OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 23 February 2021

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 23 February 2021

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HEALTH AND SPORT COMMITTEE

7th Meeting 2021, Session 5

CONVENER

*Lewis Macdonald (North East Scotland) (Lab)

DEPUTY CONVENER

*Emma Harper (South Scotland) (SNP)

COMMITTEE MEMBERS

George Adam (Paisley) (SNP)
*Donald Cameron (Highlands and Islands) (Con)
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 PARTICIPATED:

Viv Dickenson (CrossReach)
Bob Doris (Glasgow Maryhill and Springburn) (SNP) (Committee Substitute)
Susan Dumbleton
Eddie Fraser (East Ayrshire Council)
Jeane Freeman (The Cabinet Secretary for Health and Sport)
Mairi Gougeon (Minister for Public Health, Sport and Wellbeing)
Annie Gunner Logan (Coalition of Care and Support Providers in Scotland)
Cassie Hersee (Isle View Nursing Home)
Joanne Pierce (Scottish Government)
Dr Ann Wilson

CLERK TO THE COMMITTEE

David Cullum

LOCATION

Virtual Meeting

Scottish Parliament

Health and Sport Committee

Tuesday 23 February 2021

[The Convener opened the meeting at 09:45]

Subordinate Legislation

Carers (Scotland) Act 2016 (Adult Carers and Young Carers of Terminally Ill Persons: Timescales for Adult Carer Support Plans and Young Carer Statements etc) Regulations 2021 [Draft]

The Convener (Lewis Macdonald): Good morning and welcome to the Health and Sport Committee's seventh meeting in 2021. We have received apologies from George Adam and Alex Cole-Hamilton, and I welcome Bob Doris as a substitute for George Adam. I ask all members and witnesses to ensure that their mobile phones are in silent mode and that all notifications are turned off.

Agenda item 1 is consideration of a draft affirmative instrument. It is for the committee to consider the instrument and report to Parliament accordingly, and we will have an evidence session with the Minister for Public Health, Sport and Wellbeing and her officials. Once we have asked our questions, we will have a formal debate on the motion.

I welcome to the committee Mairi Gougeon, Minister for Public Health, Sport and Wellbeing, who is accompanied from the Scottish Government by her officials: John Paterson, solicitor and deputy director, legal directorate; Lindsey Henderson, head of carers policy; and Joanne Pierce, carers policy officer. Thank you for joining us. I invite the minister to make a brief opening statement.

The Minister for Public Health, Sport and Wellbeing (Mairi Gougeon): Thank you for the opportunity to speak about the regulations. I acknowledge that we would all like Parliament to have considered the regulations before today, when it is almost three years after the Carers (Scotland) Act 2016 came into effect.

Everyone agrees that, because of the extreme pressure and urgency of their situation, unpaid carers of terminally ill people should be prioritised, but it has been hard to achieve consensus on appropriate timescales. Finding a workable approach that ensures that urgent issues are identified and addressed quickly for those vulnerable carers has led us to a detailed set of regulations. The regulations will give carers two new key rights, if they decide that they want an adult carer support plan or a young carer statement.

First, such carers will have the right to a substantive conversation, within five working days, to look at their caring situation and identify immediate or urgent issues and needs for support. Having that early conversation with someone who understands what a carer is going through and knows what support is available can be a help in itself.

Secondly, such carers will have the right to an adult carer support plan or young carer statement within 10 working days of requesting one or accepting an offer to prepare one. If that is a light-touch plan that focuses on the most pressing issues and needs for support, the local authority needs to agree with the carer when it will address outstanding issues in a follow-up plan or statement. When it is appropriate, there is nothing to stop authorities working more quickly, and the carer always has the right to do things at a slower pace, if they prefer to do so.

It is worth highlighting that the regulations will come into force on 31 July; by that time, we expect the current exceptional pressure on authorities and local carer services to have eased. Those organisations have always stressed that they prioritise carers of terminally ill people, and we set that date to allow them to adapt their procedures once they are under less pressure. I am happy to take questions from the committee.

The Convener: I invite colleagues who have questions to type R in the chat box.

The issue of identifying carers and people who are terminally ill has been raised by organisations that, with the Government, have been involved in working towards producing the regulations. Putting timescales in place for people who are identified as carers is a positive step, but the regulations do not directly address how we identify people as carers. Will you comment on that?

Mairi Gougeon: You are absolutely right—it is key that we recognise carers and identify them as quickly as possible, so that what we set out in the regulations kicks in as soon as possible. That is the purpose of the regulations. The last thing that we want is any delay in supporting carers of terminally ill people. Those carers can be identified through their general practitioners or their health authorities, so that the process kicks in as quickly as possible. That is a vital element of the process. I do not know whether any officials have anything to add.

Joanne Pierce (Scottish Government): You asked about the identification of carers, convener. We ran a marketing campaign for six weeks before Christmas because identifying all carers—not only carers who look after someone with a terminal illness—is an issue. The marketing campaign was about helping people to identify as carers in general and about understanding that they are carers. That works across the board with all carers.

Emma Harper (South Scotland) (SNP): I welcome the regulations—a lot of work has gone on to produce them. I note that Age Scotland raises the concern that carers who have reached crisis point might find it difficult to retain information. It suggests that there is a

> “need for support which is accompanied with simplified written information which records the agreed outcomes.”

Will the minister confirm that that will be required of local authorities, for example? How will people be supported to have written information available?

Mairi Gougeon: I thank the member for that point. That is why what we have set out in the regulations about establishing the light-touch plan within the first 10 working days after contact with a carer is so important, because that should highlight and identify any immediate and urgent needs that the carer has, as well as identifying a future date when they can revise the plan and see whether further information is needed as a result. That will very much be part of the process.

I completely understand the concern that Age Scotland expresses—there is a lot of information to take in at what can be a traumatic time in somebody’s life, so we want to make sure that the information is well understood and that, ultimately, carers get the care and support that they need.

Emma Harper: Age Scotland is key in helping to support, deliver and disseminate changes to the regulations. Will the Government continue to make sure that organisations that support older people have the information that they need to support their members?

Mairi Gougeon: We have had close engagement with a number of third sector organisations throughout the work on preparing the regulations. That work will certainly continue as we progress.

The Convener: I see no other members who wish to ask questions. We move to the formal debate on the affirmative instrument on which we have just taken evidence. I invite the minister to move motion S5M-24035 and then members can contribute to the debate if they wish.

Motion moved,

That the Health and Sport Committee recommends that the Carers (Scotland) Act 2016 (Adult Carers and Young Carers of Terminally Ill Persons: Timescales for Adult Carer Support Plans and Young Carer Statements etc.) Regulations 2021 [draft] be approved.—[*Mairi Gougeon*]

The Convener: No members wish to contribute to the debate.

Motion agreed to.

The Convener: That concludes consideration of the instrument, and we will report to Parliament accordingly.

Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2021 [Draft]

The Convener: We move to consideration of another draft affirmative instrument. The Minister for Public Health, Sport and Wellbeing is with us to address members’ questions, and she is supported by officials from the social care policy and delivery division: Marianne Barker, the unit head, and Ian Golightly, policy officer. I invite the minister to make a brief opening statement.

Mairi Gougeon: Thank you for the opportunity to speak to the committee. The draft regulations make annual increases to the rates for free personal and nursing care payments, which help to cover the cost of those services for self-funding adults in residential care.

In recent years, the payments have increased in line with inflation. Had we done the same this year, we would have uplifted the figures by 1.94 per cent. However, emerging evidence, including that from the Scottish care home census, shows that the cost of providing care has increased significantly. To help to address that, the instrument makes a 7.5 per cent increase to the weekly payment rates for the year 2021-22, which is a significant increase on the inflationary rate that was used previously. That means that the weekly payment rate for personal care for self-funders will rise from £180 to £193.50, and the nursing care component will rise from £81 to £87.10.

It is estimated that the increases will cost about £10.1 million in the next financial year. That will be fully funded by additional provision in the local government settlement, as outlined in the recent 2021-22 Scottish budget.

The most recent official statistics show that more than 10,000 self-funders receive free personal and nursing care payments, and they should all benefit from the changes. I am happy to take the committee’s questions.

The Convener: I ask members who have questions to put an R in the chat box.

I ask you to elaborate on your point about the different percentage increase this year. The pandemic has had an impact on the care sector in general and on care homes in particular. Is the additional increase designed to meet specific Covid-related needs, or has it simply become clear that the underlying finances of the care sector require such support and would have done regardless of the pandemic?

