and Development Scotland): To echo what John Wood has said, our concerns are around the qualitative rather than quantitative issues, particularly for the Care Inspectorate. Auditors, by their very nature, will audit whatever they are asked to audit. If that involves counting heads, that is what they will do. It is easier to count heads than to measure quality.

There is an imbalance between the objective of high-quality care services that we would like to see and the excessive focus on tools to measure capacity, which do not always capture the whole picture or the qualitative outputs that would be of interest.

Dr Jane Kellock (Social Work Scotland): I agree with the previous speakers and those at the earlier session today.

We are already in a primary legislative environment on integration in which partners are working towards more outcome-focused approaches and looking at innovation across the sectors. The social care sector is currently adequately regulated to allow for scrutiny over our processes and procedures. This bill does not lend itself to an outcome-based approach in the current integrated context.

David Williams (Glasgow City Health and Social Care Partnership): The Public Bodies (Joint Working) (Scotland) Act 2014 clearly sets out nine national health and wellbeing outcomes that integration authorities are expected to work towards achieving. It is significant that that legislation is explicitly about outcomes for individuals and communities. There is real potential that this bill will militate against the delivery of those outcomes, because, as colleagues have indicated, it is very process oriented.

Eddie Fraser (East Ayrshire Health and Social Care Partnership): In line with my colleagues, I echo that the policy direction has been about shifting choice and control to individuals, through more self-directed support and self-management. There is a concern that, if we go down the line of regulation, particularly around one profession, that will take away from the policy direction and innovation that we have been working towards.

The health and social care workforce plan that has already been agreed between the Scottish Government and COSLA gives a sound basis of responsibilities for what needs to be taken forward.

The Convener: There is a clear view in relation to outcomes. Is there any respect in which the bill as it stands could assist with workforce planning, at a local, service or national level? If not, are there other legislative provisions that might assist in addressing the workforce issues faced by the services that panel members represent?

David Williams: Through legislation, policy direction and infrastructure, a sufficient framework is in place for integration authorities and health and social care partnerships, which have lead responsibility for commissioning health and social care provision—not in acute hospital settings, but certainly in terms of community and some in-patient provision.

That infrastructure and framework is already in place and sufficient to enable the level of innovation that my colleague Mr Fraser alluded to. Integration of health and social care is intended to transform the planning, delivery, receipt and experience of health and social care services across Scotland. Any legislation, including this bill, should be about enabling the process rather than making it more challenging.

Eddie Fraser: There are a number of workforce tools out there, particularly the nursing workforce tool. It is interesting that the tool was developed by the nursing profession, rather than being the result of regulation. No one is saying that there should not be a clear focus on safe staffing in our sector, but the bill seems to focus on a particular profession. In this new integrated world, we work across the sector and outwith the services that we manage, into the third sector and people's choices about self-directed support. Workforce tools that have been developed by the nursing profession give clarity and assurance. At the same time, though, the issue is how that cuts across the sector. It goes back to the fact that the vehicle for that can be the health and social care workforce plan.

Dr Kellock: The Public Bodies (Joint Working) (Scotland) Act 2014 is still relatively new and it would be fair to say that the integration joint boards and health and social care partnerships are feeling their way in this context.

The focus should be very much on outcomes, self-direction and working in collaboration with service users to redesign services in an innovative way. The bill does not lend itself well to that agenda and is, at the very least, premature in relation to furthering the concept of integration.

As has been mentioned, there are some gaps. A lot of the focus is on NHS services, which could have the unintended consequence of skewing the focus on to the NHS, to the detriment of social care.

One of the gaps that Social Work Scotland has found in the bill is that it covers regulated social care services and not social work services in the wider context. The bill does not include public protection services that are on the ground, working in highly complex situations in communities across Scotland. Our real concern is that the resource implications of the bill will be focused primarily on health, secondly on social care, and not at all on social work.

Stuart Bain: I draw attention to the regulatory framework that local authorities in particular work under, with safeguarding addressed through the excellent protection of vulnerable groups legislation; the work that the SSSC does to ensure that workers are properly regulated and qualified, and receive the correct levels of continuing professional development; and the inspection regime under the Care Inspectorate, which in my experience tends to focus on qualitative issues. Those safeguards are there and should not be ignored.

John Wood: The question was whether the bill or other legislation gives us what we need with regard to workforce planning. Part of the answer should be to look towards the national workforce plan, which is co-owned by COSLA and the Scottish Government and is obviously a non-legislative piece of work.

If we are talking about strategic workforce planning, it is safe to say that legislation does not offer any clear benefits with regard to where recruitment and retention are under pressure in the labour market. Our attention might be better diverted to some of the softer approaches in the national workforce plan and the benefits that that could bring.

11:15

The Convener: David Stewart would like to follow up on Jane Kellock's response, particularly in regard to social work.

David Stewart: Social work was my first job, many years ago. I am particularly interested in the exclusion of non-regulated social work staff. Some of my questions have already been covered, but perhaps Dr Jane Kellock could address the issues around the Public Bodies (Joint Working) (Scotland) Act 2014, which she referred to. Is that exclusion not contrary to the 2014 act?

