



**OFFICIAL REPORT**  
AITHISG OIFIGEIL

# Health and Sport Committee

**Tuesday 24 November 2020**

**Session 5**



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**Tuesday 24 November 2020**

**CONTENTS**

	<b>Col.</b>
<b>SUBORDINATE LEGISLATION</b> .....	1
Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 23) Regulations 2020 (SSI 2020/378) .....	1
Food and Feed (EU Exit) (Scotland) (Amendment) Regulations 2020 (SSI 2020/372).....	6
<b>SOCIAL CARE INQUIRY</b> .....	9

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**HEALTH AND SPORT COMMITTEE**

**31<sup>st</sup> Meeting 2020, 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)
- Cassie Hersee (Isle View Nursing Home)
- Joanna MacDonald (Argyll and Bute Health and Social Care Partnership)
- Humza Yousaf (Cabinet Secretary for Justice)

**CLERK TO THE COMMITTEE**

David Cullum

**LOCATION**

Virtual Meeting



# Scottish Parliament

## Health and Sport Committee

*Tuesday 24 November 2020*

*[The Convener opened the meeting at 10:00]*

### Subordinate Legislation

#### Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No 23) Regulations 2020 (SSI 2020/378)

**The Convener (Lewis Macdonald):** Good morning. Welcome to the 31st meeting in 2020 of the Health and Sport Committee. We have received apologies this morning from Alex Cole-Hamilton. I ask all members and other participants to ensure that mobile phones are on silent and that other notifications are turned off during the meeting.

The first item on our agenda today is consideration of a made affirmative instrument. As in previous weeks, the regulations relate to coronavirus and international travel and are laid under section 94(1) of the Public Health etc (Scotland) Act 2008. Section 122(5) of that act states that regulations under section 94(1) are subject to the affirmative procedure. However, provision is made that ministers can make those regulations urgently, in which case section 122(7) applies. Section 122(7) of the act sets out that “emergency regulations” must be laid before the Scottish Parliament and cease to have effect on the expiry of the period of 28 days beginning on the first day of the regulations being made, unless the regulations are first approved by Parliament. It falls to the Health and Sport Committee to consider the instrument and report to Parliament accordingly. The regulations we are considering today relate to the addition or removal of various countries and territories from the exemption list.

I welcome once again to the committee Humza Yousaf, the Cabinet Secretary for Justice. He is accompanied by Anita Popplestone, head of police complaints and scrutiny; Craig Thomson, border measures review team leader; and James Boyce, unit head, health performance and delivery.

I invite the cabinet secretary to make some introductory remarks.

**The Cabinet Secretary for Justice (Humza Yousaf):** Good morning, convener. As always, I hope that you and the committee are all doing well.

The regulations remove Greece, other than the islands of Rhodes, Kos, Corfu, Crete and Zakynthos, from the list of exempt countries, territories or parts of countries or territories. They also remove the sovereign base areas of Akrotiri and Dhekelia in Cyprus from the list of exempt United Kingdom overseas territories. They add Bahrain, Cambodia, Chile, Iceland, Laos, Qatar and the United Arab Emirates to the list of exempt countries or territories or parts of countries or territories—known as schedule A1, part 1—and add the Turks and Caicos Islands to the list of exempt UK overseas territories.

As always, I am more than happy to take questions.

**The Convener:** Thank you. I encourage any colleagues who have questions for the cabinet secretary to put an “R” in the chat box in order to indicate that before we move to the formal debate.

We heard this morning of plans that have been approved in relation to travellers returning to England, which will effectively enable the period of quarantine to be reduced from 14 days, which currently applies, to a much shorter time, with a test after perhaps five days, which would end quarantine one or two days later, if the result was negative. The comment that was made this morning was that the devolved Administrations were considering what action to take in relation to similar proposals. Can you briefly update us on your consideration of such a step?