Mairi Gougeon: As I said in my opening statement, the evidence that we have seen over recent times, including the Scottish care home census, shows that the costs of providing such care have increased hugely. Raising the payments by the rate of inflation only, which would have been typical for other years, would not have addressed the increase in cost. In an attempt to balance that out and address it, we decided on the 7.5 per cent increase, which has also been agreed by the Convention of Scottish Local Authorities.

The Convener: As there are no further questions, we move to the formal debate on the affirmative instrument on which we have just taken evidence from the minister. I invite her to move motion S5M-24001.

Motion moved,

That the Health and Sport Committee recommends that the Community Care (Personal Care and Nursing Care) (Scotland) Amendment Regulations 2021 [draft] be approved.—[*Mairi Gougeon*]

The Convener: No members wish to contribute to the debate.

Motion agreed to.

The Convener: That concludes consideration of the instrument, and we will report to Parliament accordingly. I thank the minister and her officials.

Social Care Inquiry

09:59

The Convener: Agenda item 5 is a round-table discussion as part of our social care inquiry. The committee published its report on the future of social care and support on 10 February, and the Scottish Government's independent review of adult social care was published on 3 February. Both reports were debated in Parliament just the other day.

The purpose of today's session is to hear views on the two reports. I am pleased to welcome back six participants from our evidence sessions that took place in October and November last year. I welcome Viv Dickenson, chief executive officer of CrossReach; Susan Dumbleton, a carer; Eddie Fraser, chief executive of East Ayrshire Council and formerly of the East Ayrshire integration joint board; Annie Gunner Logan, director of the Coalition of Care and Support Providers in Scotland; Cassie Hersee, manager of Isle View nursing home in Aultbea; and Dr Ann Wilson, an individual who is in receipt of care and support.

Thank you all for joining us; it is good to have you back and to hear your views after developments in recent weeks and months. To start the discussion, I will ask each of you in turn to give a few opening remarks to set out your views on the reports. There will be every opportunity to build on your initial comments as members ask questions on particular aspects, but I ask you to give us a brief overview to get our discussion under way.

I start with Viv Dickenson, to be followed by Susan Dumbleton.

We are not hearing Viv yet. I think that you are online now, so please start again.

Perhaps not. If we are not getting Viv, I will go to Susan and we will come back to Viv shortly.

Susan Dumbleton: Good morning and thanks for inviting me back. It was good to read the two reports and see them both published.

The committee's briefing paper asked us to talk about something that we were pleased to see in the reports and about any concerns that we might have. The thing that I was most pleased to see was a formal recognition of the gap between legislation and policy and the implementation of those things. It is good that that has been acknowledged. The task now is to identify the barriers to implementing what people feel is good legislation and policy that has good intent.

Having read and digested the review report, my concern is that, to reflect back to the committee the words that Jeane Freeman used in the debate, people might be concerned that the report was one

> "of fine words and laudable sentiments"—[*Official Report*, 16 February 2021; c 49.]

but that nothing more will happen. That is a huge concern of mine.

Eddie Fraser (East Ayrshire Council): As members know, since I visited in October, I have changed my role, but that does not change my background of being in social care for 35 years and being a family carer.

I welcome both reports and in particular the congruence between them, including the focus on human rights, family carers and the workforce. In many ways, I reflect what Susan Dumbleton said—the issue is the implementation. Without getting into the detail, that is the difference between an IJB and a health and social care partnership. The question is about how this will be delivered and making sure, with the good intentions that are in the review report, that we do not lose from locality working the relationships that we have in communities. I know that the intention is the opposite of that, so this is about how we implement the intention, as Susan Dumbleton said.

Annie Gunner Logan (Coalition of Care and Support Providers in Scotland): It is good to be back—thank you for the invitation. It is good to discuss the two reports in tandem. You wait 20 years for a review of social care and two come along at once.

I am anxious to stick to my two minutes, so I will say first that CCPS has given a broad and pretty enthusiastic welcome to what has been set out. It is wonderful to see the new narrative for social care being proposed. I had quite a lot to say about that the last time I was at the committee, in particular about the importance of relationships, about the emphases on human rights, independent living, prevention and wellbeing, and about the absolute centrality of self-directed support. It is all there in the reports, and it is brilliant to see it.

Building on that, the proposals are about how to reset the system. There is broad support for the proposals, as so many of them respond to the issues that we raised with the committee and in our submission to the review. We were concerned about the lack of robust critical challenge to decision making in social care, and it seems to us that the more streamlined chain of accountability through the proposed national care service addresses that.

We have been very frustrated at the poor implementation of self-directed support, and that is tackled head on. For nearly two decades we have been highlighting the impact of competitive tendering, in particular on our workforce, and that has been recognised and accepted—as it was by the fair work convention a couple of years ago.

All of that is really welcome. Much of it comes as such a huge relief that finally this stuff has been heard, understood and reflected in these significant and influential pieces of work. I thank the committee, and I thank Mr Feeley and his team. Seriously: thank you—it has been terrific to read the reports.

If you know me at all, however, you will know that nothing is ever a total bed of roses, ultimately, and there are one or two things that I think we need to understand a little bit better. The first is the application of improvement science to social care. The national health service is primarily focused on clinical issues, and social care is not. We need to understand a little more about how that would work and how it would alter our current arrangements for quality measurement, quality assurance and the link to regulation.

Turning to the second point, while we broadly welcome the proposals for the national care service, we do not yet quite understand how an appropriate balance will be struck between central ministerial control and accountability, which we absolutely agree is needed, and local community and individual decision making. All of that needs fleshing out a bit more, so that we can properly understand how the proposals will work.

Finally, reflecting on what colleagues have already said, the implementation gap is a risk not just to national policy on SDS or anything else but to the recommendations in the reports. We need to get on with it—that is our view.

Cassie Hersee (Isle View Nursing Home): Thank you for letting me come back to you. We welcome the reports, which we thought were great. As Annie Gunner Logan said, such a report was long overdue, now two have come along at once.

There were aspects that we felt were missing. There was no in-depth discussion about how we would create parity of esteem with our NHS colleagues. I disagree with Annie, in that an awful lot of clinical work now happens in social care. I am a qualified nurse, and I could easily go and work on an acute medical ward with the skills that I have. There was not a lot in the reports that referred to parity of esteem, or to the training and qualifications that could perhaps be created in the future for nursing and care staff specifically in this area of work. There is no nationally recognised qualification in dementia care or anything like that.

Those are some of the aspects that were missing, but the reports are generally really good.

The Convener: Ann Wilson is next.

We have a bit of a technical issue with Ann's sound. I hope that Viv Dickenson is now back online. We will come back to Ann Wilson in a moment; first, we will go to Viv Dickenson.

Viv Dickenson (CrossReach): Hello. Can you hear me now?

The Convener: Yes, we can hear you perfectly.

Viv Dickenson: Good morning. At the end of my previous appearance, I said that we would really like to see something that valued the people who are supported by social care, by putting them at the centre and ensuring that they had the biggest say in the support that they were offered. Both reports lead to that, so for that we have to thank you.

We also wanted something that valued the people who work in social care by recognising them for their skills and expertise, and by moving to fair work for the sector. That, too, is covered.

We wanted something that valued the social care sector for what it uniquely brings, which is an approach to supporting people that is based on strong relationships and which, at its best, facilitates and empowers so that people have the best chance of living the life that they would choose for themselves.

We also wanted something that gets us away from trading packages and is vested in holistic support, collaboratively. The independent inquiry and the Health and Sport Committee review both speak to that.

On the whole, therefore, we see the recommendations as incredibly helpful and positive. There was also something about the national care service looking over standards. As Cassie Hersee has said, allowing some equity for that workforce is particularly welcome.

As a very large sector provider that talks to a whole lot of areas, we have questions. Some of those have come out of the report and need a bit more work or clarity for us.

For example, on children's services, we are really keen to know how the review of adult social care dovetails with the children's review that features in "The Promise". We should not miss the opportunity to understand the intergenerational cycles of poverty and/or family breakdown, and to work much more holistically rather than in silos.

On homelessness services, we were really pleased to see the submissions on addictions that highlighted the need for support for those who are struggling with addiction. However, we are concerned that there is no specific mention of where services and support for those who are homeless, or at risk of homelessness, lie. We are also interested in where criminal justice services might lie in the future. None of those people exist in silos. Some of those issues and problems are interconnected, and we need to ensure that, whatever the system looks like in the future, the people who rely on it for support are able to talk complexity and have in place support that matches that.