Dr Kellock: When we look at integration, we are looking at the potential to have non-regulated social work services. The staff are regulated in terms of the SSSC, but the service that they provide is not one of the services that the Care Inspectorate regulates. At the moment, local authorities and the NHS are looking across the board at where front-line statutory services can come together and work in a more integrated manner to improve outcomes for service users. As it stands, the bill separates out social care from health. There is no sense that there is any future proofing around what any new models of support might look like, either on the care side of the equation or in the front-line public protection part of the social work and health business. The bill does not reflect what the integration authorities' role is about.

David Stewart: You are saying that there is a bit of muddled architecture in terms of the legislative hold on what we are talking about.

Dr Kellock: Yes, and Social Work Scotland has taken a nuanced and pragmatic approach. We oppose the bill as it stands, but if it goes ahead, we would wish to see social work services included in it, not excluded.

David Stewart: Would other members of the panel like to contribute?

Eddie Fraser: In relation to social work services being included, we need to point out how complex an issue it is. Social workers work as part of a team around people—around a child, a family or an older person—so the context of regulating social work depends on the local context in which they are working. If local social workers do not have a multidisciplinary team around them, you need a lot more of them. If you have adequate teams around a child or a community, you might need less social work. That is where it becomes difficult. How do you regulate the local context? It is about how we look at the whole team and the local context—not just social work or nursing, but the totality. Some of that can be outwith our realm and might involve teachers and others responding in local communities.

David Stewart: Panel members are expressing concerns in different ways. There were some hints from Jane Kellock about how the legislation could be improved. Do the witnesses have suggestions about that? Obviously, the bill can be amended at future stages, so how might it be improved? Considering that is our job, as members of this committee.

The Convener: That is a very general question, so succinct answers from witnesses would be appreciated.

David Williams: I will have a go at that one. From my perspective, less is more—that is my response to the comments that Mr Fraser has just made about the bill.

The arrangements that often need to be put in place to protect children or vulnerable adults or in relation to multi-agency public protection arrangements—MAPPA—for individuals who present risk in communities are unique and complex, and it is therefore difficult to legislate for staffing arrangements around them. That is regardless of the sophistication or otherwise of workforce tools. If Parliament is minded to proceed with it, the bill needs to have at its heart flexibility, responsiveness and professional judgment, as opposed to something that could become a mechanistic tick-box response.

Stuart Bain: There should definitely be a focus on quality rather than quantity, and a recognition that local conditions are relevant to staffing decisions and should be reflected in everything. Finally, workers should be included, with regard to consultation on staffing arrangements and worker wellbeing, which is also important.

John Wood: We did not think that the bill should cover social care in the first place. Our board members were keen for me to express that to the committee.

I reiterate the point about professional responsibility not being reflected in the bill. If we are looking at improvements, that would be an area for attention. I am not sure what "local context" refers to when it is listed in the bill as something to consider. It would be important for the tool developed as a result of the bill to take into account the challenges in workforce supply. We have touched on that this morning and will do so again later. If the bill and the tool do not take into consideration that it is difficult to recruit people into roles, the first hurdle will be a real challenge.

Sandra White: I want to ask about staffing; I am concerned about what I have heard. Like others on the committee, I see that my constituency case load is about social work, care homes and bed blocking. We heard in evidence at the committee last week that the bill was nurse—or RCN—led. They wanted a tool to prevent bed blocking by showing that more nurses were needed. Has the bill gone far enough? It is a good idea if it works that way, but have social work and social care been involved enough in how it develops? It sounds great at the top—have this tool, and if you

are short you can have more nurses and reduce bed blocking—but has anything been done at the lower end, where people are getting care, in the community and care homes? Has your sector been involved enough?

John Wood: The fundamental point is that, before the bill was introduced to Parliament, and the policy was announced, we were not aware of any appetite for such legislation. We have had conversations with officials since the announcement of a safer staffing bill, but the appetite was not there beforehand to co-produce the bill. We have received good assurances that the tools will be co-produced with the Care Inspectorate and we will hold the Government to that, but the bill itself has not been co-produced.

David Williams: If we think back to the integration agenda and the beginnings of the bill, the perceived wisdom was that it was there to address the issues of bed blocking and delayed discharge. It is proving to be much more than that—I emphasise that point strongly.

Health and social care partnerships have been asked to give significant attention to delayed discharge. Across the country, they are responding differently to the issues and needs in their locality in how they expedite and improve the position in relation to delayed discharges. The innovation and creativity that come from the bill and the integration arrangements will facilitate that, and the picture has improved; there have been significant reductions in bed days lost in the acute hospital sector across the country as a consequence.