**Humza Yousaf:** I am happy to do so. When I appeared before the committee last week, I alluded to the fact that there was likely to be an announcement in the coming days. Today, as you say, there has been an announcement by the UK Government. On the positives, engagement has been constructive with the UK Government. It has engaged with my officials and engaged with me as a ministerial colleague, and we discussed this issue at our last Covid meeting. I am in a very similar position to my colleagues in Wales and, I think, Northern Ireland as well; certainly, the Welsh Government expressed the same views as the Scottish Government. My position, which is not too dissimilar to what I said last week, is that I definitely think that there is merit in looking at the test and release proposal of the UK Government.

As you can imagine, I have spoken to our chief medical officer about this, and we have a few concerns. First, do we understand and do we have detail about the efficacy of the proposal? Where is the evidence base? We do not have the evidential basis for the test and release proposal yet, so we asked for that last week when we were told about it. The first thing is whether we can get the evidence base that underpins the proposal. My officials may be able to say whether we have received that yet, but I certainly have not seen the

evidential basis. The first issue is we are waiting for that.

The second issue is that the test would rely on private testing capacity in order not to use up national health service capacity. I think that that is right, but what we have to do from a Scottish perspective is ensure that we have that private sector capacity available.

The third question, which I think I alluded to last week, is the question of timing. The UK Government's proposals would come into place around 15 or 16 December. Is that a suitable time to test a pilot? This is a pilot. It has not been done before in the UK. It could have some teething problems. Is the best time to test that when you are likely to have an uplift, albeit a modest uplift, in numbers during the peak travel period, or would it be better to test a system like this in an off-peak period? That is a question that we are considering at the moment. I hope that that answers the question. As I say, the system will not come into place in England until the middle of December, I think, so we have some time to work through those issues.

**The Convener:** You used the word "pilot", but my understanding is that the intention is that this will apply to all travellers arriving in England at airports or seaports. It is a pilot perhaps in a technical sense but it will work on a much larger scale than we would be operating.

I understand that you are waiting for some evidence on the public health side, but would I be right to assume that you and your officials have been considering the issues around the infrastructure and the mechanics for making that happen are ones for some time?

**Humza Yousaf:** Yes, absolutely. There is engagement with the airlines and, in particular, the airports. I do not know whether they have put out a public comment, but when they were telling us about the media requests that they were receiving on this, they were certainly going to point to positive and constructive engagement. I think that the airports will be pushing us to ensure that they are not at a competitive disadvantage, and I can understand that point. My colleague, Michael Matheson, will of course be engaged in that discussion.

**The Convener:** On the evidential basis, I understand that you are waiting for some further information from the UK Government on that. Again, there will be a view that the general scientific and medical advice that is received by you and your colleagues in the Scottish Government will not be different in essence from the advice received by the UK Government, although it may differ in detail. Is there any fundamental problem from the point of view of the

Scottish Government in proceeding with the proposal, assuming that the detailed advice is compatible with your own analysis of the situation?

**Humza Yousaf:** There certainly is not an in-principle or ideological objection. If we can align with others across the UK on a test and release basis, we would want to do that. Our position is based on the logistics and the clinical advice. When I talk about clinical advice, it is also about the efficacy of what we are doing.

Rightly, there have been probing questions—including questions from this committee—about compliance around the 14-day self-isolation period. I have been up front about the fact that, although spot checks are done by Public Health Scotland and there is follow-up by Police Scotland, there is no doubt there are questions about how well the 14-day isolation period is being complied with.

Although 14-day self-isolation is the most effective measure, the question is whether, if there were a shorter period, people would be more likely to comply with that, which would make it an effective measure. That is what the UK Government's argument is. I think that there is some logic to that. What we are asking for is to be shown the evidence base for that. The issue is not just clinical; it is about behavioural psychology and so on, and we would like to see that evidence base. If the evidence supports the test and release proposal, I can absolutely see the logic of moving ahead with it.

**The Convener:** Thank you, cabinet secretary. Donald Cameron will ask the next question.

**Donald Cameron (Highlands and Islands) (Con):** On the same topic, would it be your ambition to mirror what is happening in the rest of the UK? If you are satisfied, would you see the sense of applying the same regime across the four nations of the UK?