We are also interested in care homes for older people. We completely understand and endorse the aspiration that people should be able to live in their own homes for as long as possible but, if they cannot, they should have the right to live somewhere that feels like home for them. I am not completely sure that we understand how the sector will be supported to ensure that, when residential care is offered, quality provision is assured to all and finances are carefully worked out in order to ensure that people are not being exploited because of the location in which they live or the particular demand for services.

We are really optimistic. Implementation will be a big thing. We owe it to the people who have lobbied for the review to happen, and who rely on social care services for support and/or for their livelihood, to make sure that the implementation is good, that it is swift and that it absolutely hits the spot.

That is my initial reaction to both reports.

The Convener: Thank you very much. I thank all the witnesses. I will come back to Ann Wilson shortly. In the meantime, to set the scene for the rest of our discussion, I ask members who have questions or supplementary questions to put an R in the chat box. A number of questions are already lined up, I know.

I say to witnesses that the questions will generally be open and, therefore, while I will always start with one witness, any others who wish to answer the same question should please, again, put R in the chat box, and I will try to bring them in. We have more than an hour for discussion, but that will fly by because there are such important questions and a variety of views.

We will try Ann Wilson first for a general overview, and then go to the first question.

No: perhaps we will come back to Ann shortly.

My question for witnesses in general is about the proposition in both reports about involving carers and those in receipt of care, such as Ann Wilson—clearly, we are very keen to hear from her and will come back to her shortly.

Both our report and the report of the independent review talked about the importance of engaging carers and the recipients of care in the delivery of services. How do the witnesses want to be involved in the planning and commissioning of services? Susan, I will ask you first before I bring in the other witnesses. How do you, as a carer, want to be involved in planning and commissioning, and how could your involvement be effectively supported?

10:15

Susan Dumbleton: The question is a good one and should perhaps be, in the first place, "Would you want to be involved in the planning and commissioning of services?" I might want to be involved, but I am not here as a representative, in any sense; not everybody will want to be involved.

I would want to be involved in a very proactive way. It is a bit like the question about the best time to plant a tree, the answer to which is "Twenty years ago". When is the best time for me to be actively involved in planning my daughter's social care support? It was at least 20 years ago. However, such planning does not happen, which reflects what Viv Dickenson said about people working in silos. Despite silo working having been recognised for many years—decades, really—it is still a big barrier to effective planning. The national care service might help to rectify that.

Planning for services needs to start long before most service providers think that it needs to start, in my view. I have many examples of crises arising when they did not need to. They could easily have been prevented if something had proactively started a while back. For example, when my daughter was still at primary school, I wanted to start talking about her transition to secondary school. I think that she was in primary 5 at the time. The headteacher was absolutely horrified and said, "Why would you want to talk about that now?" Well, I wanted to talk about it because—as you said, convener—time flies and you need to get involved at the start, which is long before the services think the start is.

I would want to be involved in a way that recognises that people and circumstances change—of course they do. A broad approach to planning needs to start as soon as possible, and certainly before the need for social care arises. That is my answer.

The Convener: It was a helpful answer.

Cassie Hersee: As I think I said when I gave evidence to the committee previously, the problem is that when people are admitted to our nursing home, it is always because there is a crisis. Very rarely is the admission planned. A desperate social worker will say, "We need the bed."

I am always conscious that we cannot offer relatives choice. Particularly in rural areas such as mine, people do not have a choice; there is no skilled dementia care in the community that could help families to keep relatives at home for longer and prevent crises from developing. It comes down to money, as it does every time. We need more choices for people who come into nursing care and residential care, and people need to recognise the difference between the two. There needs to be a step up from residential care to nursing care, because the two are very different. Planning needs to start in the home, when things are slowly starting to break down. A lot of people go straight into a nursing home, because there is no available residential care in their area. The nursing home sector is part of the acute sector; many people do not need to go into nursing care so early and could be cared for in the community if we had dementia specialists on the ground who could go in and support families.

Annie Gunner Logan: There are two levels to the question of how to get people involved in planning and commissioning care. The first is, obviously, the individual level. We have already legislated for that and we have self-directed support. An individual should be offered as much control and choice over their support as they wish. Both reports have identified that we have not implemented that approach properly, or, at least, that we have implemented it patchily. All of the recommendations about giving a push for self-directed support will address that at that level.

The other level is the strategic level, and the question of how to involve people at that level is trickier. Often, that is conceptualised as people sitting around a table to make decisions. That approach becomes complex when you are talking about a whole population. The Feeley report contains some recommendations about strengthened representation on integration joint boards and there are some proposals about ensuring that voting rights on those boards pertain to people other than the statutory colleagues who are there. Those recommendations go some way towards improving the approach. However, involvement has to go beyond just sitting around a table. There are other significant ways of involving people that mean that their views are taken into account even though they are not sitting around a table. That approach involves IJBs collecting good information and having good feedback loops from communities. IJBs need good data. In our view, the report does not say enough about data and the digital approach.

The recommendations around the pivot to prevention and early intervention are critically important, because it inevitably means that you will have to go out to communities to find out what people want and what they understand about social care. Your committee report made a big call for there to be more public awareness of social care. That is an excellent recommendation, because you cannot get involved in something if you do not know what it is and do not understand its complexities.

The Convener: Thank you. We will now let Dr Ann Wilson in.

Dr Ann Wilson: Can you hear me now?

The Convener: We can.

Dr Wilson: Thank you very much for being so patient with me.

I have read the report and I listened to the debate in the chamber, and I welcome what is being done.

In the Social Care (Self-directed Support) (Scotland) Act 2013, the emphasis changed from care being given to a person to the person being in the centre. That was greeted as a great advance, and it represented a big step forward. However, it is still not being implemented properly. It is, at times, almost impossible to get hold of a social worker, and the system seems to fall back into crisis-management mode very easily. Implementation is where the fault line is.

There needs to be more training and, most important, monitoring of the service at the point of delivery. I applaud what the report says about the move to collective bargaining in order to establish national pay and conditions for care and support workers. That is long overdue. Surely the pay and conditions set-up for national health service workers provides us with a template that we can use. In any case, I would like priority to be given to an immediate interim pay rise to a basic £15 an hour, with the necessary finance to services, while negotiations take place. That would mean that the people who are working at the coalface do not need to work years for things to be put in place.

Unpaid carers are still not recognised for the care that they give—even now, after all the fine words from Government and MSPs in Parliament. For example, paid care and support workers are in the first group for vaccination but unpaid carers have to wait until we get around to vaccinating those in group 4. I think that that is a disgrace. It makes me rather suspicious that we are still merely seeing fine words and are not thinking about putting things into action.

There is still much debate about centralisation of services, and I feel that there should be national standards in pay, pensions, conditions and quality of monitoring. However, delivery of the service must take place locally, to reflect existing conditions. A rural area such as Dumfries and Galloway is very different from the middle of Glasgow.

Finally, there is no place for profit making in provision of care and support. We recognise that the tragedy of illness should not attract profit, and neither should care and support. However, there is a place for freedom of choice for a recipient to decide where their care and support should come from. If private agencies are to remain, they should be closely monitored and their charging policies regulated.

Thank you for allowing me to comment on this exciting and thought-provoking review. I look forward to its implementation in the future. I stress that we have to look carefully at that implementation.

The Convener: That has been a clear message from a number of witnesses.

As a person who is in receipt of care, how would you like to be involved in the planning and commissioning of services? What support would you need if you wanted to do that?

Dr Wilson: I would certainly like to be involved from the beginning in discussions about how the information should be conveyed. I find the type of videoconferencing that we are engaging in today a suitable way to be involved.

Eddie Fraser: It is interesting that, when we talk about involvement and engagement in social care, we move very soon to talk about engagement of social work at an early stage. We have reached a stage when social workers become involved at a time of crisis rather than being involved in early intervention and prevention. That is no good for anyone—not the person who is involved in the crisis, the family carer or the social worker, who has to phone around six different care homes to try to make arrangements for someone in a crisis in the hope that they do not have to end up being admitted to hospital.

The move towards early intervention and having a resource that can respond to crises in a way that can keep people in their own homes, if that is appropriate, is important in terms of what we are doing in the whole system. That early intervention gives people time to think about their future. We have spoken previously about the reasons for discharging people from hospital early. In our area, we do that deliberately in order to get people home, because it gives them more time to think about what they want for the future, and it leads to fewer care home admissions. If you are making decisions in a hospital ward, when you are in crisis, they are often not as good as the decisions that you would make in your own home.