Sandra White asked whether, if we had more of X, Y and Z, we would be able to improve on our performance again. The answer is yes. That is particularly true in the community, where there are increasing levels of frailty and acuity of need among significant numbers of the population, who could be better supported to remain in their own homes. However, the bill will not necessarily assist with that, because that comes back to people's unique circumstances—their individual needs—and how the array of support around that individual can be better brought to bear to improve the outcomes for that individual.

Stuart Bain: I can offer some anecdotal experience from my health and social care partnership. The fact that we could be flexible has reduced delayed discharge. We were able to shift social workers from a community setting to working in hospitals to help with the identification of need. We were then able to change some of the focus in care homes, where we have enablement bed arrangements—people move into our care homes for a brief period to get back on their feet and able to care for themselves. Our focus with care at home has also changed and we have moved to an enablement model, with short-term intervention carers, to help people to go back to independent living and move out of hospital.

That flexibility has enabled us to be quite successful in the past 18 months in reducing the amount of delayed discharge. That is an illustration of what David Williams was talking about.

Eddie Fraser: I want to focus on two areas. First, we are very successful at getting people home appropriately, so delayed discharge is not a huge challenge for us; our challenge is the number of people attending hospital and being admitted to hospital. Our investment over the next couple of years will be in the community to prevent people from going into hospital in the first place. From the money for primary care and additional money for intermediate care, we will invest £10 million in rehabilitation over the next two years, to support people at home, rather than them having to attend hospital.

Secondly, we have talked about capacity in care homes to support people with complex needs and their discharge, but John Wood and I spoke at an event a few weeks ago about nurses in the care home sector and it is well known that there is a real challenge in recruiting and retaining nurses in care homes. It is such a problem that at times the Care Inspectorate has had to go in and do bespoke work with care homes, to work out what nurses have to do and what senior social care workers can contribute.

Given that such flexibility is required in relation to issues such as staffing in care homes, we need to be very careful that the legislation does not cut across that. We need to ensure that care homes can continue to operate effectively.

11:30

Sandra White: I am interested in what you said about how difficult it is for care homes to get nurses. The previous panel said that most nurses who work in care homes are 40, 45 or 50 and over and are very experienced. Is that right? The RCN and others told the committee that there is a move to get nurses through university and bring them into the sector. How will that affect the sector? Is it more difficult to recruit older, more experienced nurses?

Eddie Fraser: Yes, it tends to be more difficult. Our community-roster staff and staff in care homes often work unsupervised—indeed, they are often on their own. They need a whole level of experience if they are to be able to do that. Our senior nurses in care homes are also often the managers of the care homes. Many of them come up through the hospital system and then come

across to the sector; they have grown in the protected environment of the hospital.

Our partnership is about to take on nine graduate nurses and we will work with them, in partnership with general practitioner practice nurses and community nurses, to develop a younger cohort of nurses—by "younger" I mean newly qualified. You are right about the age profile of not just our care home nurses but our community nursing staff.

Bob Doris: The take-home message from the previous panel, which was made up of social care providers, was that if a tool is brought in it will need to allow for flexibility and professional judgment, and the message that I have heard from David Williams and Eddie Fraser is that a tool must not be a barrier to innovation, reform and restructuring—Eddie Fraser was just talking about that kind of activity.

When my constituents think about safe staffing levels, they probably think about hospital wards and care homes for the frail elderly, so they are thinking about patients with multimorbidities, Alzheimer's and so on, but there is a bigger picture, which Dr Kellock clearly described.

I did not put this question to Scottish Care, but I will put it to Mr Wood, Mr Williams or Mr Fraser. If I were to ask Scottish Care whether it is content that the national care home contract suitably remunerates care homes in the third sector, on an equitable basis in relation to the care homes that local authorities run, in the context of safe staffing levels and all the outcomes that we want, would it say that it was happy?

The Convener: I am not sure that we should ask other people to speak on behalf of Scottish Care; its representative has just left us. There is a more general question to be asked about—

Bob Doris: Well, let me ask it in another way. I know, from local care home providers and other care home providers who have contacted me over the years, that providers have issues with the national care home contract. They do not believe that it is necessarily equitable for third sector providers—that is what they have said—and they believe that preferential treatment is given to local authority care homes. How do I know whether that is accurate? I do not.

We know that negotiation goes on between COSLA, the Scottish Government and Scottish Care. That brings us back to the proposed workforce tool. How do we get transparency into a system without some form of diagnostic tool that can take into account the workforce, the skills mix and the workload? I get that it must also take into account the individual circumstances in each care home, but in a way such a tool means that I, as a politician, can say, "Yes, there is transparency; I can see that we are financially remunerating third sector care homes properly." How can we do that without having a robust, agreed, statutory tool?

The Convener: Does anyone want to respond, in the context of the bill that is before us?

John Wood: We are live to the interplay between the bill and the national care home contract, as my colleagues at Scottish Care would say that they are. Questions about the rate that the national care home contract produces might be for another day, but it is safe to say that we are working closely with Scottish Care to reform the contract and to arrive at a rate for next year and onwards that is evidence based and sustainable. We think that we got a settlement along those lines for this year and that that will be the case from next year, too.