**Humza Yousaf:** The short answer is yes. I should say that it is not happening in the rest of the UK. At the moment, it is happening in England. I know that Wales has similar concerns. I could not state Northern Ireland's position; it is still to take a view. Certainly, in principle, it would make absolute sense for there to be alignment across the four nations and it would be preferable for that to start at the same time, if possible, but I know that you understand that we also have to be guided by our clinicians and the clinical advice that we receive.

**Donald Cameron:** I have a rather technical question about the sovereign bases in Cyprus that you mentioned. Could you give a bit of explanation about the situation in that regard? I think that I am right in saying that Cyprus was removed from the exempt list at the start of November and the

military bases were, effectively, kept out of that. Now, however, they are also being removed from the exempt list. Can you flesh that out a bit?

**Humza Yousaf:** I can. There were a lot of interesting discussions about this. As you say, they are sovereign bases, so they were not included when Cyprus was removed. Of course, you will know about British military interest and assistance in Cyprus over the years. There was just a question about whether including Akrotiri and Dhekelia in the exemption would cause any problems for the Ministry of Defence. That was why they were not removed in the first instance, but when the MOD was able to confirm that removing the sovereign bases would not cause it any issue, the decision was made—to make it a lot neater, frankly—to remove them. To be honest, it does not make much of a difference anyway—certainly not to Scotland—but we were conscious that we did not want Scotland to make one decision that might impact the MOD or armed personnel in other parts of the UK. Once we got that sign-off from the MOD, we were more than comfortable about removing the sovereign bases. We were just waiting for the MOD's approval.

**The Convener:** Emma Harper will ask the next question.

**Emma Harper (South Scotland) (SNP):** Good morning. The UK Government's website says that the cost of the testing strategy for international arrivals will basically be provided by the traveller, and that all testing will be done by private labs, although those labs will be approved by the UK Government. Could you say a couple of words about that? I am also interested in continuing to ensure that whatever we do is evidence based and driven by the fact that we need to protect people's lives. We need to use the evidence to inform decisions that are made.

**Humza Yousaf:** In short, there is agreement across the four nations. I do not think that I would be speaking out of turn at all if I said that we all believe that the cost of the test and release system should be borne by the traveller. If there is some kind of arrangement with the private sector, that is fine, but the essence of the proposal is that it should not infringe or impact in any way the NHS testing capacity. There is not a good justification for using NHS testing capacity—although we might have that capacity—for the benefit of people going to the Canary Islands for some winter sun. We are all aligned on that basis. That is why it is important, from a Scottish perspective, do to do the logistical work to see whether we have sufficient private sector capacity. That work is ongoing.

10:15

There is nothing for me to add on the evidence base, other than just to reiterate what I have already said. We are keen to move on a four-nations basis. There is a lot of sense in that, but we just need a little bit more understanding for the evidence base of the proposal. I am sure that it will be forthcoming. I would also like, as you would imagine, to continue to take views from our own CMO, particularly around the timing.

From what I am told by transport colleagues and Transport Scotland, based on their engagement with airlines, I understand that they expect only a modest uplift in passengers travelling this winter, so the timing issue may become a little bit more moot. However, I still want to make sure that we are exploring all those issues.

**The Convener:** There are no more questions from members, so we will now move to agenda item 2, which is the formal debate on the made affirmative instrument on which we have just heard from the cabinet secretary. I remind members and others that this is a formal debate. The officials will not be taking part in the debate and no questions can be put to the cabinet secretary. However, of course, if members wish to contribute to the debate, they are more than welcome to do so.

I invite the cabinet secretary to move the motion S5M-23365.

*Motion moved,*

That the Health and Sport Committee recommends that the Health Protection (Coronavirus) (International Travel) (Scotland) Amendment (No. 23) Regulations 2020 (SSI 2020/378) be approved.—[*Humza Yousaf*]

*Motion agreed to.*

**The Convener:** The motion is approved. We will report to Parliament accordingly. I thank the cabinet secretary and his officials for their attendance this morning.