I agree with Annie Gunner Logan that there is another level of engagement, at the planning level, and we need to ensure that that is meaningful. Clearly, the Feeley report talks about bringing together the strategic planning group with the IJB. To be fair, it points out that the danger in doing that is that you end up with a huge group, which could lead to people feeling that they are even further away from the decision making. We need to be careful about that.

In our area, our strategic planning group has been successful because we have joined it up with the wellbeing group that is involved in the community plan. That means that the people who are involved are not only those who are involved in health and care, but also our education colleagues, police colleagues, fire and rescue colleagues and so on, which means that there is a wider engagement. We would not want to lose that in any structures or arrangements that arise.

10:30

At the end of the day, all this goes back to the relationships between the statutory service sector and organisations such as carers centres and advocacy services. It is about the trust and value that we place on one another. If we all trust and value one another equally, we will go forward. If we get into power relationships, we will not go forward. The report shows that there are issues not only with relationships between statutory services and the third and independent sectors but with relationships across statutory services. There are clear indications that if the integration of health and care had worked better, we might not be where we are just now. It is essential that we engage with people who use services and family carers. As everyone has said, that engagement must take place at the right time and as early as possible.

Emma Harper: Good morning, everybody—it is good to be back with you again. Derek Feeley's report talks about shifting from old ways of thinking to new ways of thinking. Cassie Hersee, Sue Dumbleton and Eddie Fraser have talked about moving away from crisis management. The old way of thinking involved crisis management but, according to the report and as Eddie Fraser described, the new way of thinking is about being preventative and anticipatory. Are we making progress in moving from crisis management models to preventative and anticipatory models?

Viv Dickenson: I would like to think that we are making progress on that. There are certainly plenty of opportunities, if people are willing for that to happen. I agree that a crisis is not a good time to make a decision, so the more we can do to move things downstream, the better. I referred to that in my earlier remarks when I talked about recognising the opportunities to take a holistic view with people. That means talking about complexity and involving people meaningfully at different points in their lives, so that they can make decisions for the next point in their lives and can understand what their options are.

In the third sector, we have good processes in place. We are advocates for the people whom we support, and we are trying to get upstream of crisis decision making and to use more preventative and anticipatory thinking, but there is still a long way to go. Even the way in which services are commissioned means that we often take people when they are in a crisis and are not able to work with them when they first experience challenges. The review of the commissioning system and proper implementation of SDS and other areas of commissioning will help us to make progress. I thank Emma Harper for her question.

Susan Dumbleton: I was shocked and brought up short by reading about the data gaps that are identified on page 10 of the committee's report. I do not see how any progress is possible if people do not have the data to work on. I do not understand why there are data gaps. We have national organisations that can collect data, we have universities that can do brilliant research and we have statisticians who can bring all the data together, so I do not understand what the barrier is. I do not see how any progress is possible if people, at whatever level in planning and commissioning, do not know what they are dealing with.

The Convener: That is a very powerful point that chimes with the committee's views.

Annie Gunner Logan: That is such an important issue. There is massive willingness to do it. Third sector support often veers towards reaching a point at which we can reduce support because people do not need it any more—never mind preventing an escalation, but actually even hoping to step away so that people can manage their own lives and take their own decisions without support. However, as Viv Dickenson said, people are often referred to third sector services at the point of crisis, at which point it becomes a much more complicated prospect.

That does not only happen in adult social care. The Feeley report mentions the connection with "The Promise" and children's services. Viv Dickenson also mentioned "The Promise", huge amounts of which are about putting in place proper family support so that children do not have to enter the care system in the first place. This is bigger than adult social care; we are all trying to get to that point.

Nobody has mentioned money yet, have they? In fact, I think that Cassie Hersee mentioned it. That is the elephant in the room, because over the years we have seen a ratcheting up of eligibility criteria where people do not get support until they are on their knees. That system drives crisis response, because those are the only people we end up responding to.

From the point of view of the third sector, people often arrive at formal, commissioned services at a point of crisis. If we consider the wider third sector—I am sure that members will be familiar with associations such as Food Train—and other volunteer-led services in the community, those tend to be the first ones that get the chop when money is tight. However, those are the ones that keep the prevention and wellbeing agenda alive.

Let us not only consider the formal commissioned statutory services; let us consider the wider community support that is out there for people and is totally geared to reducing the number of people who have to come into the system in the first place. We should not lose sight of those organisations.

Eddie Fraser: [*Inaudible.*]—it is also important to join up some of the agendas that we have now.

The committee also considered primary care. Often the first point of contact is through primary care, and there is some investment in the third sector through link workers. That means that people who are in the early stages of struggling can be linked up with local community groups, for example, rather than wait until there is a crisis. It is important to consider wider investment in that area.

There are a couple of things to say about data. If you do not ask the right questions, you will not get the data. If a carer gives up work to provide care, that level of care suddenly almost disappears. Instead of it being an unmet need of a social care service, a family carer picks it up and we do not gather data about the hours of care. When a person is not able to care, how can we properly plan for alternative means to support that need? The issue of data in social care is important.

We are good at counting hours and costs, but we are not good at counting the actual value of care. It is about how we value the social care skills of compassion and relationships. It is really hard to do that. It is easier to count infection prevention and control and so on rather than look at the relationships. It is about what data is gathered and ensuring that we link up across the different agendas to ensure that we intervene at the earliest point rather than at the point of crisis.

Emma Harper: Thank you, everybody, for your responses. I am interested in what Annie Gunner Logan said about third sector support. We know that the third sector helps people to get access to support mechanisms and helps to connect people socially. That is important. Obviously, a lot of third sector activities have been impacted by or have ceased during the pandemic.

I am also interested in what Cassie Hersee said about nursing homes versus residential homes. One of our local housing companies has houses that are fit for life—they are dementia friendly, wheelchair friendly and accessible. That is also important when we are talking about not residential homes but homes in the community where people can be supported.

I am interested in how we nudge people to ensure that public bodies and the third sector work together more efficiently so that people do not end up in care homes, residential homes or nursing homes and we can keep them in their own homes for longer. How do we nudge all that on a bit faster?

The Convener: That is a good question.

Cassie Hersee: My views tend to be quite narrow, because of where I work. There is something else that we need to consider. I know that Scotland has Glasgow and Edinburgh, but it also has incredibly remote rural communities, and I am in one of them. We are two hours from the nearest hospital; if we are lucky enough to get a helicopter, we are half an hour away. We have no transport links such as a bus. All those factors feed into the support and care that we can offer and deliver locally.

I go back to my favourite subject—I always talk about it—which is having the money and investment to develop community resources so that people are not whisked down the road for two hours in the back of an ambulance. We need resources locally. My care home is not the only one to be in a remote rural area—loads of Scotland is remote and rural.

Greater consideration and planning for the future are needed. The review report is wonderful, but the focus needs to be on the whole of Scotland and its geography and not just on the Glasgows and Edinburghs, where services are on people’s doorsteps.

Dr Wilson: I fully agree that much earlier planning is needed. We need—what is the word? Public awareness of the social care system needs to be upgraded. The trouble starts because people do not recognise early enough that they need to plan for care. It would be wonderful if it was a normal thing for people to plan for the question, “What would happen if ... ?” We need publicity everywhere throughout the system—including in primary care, such as GPs and their surgeries; in newspapers; and in radio programmes.

People need to talk and raise public awareness of social care. Sometimes, a person seeks help, support or care only when a crisis occurs, which is a problem.

Annie Gunner Logan: Emma Harper made an important point. We could talk all day about the importance of prevention and early intervention, but the critical question is how to drive that. To come back to what Eddie Fraser said, how we drive that is by changing power relationships and priorities.

Like it or not, there is a hierarchy of importance in health, care and support. At the bottom are small volunteer-led and user-led community groups, at the top—arguably—is NHS acute care and then there are all the points in between.

The Feeley report proposes larger IJBs; I see what Eddie Fraser says about that possibly being unwieldy, but that would mean at least that other people were represented and had voting rights. If the people who are at the top of the power tower had fewer votes than everybody else on IJBs, we might see change being driven.

I will have to go back to the report to check it, but I think that there was also a proposal that IJBs would have to demonstrate specifically what they were going to do to shift towards prevention and early intervention, as a requirement. Again, we have come to the point when we cannot just have everyone talking about how important something is, then doing nothing about it. The proposals seem to go some way towards shifting some of the power and priorities.