On how we get transparency on staffing levels and the funding that follows from that, while the rates within the national care home contract are a specific issue, there has been a conversation about developing a capacity or capability tool as part of reform of the contract. However, that has happened in isolation from the bill. I do not think that that necessarily needs to change, but it is important that when, further down the line, the Care Inspectorate works with partners across the sector to develop tools, that work is informed by the care home sector and perhaps the national care home contract. The two need to be aware of each other.

David Williams: I just want to reiterate my earlier comment that the legislative and regulatory framework for the provision of care in care home environments, particularly in this instance, is already in place through the Care Inspectorate and the standards for care that the Parliament sets. That framework applies in exactly the same way to the private care home sector, the voluntary care home sector and the local authority-provided care home sector. There is no difference in that respect.

The Convener: Will the bill make any difference to how commissioners—for example, local authorities and integration authorities—commission care and services from the different sectors?

Eddie Fraser: As has been pointed out in a number of submissions, if we go down the route of regulating through legislation certain parts of our nursing workforce—say, those in adult care homes—but not others, that might skew commissioning. We would have to commission for those areas, and there might be other areas of our business that were not regulated and which we could not commission for. That would be a real risk for us, because among those areas might be some that I mentioned earlier that deal with the

prevention agenda and help to stop people needing certain services. Complex issues arise from looking at only one part of the issue.

On pay, John Wood made an important point about the national care home contract, but it is also important that we continue to reflect the recent good work on the Scottish living wage and ensure that we can recruit and retain people in social care jobs, particularly in care homes, and can provide continuity of care for tenants. That has been a real challenge for us. The change that we have seen in that respect has, I think, been positive.

David Williams: A number of the submissions express a lot of concern about the financial viability of provision if the legislation goes ahead with insufficient funding from either the commissioning bodies or central Government. It strikes me that, if we in integration authorities are to be tasked with commissioning innovation and services that are changed and transformed, we would rather do that by design—as a result of something that has been well thought out and well planned—than as a consequence of business failure.

Brian Whittle: I note that in the evidence that we have taken from panels on this bill, the terms "innovation" and "flexibility" are continually being brought to the table—it certainly did not take long for those words to arrive in this discussion. Given the recognition of national workforce pressures and the need to rely on a degree of flexibility and innovation, I have to wonder where the bill sits with regard to continuing to deliver all of that.

I also want to ask specifically about the third sector. SCVO has stated that 40,500 people in the third sector work in social care with a huge variety of organisations of different sizes. Does the bill take that, and the possible ramifications of that, into account?

I realise that I have just asked you a lot of questions.

Dr Kellock: It is difficult to see how the bill could take account of all the different types of service provision across the third sector and the public sector in any meaningful way that is not already covered by existing legislation.

Eddie Fraser: Because the majority of our third sector operations are out there in the community, I would say that, at the moment, the bill does not encompass a lot of the work that we commission from the third sector. I recognise that there are some third sector organisations that are still in the care home business, but the vast majority of them operate in the community—they work with people in their own homes—so I think that the bill will have a limited impact on the third sector.

Brian Whittle: Does the bill have the potential to reduce the need for agency staff? That is a key issue. Does the financial memorandum take into account the potential requirement for extra staffing to comply with the bill?

The Convener: Two questions have been asked: the first is whether the bill will increase or reduce the need for agency staff, and the second is about its wider financial implications.

Stuart Bain: At the moment, we already try very hard not to use agency staff. That is driven by the fact that it costs us more to use agency staff rather than by better workforce planning. We do not use agency staff unless we absolutely have to.

The use of agency staff is driven by two things: local market conditions and the kind of work that we are able to offer. The issue of local market conditions has been talked about all morning, so I do not need to go back into that. As far as the work that we can offer is concerned, if we are seeking someone for a couple of shifts or to cover a single night shift, it does not amount to a job for someone. Although we have a pool of casual workers whom we can call on, it is quite an insecure form of work and does not suit many people. People might prefer to register with an agency, because they know that that will enable them to pick up work from a variety of providers, which then means that they are not available for permanent employment by us or anyone else.

That is an inevitable consequence of the way in which care is configured. Care is not delivered in nice, 9-to-5 packages that suit everybody; it depends on the needs of the service user. We have to deliver care at different times, and that does not necessarily suit people's working patterns. That is what drives the use of agency workers, rather than an inability to plan for the workload per se. As an HR professional, I am very keen on workforce planning and think that it is a good thing to do, but it is not what drives the use of agency staff.

Using casual workers has a bad name when it comes to employment practice and using agency workers has a bad name when it comes to expense, but we use such workers not because we have not thought about it; we use them because the need drives it.

John Wood: In response to the first question, I reiterate Stuart Bain's point that, in and of itself, the use of agency staff is not necessarily a bad thing. As for whether the bill will reduce our dependency on agency staff, we do not know. I do not know whether evidence has been presented to suggest that it will have an impact on the use of agency staff. I am not shrugging off the question; I simply think that we need to look seriously at whether the bill will add value in that regard. From

what we can see, there is no evidence to suggest that it will help to reduce our dependency—if it is a dependency—on agency staff.