### **Food and Feed (EU Exit) (Scotland) (Amendment) Regulations 2020 (SSI 2020/372)**

**The Convener:** The next item is also consideration of subordinate legislation—this time, a negative instrument: the Food and Feed (EU Exit) (Scotland) (Amendment) Regulations 2020. Members will note that, in the briefing paper provided, it is suggested that we might wish to explore how the new functions conferred by the SSI on Food Standards Scotland—particularly those that relate to third countries—will work in practice. We might also want to ask what will replace some of the existing powers that are being revoked by the regulations. The suggestion in the paper is that we can either write to the Scottish Government to make those inquiries, while

agreeing to make no recommendations today, or await the Government's answer and then consider the matter further.

**Sandra White (Glasgow Kelvin) (SNP):** I have read the paper and agree with the recommendations. There are a couple of things that I want to raise, which are mentioned in paragraphs 6 and 8 of the paper. The Delegated Powers and Law Reform Committee is looking at the instrument today and we do not yet have its answer as to whether there are any matters that it wishes to raise. The paper mentions that, if we agree to the instrument today and any matters are raised by the DPLRC, it can come back to this committee. I ask for a wee bit of clarification on that. If the instrument is agreed to and then the DPLRC raises concerns regarding it, how does that work in the legislative process?

**The Convener:** It is not a problem in the sense that the DPLRC's role is to consider technically the compliance and so on of the regulations. Clearly, it would be a problem if the issues that it raised called into question the substance of the regulations themselves. However, the paper does not suggest that there is anything fundamentally at risk in our passing the regulations, although it does raise technical points.

It is, of course, open to us to decide, and perhaps, in response to Sandra White's suggestion, we could contact the Scottish Government today with the questions that we want answers to. We could then postpone our final decision on the instrument until we have heard from the Government and the DPLRC—I am certainly relaxed about doing that. We do not have to sign off the regulations today. Anytime over the next couple of meetings will be soon enough, because they relate to changes that will come into force in due course and not immediately.

**Emma Harper:** The paper says that the statutory instrument confers new functions on Food Standards Scotland and local authorities, and there is a list of the new functions. If we are going to assign new functions to Food Standards Scotland, do we need to be concerned about resourcing issues such as whether there are enough staff to cover the new functions? Is this to be just another burden on Food Standards Scotland, which we did not have before exiting the European Union?

**The Convener:** That is a very fair question. The paper suggests that we might want to know how the new powers that relate to third countries will work in practice, given that Food Standards Scotland does not operate in third countries. We can add to that question the question of whether Foods Standards Scotland and local authorities will be resourced to deal with the new powers that are conferred on them by the regulations. Again,

we can make a decision on the instrument at our next meeting or the meeting thereafter if we get the answer to those questions in time.

If members are agreed, that is what we will do. We will write to the Scottish Government, asking what the intention is in revoking the regulatory power for use when a third country may have caused concern and how that power is to be replaced. We will also ask Sandra White's question about the concerns that may or may not come from the DPLRC and Emma Harper's question about the resources that are available to Food Standards Scotland and local authorities. Finally, we will ask how Food Standards Scotland's responsibilities in third countries will be carried out in practice. With all of that information, we should be in a position to consider the instrument again at a future meeting. We have to clear it before Christmas—that is the timescale that we are working to, so it does not have to be dealt with today.

Are we all agreed that we should take that approach?

**Members indicated agreement.**

**The Convener:** Thank you very much.

## Social Care Inquiry

10:23

**The Convener:** The fourth item on our agenda is a round-table session as part of our social care inquiry. Today, we are hearing from people with a prominent role in the delivery or commissioning of care. I welcome to the committee Joanna MacDonald, chief officer, Argyll and Bute health and social care partnership and chair of the Social Work Scotland adult social care committee; Viv Dickenson, chief executive officer of CrossReach; and Cassie Hersee, manager of Isle View Nursing Home in Aultbea. I welcome all of you to the committee. I invite each of you to introduce yourself to the committee and say a word or two about the areas that you hope to address today, starting with Joanna MacDonald.

**Joanna MacDonald (Argyll and Bute Health and Social Care Partnership):** Good morning. I am pleased to be here. I am chief officer in Argyll and Bute, which has 23 inhabited islands, and is very remote and rural. It has been an absolute privilege, particularly over the past eight months, to see the work that has been going on across health and social care, in particular around adult social care, so I am pleased to be part of the discussion this morning.