10:45

Susan Dumbleton: I agree with what Annie Gunner Logan said, both on that and on what she said before. It brings me back to my first appearance before the committee, when I seem to remember that I talked at some length about the importance of what I called social capital, which has been recognised by the Scottish Government to the extent of a fairly recent report.

As a society, we need to invest in the whole idea of social capital, because it is what keeps social care going. Annie Gunner Logan gave the example of the Food Train. There are many such organisations that would not necessarily consider themselves to be part of the social care system but are the ones that keep people’s lives going, and not only keep them going but keep them meaningful, involved and connected with other social networks. Those organisations provide the relationships that people have talked about as being so important, and which absolutely are important.

Perhaps a strengthened IJB, with voting rights, might improve the situation, so that networks can be recognised for their importance in the cohesiveness of society and for, at a very informal level, supporting people to live their lives.

Emma Harper: I thank everybody for their answers so far. We spend a lot of time focusing on defibrillators in public spaces, cardiopulmonary resuscitation and physical activities such as the heartstart programme. Do we also need to focus on support for dementia champions? We have dementia champions in hospital wards that accommodate older people but, with an ageing population, we might need to support people more in community situations. Do we need more dementia champions in the wider community, so that people can keep an eye on each other, or recognise when somebody might need a wee bit more support? Would it be advantageous to focus on that?

Viv Dickenson: Yes, I think that it would. Last time, we talked about the need to get alongside communities to help them to understand dementia better, and to take away some of the stigma that still exists about dementia, particularly among the older population. We do not have champions, but ambassadors in our services. All our services for older people now have dementia ambassadors, who are there as a point of contact for families and the rest of the staff, to help them to advocate on behalf of the person who has dementia, and to point to resources and tools that might be useful for them. It would be incredibly helpful if that were rolled out into communities.

We also have a lot of downstream work going on in communities. We have a project called “Heart for Art”, which is a space where people can come together and just chat about where they are at. It is about supporting people to—as Susan Dumbleton said—help them to retain networks and communicate, when they are unable to communicate in the way that they did, and to help families to navigate the system. There is something really good in the idea of having dementia ambassadors in communities.

The dementia-friendly communities initiative that was taken forward by the Life Changes Trust has helped to embed some of that; it is worth building on for the future.

Eddie Fraser: People who really understand dementia being available to give advice and support is a positive idea. When we talk about local communities, we should think about how to have caring communities, so that people with dementia or a learning disability feel safe going to town and into shops because there is a general level of awareness and compassion there. That should be on top of and not instead of the people who are around. Some of this goes back to what I said about primary care, link workers and community connectors. How can they link to folk who could be dementia champions and give people advice? We should not lose the positive work that was done on post-diagnostic support for dementia; we can continue to build on that.

Brian Whittle (South Scotland) (Con): Good morning, and thank you for taking the time to speak to us.

I am really interested in the impact of the pandemic, which has obviously been significant. The impact was acknowledged in the review, the committee report and the debate about the review. There has been recognition, especially in the early months of the pandemic, of issues including deaths in care homes, access to personal protective equipment, infection control, changes to care and support, and how well staff are protected by employers. The review highlights that the pandemic has

> “exposed structural inequalities and pre-existing inadequacies in the current social care support system”.

I declare an interest, in that I have experience of that with a family member. How confident are witnesses that issues that have been highlighted during the pandemic will be addressed by the proposed reforms?

Annie Gunner Logan: That is an important issue. Thank you for bringing it up. I will leave it to Viv Dickenson and Cassie Hersee to speak about care homes, because that is their area of interest. I am interested in how care at home, housing support and supported living have been affected during the pandemic. The committee has had evidence from disabled people’s organisations that some people’s care was removed pretty much overnight. We still need to get to the bottom of why that happened.

Since last April, the cabinet secretary has released an additional £262 million into social care to support sustainability of organisations and services. It is of huge concern to our membership that a vanishingly small amount of that has gone to their organisations, despite their having claimed money for—as Brian Whittle said—PPE, extra staffing and other costs that were set out in the sustainability payment guidance. We recently collected data from our membership and found that, so far, they have claimed only about £8 million, and have been able to access only just over £3 million.

We cannot understand why it is being made so difficult for those organisations when they are performing brilliantly. They have kept services running all this time, and they have managed to support their workforces and maintain services, but we are making it colossally difficult for them to claim sustainability money. It is a serious issue—we wonder whether some services will still be here when all this is finished.

I will return to my previous point about smaller third sector groups—not necessarily the ones that I represent, although the groups that I represent certainly rely on and work with smaller community groups. Some such groups are vanishing because they have not been able sustain themselves during the pandemic. I know that I have raised the issue with the committee before now, but I am raising it again because there are questions to be answered.

The Convener: That was very helpful. I encourage you to put in writing for the committee the point about the difficulty of accessing the funds that have been made available, because we might be able to highlight the issue in a supplementary report or in correspondence that might arise from this meeting.

Cassie, do you want to respond to Brian Whittle’s questions?

Cassie Hersee: Pandemics are never great, and this one was very unexpected. It was difficult for us at first. We have probably spent the past 15 or 20 years being instructed by the Care Inspectorate to make our nursing home homely. A care home needs to be an environment that can become a person’s home, because that is what it is; it is where they live.

However, inspectors from every department that you could think of descended on us and asked us to turn our home into a clinical environment. We have gone from being homely, with lots of soft furnishings, to having clinical waste bins everywhere and everyone wearing not very fetching scrubs. We are starting to look almost like a hospital ward. That is difficult, because it goes against everything that we know is in the best interests of people with dementia, who need to feel that they are in a comfortable and relaxed environment.

PPE was a huge issue, at first. We could not access any. Our suppliers would not supply us, because stocks were being ring fenced for the NHS. That brings me back to parity of esteem. We were sitting there, screaming, “But our residents are the most at-risk people”, and we could not access PPE.

Things have improved dramatically. We have had a year of playing this game and things are much improved. We are able to reclaim some of our costs. We are a tiny home, with 23 residents, and it cost us £9,000 to buy the scrubs that we were instructed to buy. We had to refurbish our laundry, which cost £10,000. Those are huge costs for a tiny care home. Annie Gunner Logan was right to say that a lot of places will not be here at the end of the pandemic; they will go under because of the expenses that they have had to lay out. Some homes have had to reconfigure their buildings almost completely.

Viv Dickenson: Brian Whittle made an important point. I am incredibly worried about recovery, and CrossReach is a large organisation that has some resources behind it. As Annie Gunner Logan is, I am concerned about the hard factors—the finances behind the sector and our ability to call on sustainability moneys and ensure that we can be financially robust and remain here for the people who will need us in the future—as well as the softer factors that Cassie Hersee talked about.

The reports should give us a way to support recovery because, fundamentally, they are about the importance of recognising relationships and the factors that help people to feel that they are valued, included and in spaces where they want to be cared for. The reports absolutely allow for that, but unless we get the recovery on track now in a way that supports that approach, we will not be able to meet the reports' aspirations.

An area that is particularly interesting is public confidence, specifically in relation to care homes. People's confidence in care homes' ability to provide good care has been fundamentally damaged, partly because of media reporting and partly because of issues such as clinicalisation of services, which Cassie Hersee talked about and is something that people do not necessarily want for the future. Those two big issues need to be addressed.

The third issue is insurance. Insurers are expressing doubt and concern about the future of social care, about claims coming in and about all the other stuff to do with Covid that has happened, so the sector has a real problem. We are working with the Scottish Government on that. We have to get back the confidence in care homes and the social care sector that will enable us to recover, to be there for the future, and to get behind the aspirations in the reports and change things for the people who will rely on social care in the future.

Thank you, Brian, for your question, which contained a lot for us to address in the context of the recovery journey.

11:00

Susan Dumbleton: My view that the pandemic has damaged the social fabric has not changed since I first came to the committee in November. It seems to me that almost everything that is informal and supportive and which has to do with social capital—which we were talking about earlier—has taken a huge hit. Some of it has gone and will not come back. It is such a challenge for us all, for the future, to work out how we will we rebuild those informal and almost invisible supports. They were around, but they did not operate within a formal system: they were just part of society, but they are gone.

I understand that there must, of course, be a focus on high-level support for people, but there must also be support for recreating the social networks—the relationships that people have talked about so much this morning. I do not know how that can be done, but it is vital. Otherwise, people's lives will be much more sterile than they would have been.