On the second question, we are concerned about the financial implications. The previous cabinet secretary made a welcome commitment that the Scottish Government would meet any additional financial burdens. Our concern is that we do not know what those additional burdens will be, but we know that they will relate not simply to the fact that the statutory tool might result in a need for more staff.

The need to train service managers and workforce planners in the use of the tools will create a resource demand, which could be significant given the number of providers that are involved; and once people are trained in the use of the tools, maintaining that strategic capacity will be another resource demand on commissioners.

11:45

The Convener: Does David Williams wish to contribute?

David Williams: I would only repeat what the previous speakers have said.

Keith Brown: It is pretty clear from COSLA's submission and from what has been said today that COSLA opposes the bill and cannot identify benefits that will arise from it. Social Work Scotland's responses today suggest that its position is similar, but its submission suggested areas for amendment. Does Social Work Scotland think that the bill can be improved or that it is not worth doing that?

Dr Kellock: The first point of our position is similar to COSLA's, as we do not support primary legislation for the proposed purpose. As we have said, sufficient legislation is in place through secondary legislation, and there are the new standards and workforce planning guidance, all of which support safe and effective staffing. That is Social Work Scotland's main position. However, it is fair to say that we will take a pragmatic approach if the bill is passed.

The main concern that our submission raises is that the exclusion of social work services from the bill could result in the unintended consequence of inequity in resource allocation. Focus and activity could be diverted to numbers for staffing up, and to pursuit of tools that might or might not be effective in the context that we are discussing, which includes community contexts, rather than focus and activity being on the requirement to develop approaches that meet the requirements of the existing legislation on integration and SDS. The bill crosses over the main purpose of the existing legislation, which lends itself well to our pursuing a more outcomes-focused approach and perhaps moving more towards a community social work approach, along with our partners in the public and independent sectors.

The Convener: In short, you would rather not have the bill, but if the bill were to be passed, you would prefer the approach to be even handed.

Dr Kellock: Indeed.

Miles Briggs: I am interested in the unintended consequences that your submissions describe, which we have touched on. East Ayrshire health and social care partnership's submission makes the point that implementation of the bill could drive

"savings in ... areas to move to areas which are covered by the Bill."

Will you expand on that? Glasgow city health and social care partnership's submission raised the concern that

"the legislation will add another process and pressure on the system".

Will you expand on how those unintended consequences will affect your areas?

Eddie Fraser: I touched on the specific point earlier. If one part of our workforce—nursing—is regulated, we will require to invest to address that, which could skew what we do to work as a team with our allied health professionals and social care staff, and it could affect the amount that we invest in the third sector for our community connector link workers. If one part of the business is regulated and we are required to invest in that, we invest in it; we do not see alternatives.

When we recently recruited for our intermediate care and rehabilitation service, we were flexible, because a range of professionals can support people, as long as they work as part of a team. That involved considering the available workforce to make an impact now, and thinking about the balance between nurses, physios, occupational therapists and some of the senior social care workers, whom we are bringing together. Our concern is that, if one part is regulated, we will be required to do that, which will reduce flexibility in the rest of the multidisciplinary team. That is the specific point that we were trying to make.

David Williams: Another point is that the emphasis in the bill is substantially on the high-cost and intensive provision, which in essence means hospital and residential care. As Eddie Fraser has just highlighted, if the investment needs to be in those areas, that is counterproductive and counterintuitive, given the expected general direction of travel for integration authorities, which is to shift the balance of care and to support more people in the community. Perversely, we will end up taking money and resources from more upstream provision in the

community in order to continue to sustain high-cost intensive and institutionalised forms of care.

On the point about other processes and pressures, our experience is that if we are required to do something, we inevitably need to be able to demonstrate that we are delivering it, which requires that processes and procedures be put in place. Resources will probably be required to count our delivery of the required levels of staffing, both in directly provided provision in the council side of the business in health and social care, and in the commissioned and procured services for which we are responsible. That is a bureaucratic burden that we could do without.

Miles Briggs: From what you have said, it seems that you believe that the bill could destabilise or go against the spirit of what we are trying to achieve on health and social care integration—on which we have built consensus—two years into that process.

David Williams: In short, the answer is yes. As colleagues have intimated, for a range of reasons, there is potential to stifle innovation and creativity. There is a requirement and expectation that integration authorities will deliver on transformation, but that cannot happen if there is a top-down stipulation that we must do X, Y and Z to deliver something that is required by legislation. As I said, resource allocation might be focused in a way that is counterproductive to the general direction of travel.

Dr Kellock: We agree with that position; Social Work Scotland shares those concerns.

The Convener: David Williams mentioned the potential to inhibit innovation and flexibility. Do other witnesses wish to comment on the risk of stifling innovation?