In relation to my role as chair of the Social Work Scotland adult social care committee, we went virtual with our meetings in the spring when Covid was pending, as many groups did. We have been meeting monthly and, because of that virtual approach, we have had more engagement across the whole of Scotland, particularly in relation to people not having to travel from our islands. I will talk about this later in our discussion, but it has been an important forum for people from different local authorities with mental health, learning disability and physical disability backgrounds as well as touching on community justice and adult social care—we support people who are ageing as well as people who are offending.

That monthly meeting has become invaluable and we will be continuing with that post-Covid. An average of 20 to 25 local authorities attend the meeting. It has been invaluable with some of the quite wicked issues, particularly earlier on in the pandemic and in relation to looking to the future and what adult social care can provide, so I am delighted to be here to talk about that.

**Viv Dickenson (CrossReach):** Good morning. I am pleased to be here with you this morning. I am the chief executive officer of CrossReach. CrossReach is one of the largest and most diverse voluntary sector care providers in Scotland. It has been around for about 150 years and it supports

people with a range of challenges, abilities and disabilities to live as normal a life as possible. Our work in adult care spans homelessness, criminal justice, learning disabilities, addictions, mental health, dementia and older age. We also provide children's services and work with people in transition between children's and adult services. Although much of our work is commissioned, complementing the statutory provision, we also have a lot of charitable work going on, which focuses on early intervention and prevention.

We employ around 1,700 staff, mobilise around 300 volunteers and provide support to over 11,000 people annually. I am delighted to explore some of the tricky issues with you that Joanna MacDonald was talking about around service commissioning and staffing, but principally about supported people, who should be at the heart of this.

**The Convener:** Thank you very much. Cassie Hersee is next. We are not quite hearing you, Cassie.

**Cassie Hersee (Isle View Nursing Home):** Can you hear me now?

**The Convener:** Yes, we are hearing you perfectly now.

**Cassie Hersee:** I manage a 25-bed nursing home, as opposed to a care home, in the remoter area of the north-west Highlands. Hopefully, I represent the views of many of the other nursing home managers in the region. Our nursing home is probably slightly different, in that we take people with dementia; we also take people in need of palliative care and serve the local community, given our remoteness and the inaccessibility of resources to us. My contribution today will be mainly around the response to the Covid pandemic and how it has impacted on our work and what the future will be for health and social care post-Covid. I am delighted to join in the discussion.

**The Convener:** Excellent—thank you very much. It is great to have you all here. We have heard from users of services and we are keen to make sure that their voices are heard in whatever decisions the Government makes. We are keen to ensure that your voices are heard too. As I indicated earlier, I would encourage members of the committee and witnesses to put an "R" in the chat box when you want me to call you. I will start by asking Emma Harper to kick off on self-directed support. After witnesses have responded to Emma Harper's line of inquiry, I will come to David Stewart.

**Emma Harper:** Thanks, convener. I am interested in self-directed support because we heard last week about how it can be applied differently. I am interested to know about how different local authorities implement self-directed

support. We heard that it can be quite popular and it can be understood as a route that should enable people to be involved in decisions about their care.

10:30

In his evidence last week, Jim Aitken basically said that self-directed support was a “postcode lottery”, using that as negative terminology. I live in a rural area, but self-directed support in urban areas might need different approaches. Can you give me some examples of how you feel self-directed support is or is not working?

For me, for instance, a postcode lottery might be a good thing, because it allows local authorities to determine the best approach for self-directed support in particular areas, such as across rural regions.

**Joanna MacDonald:** Thank you for that question. It is fair to say that self-directed support is delivered differently across Scotland and that reflects the different services and opportunities that there are, which vary greatly between urban and rural areas.

There is a big piece of work going on at the moment on self-directed support inconsistency, which is being hosted by Social Work Scotland on behalf of the Scottish Government. This work was presented to the Convention of Scottish Local Authorities a couple of weeks ago. It is looking at how we standardise the principles of self-directed support, which are all about rights, respect, relationships, recognition and empowering individuals.