Eddie Fraser: To reflect what others have said, I say that it was interesting to speak about the right way to go. There is a need for early intervention and prevention, and there is a need for investment in that part of a person's journey to make sure that they are engaged. Just now, there is a need to build confidence in the social care system by investing at that end, but we are also having to invest in things that make people feel safe—services, PPE and all sorts of infection prevention and control measures. This is about how we strike the balance between those two things. We need to build confidence, but if we are going to change things, we need also to get into early intervention and prevention.

We have focused on older people's services. However, if we look at the changes that have happened during the pandemic to other services—for learning disabilities, mental health and addiction—we see that many relied on peer-support groups that no longer exist or have not been able to exist, apart from online. Some support services have been absolutely heroic in turning things around to provide crisis response, but they can no longer provide the recovery service that they provided before. As Brian Whittle said, post pandemic the issue is how we move back into recovery mode in terms of people's personal recovery journeys. We need to be focused on that.

We do not like to talk about it, but there is also the bit about money and the need to make sure that whenever money comes to them, the new IJBs, or whatever they are, have a proper planning focus so that they invest in both ends, in order not only to ensure that services are safe and are seen to be safe, but to make it so that people do not need those services at all.

Brian Whittle: I thank the panel for those answers. There is a lot for us to consider. As Eddie Fraser rightly said, recovery from the pandemic will require much more than looking at care homes—a much wider community-based response will be needed.

The evidence in the review presented a need to look at human rights and, especially, to consider a national approach being taken to address accountability and consistency. It also highlighted a new role for the Care Inspectorate in relation to oversight of care homes. Is more national oversight of social care needed to prevent future failings or, at least, to plug the gaps in relation to inadequacies that the pandemic has highlighted?

Eddie Fraser: The balance is important. To get the profile of social care up alongside that of the national health service will take national oversight. Work on planning our future social care workforce and on links to further and higher education is being done very well. There also needs to be a balance within localities. Ann Wilson said that Dumfries and Galloway is very different from the centre of Glasgow; such differences are reflected in how we manage things. Even in East Ayrshire, Dalmellington is different from Kilmarnock. We need to know about differences in order to be able to plan services. We have to strike a balance between the local, the very local and the national.

I welcome the fact that we have a national care service, but I do not think that that should take management of social care away from the locality. I go back to what I said before: I would be really interested to see implementation of that, and for it to be ensured that it does not take away from the progress on integration of healthcare and social care services that has been made over the past few years. I would be interested to understand where the health and social care partnership would be in the management of services if the chief officer of an IJB were to be responsible for strategic planning and commissioning, rather than for management.

That is a point about implementation, but I do not want to get lost down that route. There are so many good things in what we have been speaking about today in terms of better engagement, and of recognition of the workforce and carers. They are important, but implementation will also be important so that we understand the proper balance between local and national.

Annie Gunner Logan: The new role for the Care Inspectorate was part of the question, as was what elements need national oversight. To be fair to the Care Inspectorate, some of the things that need national oversight have never been within the Care Inspectorate’s remit. The Feeley report commented on workforce, terms and conditions, minimum standards and so on, but the Care Inspectorate has never gone there and it would not be appropriate for it to do so. However, somebody needs to go there. What our workforce is paid is one of the drivers of quality in social care; the committee will have heard me talk about that on many occasions. I am very pleased about what both reports say on that.

The Care Inspectorate has had a minimum role in scrutiny of commissioning and procurement—but somebody needs to have that role. It has had a minimum role in pushing through the implementation of self-directed support—but somebody needs to do that. National impetus to drive through policy that has been agreed by Parliament but which remains unimplemented is needed. It needs a national push.

I agree with Eddie Fraser that there needs to be more clarity about the roles of local bodies—IJBs, health and social care partnerships and local authorities—and about how it all works in practice, in which we are also very interested.

However, there are two points to make about that. First, people who rely on social care are not that bothered about how it works. As we have said for years: who cares who organises it all, as long as it works properly for the user?

Secondly, the status quo cannot be an option. We need to do something to change the roles and responsibilities of organisations, because they are manifestly not working in their current forms.

Brian Whittle: I just want to finish my line of questioning, convener. In such a mixed economy, which bodies should be accountable for social care and support services? Also, how can we prevent the scapegoating of individual staff members or services when things go so wrong?

Cassie Hersee: That is an interesting point and one that my nursing colleagues and I talk a lot about. We have been really lucky because we have not had Covid, but a lot of that is to do with being in the middle of nowhere. We are aware of other nursing homes in Ross-shire and on Skye and so on that have had outbreaks of the virus and have been vilified in the press. We feel so sorry for them. The focus has been that it is the fault of the nursing home or the care home and the staff. That blaming has damaged even further the fairly low esteem that we are held in anyway, and it has increased the problems of recruitment and everything else that goes with managing a nursing home. I do not know how we stop that, but the media have an awful lot to answer for.

Dr Wilson: I agree that nursing homes and care homes have had a bad press. It is not their fault but that of the system and of the pandemic. They are looking after the most vulnerable members of society, and we knew that losses were going to happen there. My heart goes out to those places.

I go back to how we encourage people to take up social care at the earliest possible stage. I think about that a lot at the moment, because I am supporting someone who is in that very position—we know that that person needs more support, but to get them to acknowledge the fact and do something about it is very difficult. That is a sticking point.

I move on to how difficult it is to get hold of social services. Again, I am not blaming them, because I know that there have been great cuts in social services due to financial constraints.

However, we never see the same social worker twice. We have to wait for maybe a month to get hold of one in the first place. When somebody needs support or needs to discuss a support package, it is just not good enough that we have to wait and wait.

Annie Gunner Logan: I have a couple of quick points. Brian Whittle asked who should be accountable. The answer is everybody. Everybody who is involved in the system should be accountable. The real question is, to whom should they be accountable and through what system of accountability. The national care service will have a minister. Ministers will say that they are accountable already, I dare say, but they do not have the chain of accountability that leads directly down to services and back up again. That piece has been missing and I think that it is being proposed here, so that is interesting.

All the reports before us are very clear about how the workforce should be treated, what the people in it should be paid and what opportunities they should have for progression, but the missing piece is how we get people into that workforce in the first place. We are still struggling with that, and the blame culture that others have talked about is not helping.

Two issues are very pertinent to us at the moment. The first is the £500 bonus payment. Although it applies across the board for the NHS and statutory bodies, in the third sector it does not. Our colleagues from Quarriers have been very vocal about that, and they are not the only ones.

The other issue is vaccination. We are now starting to see the emergence of yet more blame culture about whether we should compel all care workers to be vaccinated. That is not helping. Either we value people and treat them as autonomous professionals, or we do not. The slinging of mud at care workers—and, in particular, at those in care homes—is unforgivable.

11:15

Viv Dickenson: I follow on from Annie Gunner Logan's point. One of the ways in which we can change systems and cultures is by ensuring that there is equal opportunity for people with lived experience to take up roles in institutions and by making sure that change is sustained, can be suggested and meets the needs of the people it is there to serve. If someone is not confident about entering the employment market, they will not be at all confident about joining social care at the moment, yet it is those voices, skills and experience that we need shaping our social care from the outside and on the inside as part of our workforce.

We have some great opportunities for people with lived experience to join the workforce but, to be frank, it is a difficult time to ask people to come into something if they are not feeling completely robust and resilient. I welcome the opportunity to think deeply about the workforce as we come out of recovery, as discussed in both reports, and how we build in opportunities for voices of lived experience and for those with the lived experience to have equality of opportunity to enter the workforce and make careers there if they choose to do so.

Donald Cameron (Highlands and Islands) (Con): My questions are on fair work and support for unpaid carers. My first question is broad: in terms of fair work, how does the panel feel the value of the social care sector should be best recognised?

Annie Gunner Logan: In short, it would be best recognised if we implemented all the recommendations of the fair work convention's report into social care that was published in 2019, which the committee report and the Feeley report also recommend. We are way behind on that. I am not sure that I can say any more than that, because we know what to do and we have all agreed what to do—we just need to do it.

Eddie Fraser: I agree. Clearly, valuing work through what we pay people and through their terms and conditions is important. It is important that people do not have to fight for them every time they return. Wider than that, valuing social care as a role and understanding its value is important, and we have seen that over the pandemic, but what social care workers do—getting out there, building relationships and being compassionate and caring for our communities—can be quickly forgotten.

It is interesting to see how many people aspire to be a nurse or take up other health roles. If you go into a school and ask how many people aspire to be a social care worker, I am not sure that you would find many, and I wonder why that is. It is because of the public image of social care. When we talk about public awareness of social care, that should not only be awareness of whether you ever need social care; it should be awareness of the value of social care and how it is a great career to be involved with, often in your local community.