Eddie Fraser: I will speak about innovation in the care home sector. We are doing joint work with the Care Inspectorate on physical activity, which is resulting in more integration of care home residents in their communities. Staff and volunteers go out with residents in the communities. One of my concerns about the bill is that it could stifle that. Will the need to look at the number of carers who are in the building prevent us from doing some of that?

In the care home sector, we are becoming much more innovative and thoughtful around self-directed support. It is not as though people just go into a care home and live out their lives there—they have an active life in the home and integrate more into communities. It is not that we do not think that there should be safe staffing in every element of health and social care; it is about the manager on the day being able to have control and say that it is fine for one member of staff to go down the street with somebody because the rest of the care home is stable at that point. That is the type of innovation that is going on in the sector, and we need to be careful that legislation does not cut across that.

Dr Kellock: I absolutely agree with that. The Public Bodies (Joint Working) (Scotland) Act 2014 and the Social Care (Self-directed Support) (Scotland) Act 2013 are both about long-term and fundamental change in what we do in the sector, and the approach for which they provide needs time to bed in. We are still in the early days of understanding what those acts mean for us, particularly given the complex conditions at the moment—people have talked about demographics, the implications of Brexit, workforce availability and so on. The bill is premature, in the context of legislation that is already in place.

David Torrance: Budgets are under constant pressure. Are the anticipated costs of the bill to public bodies, the third sector and businesses realistic? I am thinking in particular about the costs of tool development and staff training.

Stuart Bain: There is an opportunity cost to any activity that we undertake. If care home managers are using a tool, they are not doing something else. Equally, if we ask our admin or HR people to do something, the task will take time from something else that they might be doing, be that working on safeguarding, better recruitment or whatever. Members should not underestimate the size of the task: when something takes a couple of weeks out of even just one person's working year, that means that something else is not being done.

The Convener: If no one else wants to come in on the costings, I will ask a final question.

Is risk a different concept in the context of care than it is in health? Is that a challenge, and does the bill do anything to support appropriate judgment and the taking on of risk?

Dr Kellock: Risk is certainly a different concept when we are talking about care. We are talking about different settings: the approach in a ward setting in the NHS is very different from the approach in the community, where people live out their lives. People in the community have to be able to take on some level of risk, in a managed way. As the bill is drafted, it does nothing to reassure me that we will be able meaningfully to take account of that.

Eddie Fraser: When we talk about risk in relation to social care, the phrase that comes to mind immediately is "risk enablement". How do we support people to live out their lives and do the things that they want to do? Sometimes that involves risk. That might mean that a person in a care home is encouraged to walk across the room to get their newspaper, rather than have it handed

to them. It might mean enabling someone with dementia to live longer in their own home, where there might be risks, rather than move to a care home. Moving to hospital or a care home is not risk neutral, of course. The question is how we enable people to take on the level of risk that they are capable of taking on. In the context of what we in social care are charged to do, it is about risk enablement.

The Convener: Will the bill impact on that in any way?

Eddie Fraser: It will do so only in that the proposed approach to what we do is more rigid.

David Williams: We need to be careful that the bill will not create the false expectation that we are removing risk, as a consequence of—potentially—putting more staff in place. Eddie Fraser gave the example of the elderly person who is encouraged to cross a room to pick up a newspaper. Such enablement needs to be encouraged and supported. However, the care home could have any number of staff and the person might still fall. It is about how we allow people to live their lives. We need to be careful not to try to do away with risk by legislating.

The Convener: We have a final supplementary from David Stewart.

David Stewart: This will be just a minor and, arguably, simplistic point. Does any panel member draw an inference from the fact that the bill title was originally paraphrased as the 'safe staffing bill'? I see that the word 'safe' has now been removed. I am not sure whether Government lawyers have had a role in that. Do panel members think that there are any implications from the change of name?

12:00

Eddie Fraser: That reflects what David Williams was saying, to be perfectly honest.

David Williams: I appreciate the change of name, but I guess that the perspective that is still out there is that it is—and will be—considered the "safe staffing legislation". An element of that is already in play, regardless of what the final title might be.

The Convener: Our final, final question is from Bob Doris.

Bob Doris: In the last session, we were asked about the IoRN tool for working out what staffing would look like, and some concerns were expressed about it. I take fully on board the points that all the witnesses made about their significant concerns on aspects of the bill. However, there was a feeling that the IoRN tool has some deficiencies. Is there a need for a new diagnostic tool and for partnership with care providers and others anyway, irrespective of the bill?

Stuart Bain: I will make a simple anecdotal point. In preparation for the meeting, I spoke to our manager who looks after care homes in Fife about how they assess staffing levels. She highlighted that they use IoRN and a Fife Council tool called the CPAT—carer patient assessment tool. The tools are good at assessing physical need and addressing staffing levels in relation to that. However, they are not so good at assessing need in relation to cognitive behaviour. As we are seeing increasingly frail residents coming into our care homes, that is more and more important. The tool does not capture everything that we need to be concerned about.

The Convener: The last word goes to John Wood.