Donald Cameron: I move on to the issue of professionalisation. It is important to distinguish professionalisation from professionalism, because huge amounts of people who are highly professional work in the sector. The reports refer to the importance of qualifications and greater professionalisation of the sector and they focus on things such as allowing complaints to be addressed and redressed when individual rights are not upheld. Are there any risks with greater professionalisation in those terms?

Viv Dickenson: It is clear that people rely on the safety of professionalised services, so some of those things are incredibly important and we would want to see redress when things go wrong, and we want to see proper career pathways for people and qualifications being recognised. However, that might also put barriers in the way that prevent people who have not come through common career routes from entering and working in the sector. As I said, people with lived experience can be given incredible support to work in professional services. We need to ensure that we build something that allows for absolute equality of opportunity, rather than having a preference for one area or one set of people in society, which would probably be the danger. Otherwise, greater professionalisation would be welcome.

Eddie Fraser: It is important to say that we have a professional social care workforce. I do not think that professionalism poses any threats to the workforce at all. The threat relates to how people value the medicalisation of the social care workforce and to changing the tasks that people do in order to call them professional, instead of understanding that social care can be delivered professionally.

When I gave evidence previously, I spoke about my early career in home help, which involved doing practical tasks from 9 until 1, Monday to Friday, and about all the things that were done in the local community that I worked in at the time. Our personal carers do none of that now, because we have already shifted them up. When people talk about professionalisation, I sometimes worry that they are talking more about medicalising social care than about valuing social care as a profession in itself.

Annie Gunner Logan: Donald Cameron's question is interesting and has been around for a while. There has always been a fluid boundary between what we might call professionalised services and less formal care. For example, staff in Care Inspectorate registered services also have to be registered with the Scottish Social Services Council. They are subject to regulation and are accountable through that professional registration, whereas personal assistants who are employed directly by disabled people are not part of that system, even though they do a very similar job and the support that they provide is very similar.

We now see a growing interest in what we in the business call microproviders—the very small groups of local people who provide care and support. Again, they are outside the formal registration system. I am certainly not one of those people who say that they must all be registered, but if they are not, why is everyone else registered? Where is the boundary between registration and non-registration? Those questions were not addressed in the reports that we are looking at today, but they have been around for quite a while. We need to think through those questions because, on the face of it, the way in which we approach the issue does not always appear to be very logical.

If, as so many people have said, the future of social care means relying on increasing numbers of informal carers, unpaid carers, community groups and the wider support network outside of formal social care, we will have to figure out at what point someone becomes a registered professional and the threshold for that, because we have not bottomed that out.

David Stewart (Highlands and Islands) (Lab): Good morning. I apologise to committee members and our witnesses for not being present for the earlier part of the meeting. Unfortunately, I had to attend an urgent unscheduled meeting.

I will build on Donald Cameron's points about fair work and professionalisation. What are the witnesses' assessments of having more unpaid carers on boards? Clearly, decision making and policy are vital for the future.

Dr Wilson: I was thinking about how we recognise carers and the professionalisation of the care system. I have always felt that there is a lack of respect for what carers do. That is due, in part, to their name—carers. I like the fact that today we have been talking about "social care workers", which sounds much more professional and much more like a proper job, if you see what I mean.

Unpaid carers care. An unpaid carer usually has an emotional attachment to the person with whom they are involved, whereas paid care workers should not have an emotional attachment—they should have much more professional relationships with those people. I like the idea of calling people "care and support workers" or "social care workers". We should start at the bottom by using the right names and right ways of addressing people. That encourages the right sort of respect, which we owe people.

Cassie Hersee: Everything comes back to what I said about our sector not having parity of esteem. I treasure the NHS; I am an NHS nurse and I worked in the acute sector for years. However, when I moved into the independent nursing home sector, suddenly all my nursing esteem—everything that I thought I was about—disappeared. We need to be given that back, because nursing home managers are leaving in droves. I freely admit that I am one of them.

We do not want to professionalise what we do, because we know that what we do is already professional. However, there are things that can be done. We could develop a worthwhile, meaningful qualification that people would need to have—or be aspiring to achieve—before they could work in a nursing home.

Unpaid carers who look after relatives at home are very often the people we end up recruiting. After their relative has passed away, people often say, "I quite enjoyed some aspects of looking after them." We need to define a professional career pathway, just as there is when someone starts in the NHS as a staff nurse and goes on to be an E grade and then a sister. Especially in the area where my home is, unpaid carers are very likely to be the people we eventually recruit.

David Stewart: How should staff be represented on the proposed national forum that will look at workforce planning, improving quality and training?

Annie Gunner Logan: I think that we should ask them. There is a strong view that trade unions need to be there. I do not disagree with that, and I put my hand up and declare my interest as a Unison member, but we need to recognise that union membership is very low in social care and that a number of organisations have implemented effective voice—that is jargon from the fair work agenda—in different ways, such as staff representative forums. Those should also have a place. However, rather than make assumptions about how the workforce wants to be represented, my starting point is to say, "Why not ask them?"

Viv Dickenson: I agree with Annie Gunner Logan. My organisation has a staff representative forum and works with effective voice in different ways, so I was just thinking about how we would support staff to be part of decision-making bodies in future and ensure that the approach is well implemented. I agree that it is about asking people.

A variety of people work in social care—there are people who work informally and who are on different pathways. It is therefore important not to assume that the social care workforce is homogeneous and to give people as much choice as possible about how they get involved in the process.

11:30

Eddie Fraser: I agree with the other contributors. Having spent most of my life in the local authority workforce, I have found it very interesting over the past few years to work in the NHS in the partnership model. From the start, the workforce has been engaged at partnership level in how we take things forward, particularly around career development, which is even more of a reason to ensure that people are engaged from day 1. That is important with regard to trade unions, of course, but also for professional bodies that are jointly involved. We need to think about how people who are not members of such bodies or unions can be encouraged to be involved in collective bargaining.

Annie Gunner Logan: I want to come back quickly on a point in the discussion about valuing the workforce. I will find the reference for you—I cannot quite recollect who it was now—but it was put to me that the reason why we do not value the social care workforce as much as we value the NHS workforce is that we do not value the people they support. I would just like to leave that with the committee to think about, because I think that there is something potentially quite significant there.

Sandra White (Glasgow Kelvin) (SNP): Good morning. Like Dave Stewart, I give my apologies for not being here at the beginning of the meeting. I was in the same urgent meeting as him. Thank you for the opportunity to ask a couple of questions.

I will not go through the whole review. The review mentions person-centred care and a human rights-based approach, but it is not the only approach that is mentioned. Can you think of a better way, or better ways, in which people can be put at the centre of decisions that are made about their care?

Viv Dickenson: I like the human rights-based approach in both reviews. It is fundamental that people have their rights respected, and it is absolutely the way to go. I do not know that there is necessarily a better way to ensure that services are personalised. Embedding human rights is the bigger issue, and there are many different ways to go about that. Ensuring that organisations and services understand what they are talking about when we talk about a human rights-based approach and that there are really good tools to work with to ensure that that is at the centre of everything that they do is probably more important than arguing about whether the human rights-based approach is the right one.

The issue is about how we get there—how we ensure that people's human rights are respected and that services are completely personalised. Self-directed support allows for that, but there is sometimes a bit of confusion when we talk about that and people do not have a real understanding of it.

Dr Wilson: I do not really have anything to add, but I agree that the human rights-based approach is the way to go. It should be a human right that a person is at the centre of self-directed support.

Sandra White: Self-directed support and the human rights-based approach came up in both the answers. As organisations and individuals, how would the witnesses want to be involved in local discussions about the eligibility criteria and how those would be applied? Would you want to be involved in explaining self-directed support? What do organisations think they should be involved in?

Dr Wilson: The end user—the person who will be affected—should certainly be involved in helping to decide how support should be implemented.

Cassie Hersee: I know what self-directed support is, but I am not particularly involved in it in my role. I am one of those left-wing trendies who want all care to be free at the point of delivery.

The Convener: That seems fair to me.

Annie Gunner Logan: We have an interesting point, because everybody should be involved in self-directed support, because it is the mainstream default approach. That is what was legislated for in 2013. The right of people to have as much choice and control as they want over their support already exists—we are eight years on from that.

In our submissions to the committee's inquiry and to the Feeley review, we were anxious to say that people should not chase another magic bullet to sort all this, because we already have one. If only we implemented it properly, we would not still be talking about it.

I will bring up one thing that is a bit anoraky but is interesting. In a rights-based approach, one of the fundamental rights of somebody who is in the care system is to have their assessed needs met. However, the review told us that unmet need should be formally recorded. If we had a rights-based approach, there would be no unmet need, but there obviously is—not least, because of financial constraints.

In all the recommendations that are before us, such issues are the little things that we are trying to tease out in considering how the recommendations will work together. That point is small but, if we were serious about having a rights-based system, there would be no unmet need.

Sandra White: That important point neatly brings me on to my last question, which Eddie Fraser might want to respond to. The review says that commissioning and procurement decisions should be down to a person's needs rather than to budget limitations. How might the review's recommendation of basing commissioning and procurement decisions on a person's needs rather than on budget limitations be realised? That is the crux of the matter. I know that people come to loads of MSPs and to your organisations to say that they want self-directed support so that they can pick who they pay, but because of budget limitations they cannot have that. I just throw out that last question.

Eddie Fraser: We have reflected before that, if we listen to people early and listen to what they want, that often costs less than a traditional service. I am not sure whether I have used before the example that I will give. We worked with a young man who had complex needs and behavioural problems, who could not be in school. As soon as he was taken to a railway station, he calmed down. He was having respite care that cost several thousand pounds a week. Through self-directed support, a social worker built a signal box at the boy's back door, which was his safe space. What a change that made. With that safe space, he did not need the same amount of respite and he managed to get back to school. Getting to know a person and working alongside them can achieve that.

At the other end of the age scale, there was an elderly person with dementia who was agitated and wandering a lot. Instead of having that person go immediately into a care home, we put in patio doors so that he could wander about in the garden whenever that suited him and then go back in. That man stayed at home for an extra 18 months because he had that space.

As we said at the start, if we intervene early enough and listen to what is important to people, getting it right for a person will often be cheaper than doing what we have traditionally done. There will always be tensions in relation to the totality of resource that is available, but doing the right thing is often the same price as, if not cheaper than, an institutional response for people.

David Torrance (Kirkcaldy) (SNP): The committee's report speaks of the urgent need to engage the population in fully understanding how social care operates. Would a public conversation and increased understanding of social care help to reform what does not work? What form could that conversation take?

Annie Gunner Logan: Convener, I was lost in your last question—[*Laughter*.]—about commissioning and procurement. I will park that for a minute. You know that it is my favourite subject in the world.

On a national conversation about how social care works, something that the committee picked up on very specifically was the lack of awareness. We have already reflected this morning that most people find out how the social care system works—or does not work—only when they get pitched head first into it, at the point of crisis.

I am not sure what exactly is meant by a "national conversation" but it would be really interesting to take forward some kind of awareness programme. I am always aware—I think that I said it to the committee, the last time that I was here—that, on a Saturday night, we do not have the equivalent of “Casualty” or “Holby City”, or anything like that, for social care. How things work is not really in the national consciousness at all until we get pitched into it.

We absolutely need to engage the public much more in how things work. That comes back to what participants said earlier about pivoting towards early intervention and prevention. If we go out to communities and people and say, “Look, if this should happen to you, what would you want to have in place?” That starts the conversation going, and it then feeds back into the IJB—it gives it data about how to plan.

I do not think that we need to do anything other than make the system work in the way that is specifically recommended in these reports. I am not sure that we need billboard advertising or anything like that. If we were going out to communities and asking them what they want, the awareness would, I think, come largely from that.

Susan Dumbleton: [*Inaudible.*]—agree with that. It is true that a lot of people do not know about or understand the system until there is a crisis. However, an awful lot of people know people who use social care services—in fact, most of us do; there cannot be many people who do not. An awful lot of us, at some point in our lives, are also family carers, doing the work that has been talked about warmly in both reports.

Why do people not know? What is the barrier? Is it that, once someone stops being a carer, that is such a relief that they do not want anything more to do with it unless another crisis arrives? Why does it seem that there is a lack of public awareness? Is there, in fact, a lack of public awareness, or is it just that people’s experiences are not captured and built on? I do not know the answer, but I am surprised that people talk about a lack of awareness of what social care does when, in fact, so many of us are involved in it in one way or another at some point in our lives.

David Torrance: Of all the recommendations that have been made by the committee and in the review, which should be prioritised most?

The Convener: We will perhaps hear briefly from each witness on David Torrance’s final question about what the top priority is.

Dr Wilson: My top priority would be to increase pay rates for care and support workers.

Cassie Hersee: Obviously, I am going to increase my pay—that is top of the list. [*Laughter.*] However, I would also like the community that I serve—as I feel I do—to have some choice in what they can expect.

We all know what we are going to do when we retire, but not many people I am looking out of the window at know what they are going to do when they need care. Most of them are going to need it, and I would like some sort of choice to be available to them.

Annie Gunner Logan: That is a tough one. The recommendations come as a package; if we really want the system to work we need to do the lot. The CCSP is a bit worried about the impending election. In our initial response we referred to the risk of there being a bunfight because some recommendations are perhaps attractive in the context of the election and so are plucked out and fought over, which distorts the whole thing. My vote would be for taking the whole thing.

11:45

Having said that, I never like to fail to answer a question from a committee member, and I do not think I would ever be forgiven if I did not say that commissioning and procurement are at the heart of all this. If we do nothing else, changing commissioning and procurement would take us a long way towards where we need to be.

Eddie Fraser: My priority would be the first recommendation of the Feeley report, which is about believing that a human rights approach to social care is needed, and that the only way to deliver that is by looking at social care in its totality. Otherwise, we will not deliver a human rights approach either for the people who use services or for their families, carers and our workforce. Embedding such fairness and value in all social care is the most important priority for me.

Susan Dumbleton: I need to go back to something that I talked about earlier—the shocking data gap. Before anything can happen effectively, we need to know, as a society, what we are talking about. I do not see how we can build a fairer and better system to do what social care has to do in society if we do not know the numbers and have not got the projections. That would be my priority.

Viv Dickenson: I have two priorities and they go hand in hand: they are choice and control people who use services, and fair work for staff. Those priorities would address all the other things—human rights, procurement and all the rest of it. I say that you should go for those two and get them implemented well.

The Convener: I thank all our witnesses this morning. It has been a really informative evidence session, with many good exchanges of views and information. I have asked at least one witness to follow up with further information, but I hope that you all feel free to feed in any further comments. As Annie Gunner Logan said, we are approaching the end of this session of Parliament, but we will endeavour to produce a brief supplementary report or, at the very least, to correspond with the

Government on some of the points that we have heard from our witnesses. The committee will make a decision on that shortly.

I thank the witnesses for helping to inform the process not only today, but over recent weeks.

University of St Andrews (Degrees in Medicine and Dentistry) Bill: Stage 2

11:48

The Convener: The next item of business is stage 2 consideration of the University of St Andrews (Degrees in Medicine and Dentistry) Bill. I welcome the Cabinet Secretary for Health and Sport, Jeane Freeman, who is the minister in charge of the bill. No amendments have been lodged, so I invite the cabinet secretary to make a brief statement to put our formal consideration into context.

The Cabinet Secretary for Health and Sport (Jeane Freeman): Thank you, convener, for the opportunity to make a brief statement on the bill. As colleagues are aware, this is a technical single-purpose bill. I will recap. The bill's purpose is to repeal an archaic, unfair and, arguably, anticompetitive prohibition that prevents the University of St Andrews from awarding medicine and dentistry degrees. The prohibition was not intended to last for any significant length of time.

The bill has been introduced at this time to enable the University of St Andrews to award, jointly with the University of Dundee, primary medical qualification degrees to Scottish graduate entry medicine—ScotGEM—students in advance of the first cohort graduating in 2022.

I welcome and appreciate the Scottish Parliament's unanimous support for the bill at stage 1 and for the committee's scrutiny of the bill and its support for the ScotGEM programme as a whole, which is Scotland's first graduate entry programme for medicine.

As no amendments have been lodged for consideration at stage 2, I have nothing further to add.

The Convener: Thank you very much, cabinet secretary. The only requirement for the committee this morning is to consider and dispose of the three sections of the bill and the long title.

Sections 1 to 3 agreed to.

Long title agreed to.

The Convener: That concludes our stage 2 consideration of the bill. I thank the cabinet secretary for attending the committee and members for their attention. No doubt we will have the stage 3 debate on the bill in the next wee while.

11:51

Meeting continued in private until 12:02.

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