John Wood: I do not have a professional view on the IoRN tool, with which I am not familiar. However, conversations between officials are going on to look at how either IoRN could be improved or something else might be developed. I do not think that that is imminent: it will be months or years down the line.

The Convener: I thank all our witnesses for another very helpful session. We will adjourn briefly and resume in a few minutes, when we will hear from the cabinet secretary.

12:02

Meeting suspended.

12:08

On resuming—

Subordinate Legislation

Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2018 [Draft]

The Convener: The next item on our agenda is consideration of an affirmative instrument. As is usual with such instruments, we will first take evidence from the cabinet secretary and her officials. Once we have had all our questions answered, we will move to a formal debate on the motion. The instrument that we are considering is the Public Appointments and Public Bodies etc (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2018 in draft.

I welcome the Cabinet Secretary for Health and Sport, Jeane Freeman, and her officials to the committee for the first time since her appointment. I congratulate the cabinet secretary on her appointment and look forward to hearing from her. I put on record the committee's thanks to her predecessor, Shona Robison, for her active engagement with the committee over time. With the cabinet secretary are Michelle Campbell from the health workforce, leadership and service transformation directorate, and Kirsten Simonnet-Lefevre from the directorate for legal services, both from the Scottish Government.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener, for your kind wishes. I express my pleasure at being before the committee for the first time. I am sure that we will meet again on many other occasions. I look forward to those exchanges and to our continued good work together, building on the work of my predecessor.

I thank the committee for the opportunity to speak briefly to it about the amending order, which seeks to remove both the Scottish Advisory Committee on Distinction Awards and NHS Health Scotland from the remit of the Commissioner for Ethical Standards in Public Life in Scotland. The draft affirmative order applies to those two distinct public bodies.

I am sure that members know that SACDA acts on behalf of the Scottish ministers with regard to granting and reviewing distinction awards for NHS consultants. In 2010, in accordance with the Scottish public sector pay policy, we froze the allocation of new distinction awards. As a result, SACDA's duties have been limited to an annual review of current award holders, which has made membership of the committee less attractive to potential new members. In addition, the pool of potential peer reviewers at the top, A+ level has reduced, primarily due to retirement. Those issues, coupled with the fact that other members have completed the maximum term of office, including extensions, have meant that SACDA has reduced its current membership from 14 members to five. By removing SACDA from the commissioner's remit, we expect that a simplified recruitment process can be put in place to establish a board of seven to 10 members.

NHS Health Scotland is a special NHS board that was set up to improve public health and reduce inequalities. It will cease to exist as an NHS board on the vesting of public health Scotland, which will be achieved by 1 December 2019. Currently, NHS Health Scotland has a small board of nine non-executive directors. It would be very difficult and not necessarily appropriate or proportionate to appoint new members to replace board members whose terms will complete before the end of 2019. By removing NHS Health Scotland from the commissioner's remit, we will be able to retain appropriate membership and better manage the organisation's transition over the next 12 months or so of its existence.

It is important to emphasise that both SACDA and NHS Health Scotland will still operate within the commissioner's principles and ethics and that the step is being taken only to deal with short-term issues relating to recruiting committee members and retaining board members prior to a review of the distinction awards and the abolition of NHS Health Scotland.

I am, of course, happy to take questions.

David Stewart: I, too, welcome the cabinet secretary to her new post and to the committee.

I totally understand the practical reasons why the cabinet secretary is approaching the issue and will make some general points.

The cabinet secretary will be well aware that the office of the Commissioner for Ethical Standards in Public Life in Scotland is a parliamentary body. It is independent in its day-to-day activities, but is responsible to the Scottish Parliamentary Corporate Body, which I was a member of, and of which Sandra White is the current member for pay and conditions. I therefore have some experience from the other side.

In general, it is important that we look at increasing rather than reducing the range of ethical standards. I totally understand that some practical issues are involved, but I want to clarify something. One of the bodies will conclude in a year's time, and I understand that public health Scotland will take over the new role. Do you intend public health Scotland to come under the remit of

the Commissioner for Ethical Standards in Public Life in Scotland?

Jeane Freeman: Yes.

David Stewart: That is very important, and I support that.

I appreciate that the Government has frozen the distinction awards since 2010. The cabinet secretary will know that there was some controversy about the awards in the past, when they were better known as merit awards. I, for one, thank our hard-working consultants and celebrate their work, and I understand that giving financial awards is one way of doing that. Under subsequent Governments, there has been a lot of controversy about merit awards; it was thought that they were not transparent and open. I am raising concerns because, in general, I would not support removing bodies from the remit of the Commissioner for Ethical Standards in Public Life in Scotland. Indeed, I would say the reverse; I would look to ensure that there is transparency for every public body.

I understand why the cabinet secretary is going for the approach and that Parliament will have an opportunity to have its say. However, it is very important that parliamentary commissioners are parliamentary and have a strong independent role and I would be concerned if the Government were to seek to remove any other bodies from the remit of the Commissioner for Ethical Standards in Public Life in Scotland in the future.

Jeane Freeman: I completely appreciate, and agree with, the points that Mr Stewart has made. As he has said, the move is entirely practical.

Because we have frozen the allocation of new distinction awards, SACDA's current role is to review existing awards. To do that, it needs A+ reviewers and we have experienced some difficulty in recruiting them. We have indicated that we will review the position on distinction awards in the future. We have begun discussions with the British Medical Association to review some of the controversial matters that surrounded the previous system and to see whether a future system could be devised that would give the recognition that David Stewart would welcome and which would be fair across the whole of our health workforce. As we do that work, we will, of course, keep the committee updated on its progress. Should there be a future system for the application of distinction awards, and not just a review of them, we would obviously want to look at SACDA's role at that point and we would expect that to be part of the commissioner's remit.

12:15

The Convener: I remind members that this part of the meeting is for questions and answers. There will be an opportunity to make points once the motion has been moved. Are there any further questions?

David Stewart: I have a second point, although I appreciate that this question will be difficult for the cabinet secretary to answer. If the Scottish Advisory Committee on Distinction Awards comes out of the standards commissioner's remit, as we assume it will, and there is a future breach on a matter that would normally be dealt with by the commissioner, who would deal with it?

Jeane Freeman: We would expect the body to continue to work in line with the commissioner's standards. If there was a breach, we would take the opportunity, if we thought that it was correct, to refer the matter to the commissioner for his view.

The Convener: Thank you. Keith Brown has a question.

Keith Brown: I am sure that the question will reveal the extent of my ignorance of this area, as I have not been involved in it previously. I will ask it, nonetheless, and I am sure that I will be schooled in the area.

In considering this proposition, with regard to SACDA in particular, has the idea of not having the body been considered? Will that be one of the considerations as the matter goes forward? If SACDA exists just to review the awards and no new awards have been made, is there another way in which the matter could be undertaken—is that part of the thinking?

Jeane Freeman: The early work that has begun includes initial discussions with the BMA about the prospect of an award system that could meet the intention behind the distinction award system in a way that would be fairer across the whole health workforce, more transparent and more evidence based. It is very early days. With a previous consultation on this, nothing happened as a consequence because no consensus could be achieved. Should we achieve consensus this time round and reach a satisfactory conclusion, a body would be needed to undertake work that would be comparable to that done by SACDA—that body may be SACDA, or there may be a revised role. The committee would, of course, be involved in all that and its views and approval would be sought.

That is the position for the future. At the minute, the role is simply to continue a review process of those who currently have awards. Although I am not clear—being almost equally as new as Mr Brown—whether SACDA could be disbanded, my instinct is to ask why we should cause additional fuss if we do not need to. We could let the body

continue to do the job that it is there to do, but we have an opportunity with this practical step to increase the number of members it has to take forward its work.

Bob Doris: Good afternoon, cabinet secretary. SACDA's remit is now simply to review distinction awards. What power does that remit entail? Does it review and report to you, or does it review and recommend? What is the process for the review?

Jeane Freeman: SACDA reviews and reports to me. My colleague Ms Campbell might have a much better understanding of this, but my understanding is that once you have a distinction award, you have a distinction award.

Miles Briggs: The awards have been frozen for some time now. What assessment has been made of the impact of that on attracting people into the health service? As we know, we are trying to attract people to come and work here from a global pool, and we know the current shortages that we have in many specialties. Has that been included in some of this work, especially in the work that is being done with the BMA? Is there a timetable for that review?

Jeane Freeman: You asked whether there has been an impact, and the fact that we have increased the number of consultant positions and are filling those posts does not indicate any such impact to me. The BMA might have a view on the matter, and I am sure that it will bring that to the discussion. It is still early days with regard to those discussions, and we do not, at this point, have a timetable for their conclusion.

The Convener: The policy note mentions that SACDA had three concerns: the committee should continue to be composed of medical and lay members; new appointments should be submitted for approval by the chair and medical director; and processes should be transparent. Can you confirm that reassurance on those points has been provided and that the Commissioner for Ethical Standards in Public Life in Scotland was also consulted?

Jeane Freeman: Yes. I believe that the commissioner was consulted in September last year, and he expressed his contentment. He was also consulted with regard to NHS Health Scotland, and he was content in that respect, too.

The Convener: Thank you.

As members have no further questions, we move to agenda item 4, which is the formal debate on the instrument on which we have taken evidence. I remind members that this is no longer a question-and-answer session, so they must put no more questions to the cabinet secretary. Officials may not speak at this stage.

I invite the cabinet secretary to move motion S5M-12935.

Motion moved,

That the Health and Sport Committee recommends that the Public Appointments and Public Bodies etc. (Scotland) Act 2003 (Amendment of Specified Authorities) Order 2018 [draft] be approved.—[*Jeane Freeman*]

Motion agreed to.

The Convener: I thank the cabinet secretary and officials for attending. We will now move into private session for the conclusion of the meeting.

12:22

Meeting continued in private until 12:37.

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