From my perspective, the original legislation articulates that very clearly, but we have had a challenge in embedding that across the whole of Scotland. The self-directed support inconsistency group has a key role around developing a set of standards that have been discussed with chief officers and with COSLA. They will be going back to COSLA, and the standards will also help to inform the review of adult social care.

One of the areas that is quite challenging when we look at consistency of service delivery is around funding and different local authority funding. That is starting to become a concern as we are all starting to work on our budgets for next year. The question is how we fund the services in a preventative and proactive way, when perhaps there is not the level of funding that would enable us to do that.

The principles behind the self-directed support legislation are about really working with individuals. It is about good old-fashioned social work, to do with developing relationships, understanding what is important to them and what

matters to them as well as what is the matter with them. That is important work that is progressing.

The spotlight that has been shone on adult social care during Covid is welcome because we are seeing some of the really good innovation, but we need to see that happening across the whole of Scotland. It is fair to say that I am always concerned about a postcode lottery; I think that there are postcode variances at the moment.

**Viv Dickenson:** Our experience—we work from Shetland to Galashiels—is that self-directed support can be implemented quite differently in different parts of the country, but what is pretty standard is that it is not well implemented at all in terms of people having direct budgets and control and choice over the types of services that they would like, or the way in which they wish to live their life and whoever they need around them to support them.

This should not all be about services; it should be about choice and control for individuals. That is a tricky thing to get right when local authorities have budgets and standard commissioning practices. I welcome the work that Joanna MacDonald is doing on standardisation and implementation of self-directed support, because I think that it will be important for the future.

One area where it is not terribly well implemented at all is care of older people. I would be happy to talk a bit more about that, but certainly in other services, there is quite a range in the way that it has been implemented.

**Emma Harper:** Thanks for your answers so far. In David Bell’s submission, he talked about the vast majority of recipients of care and support being elderly people. If we are talking about streamlining some of these challenges, including perhaps bureaucratic processes, the role of HSCPs is important in improving self-directed support. How are we streamlining things in a more expedited way?

One of the witnesses last week said that, for him, self-directed support

“has given me back my freedom and my life”.—[*Official Report, Health and Sport Committee, 17 November 2020; c 5.*]

I would be interested to hear whether we want to continue to support more engagement with self-directed support and not necessarily have the local authorities have tight bureaucratic control over everything.

**The Convener:** Which of our witnesses would like to answer that? Viv Dickenson might have a bit more to say about older people, but I will come to Joanna MacDonald first and then come to Viv.

**Joanna MacDonald:** Most adult social care has been delegated to the HSCPs, which has enabled a lot of innovation. From my perspective, when we are getting down into the nitty-gritty of self-directed support, there is still a bit of a lack of understanding from the public as well as from others around what adult social care is. It is important to explain—as we all know, and as the committee will know—that adult social care encompasses very complex personal care, including catheter and stoma care, management of medication and complex dementias and complex behavioural management. That is all encompassed in the terminology, “adult social care”. At times, that complexity can be a challenge when we are looking at person-centred care and, as Viv Dickenson mentioned, looking at maximising choice, flexibility and control, which underpins the legislation.

Managing carers’ rights against the rights of the cared-for person has been quite challenging—more so during Covid, but it was an issue before. They will have different wishes and different views. That is a huge piece of work.

**Viv Dickenson:** I do not disagree. It is incredibly complicated to get this right, but the fundamental point is about education and about people really understanding what adult social care is. It is about relationship building and it is about supporting people to live as normally as possible.

In terms of older people, if I can go back to that point, what happens is that the family does as much as they can for as long as they can and then a crisis point is reached. It is then not clear even what choices the family has in that situation. I can talk about this as a provider of services, but also as an individual with a mum with dementia, who has just been through quite a journey. Even for me, as somebody who knows all about this stuff, it was incredibly difficult to have those conversations about how you get an individual budget or what choices you can support that person to make for the best for their own lives.

The public at large are not clear about the benefits of self-directed support and not clear about the conversations that they could be having, whether that is a supported person or somebody who is supporting them to make good choices for their lives. I do not quite know how we crack that. I know that Joanna MacDonald’s group is working on the standards, but how do we work on the more fundamental point of the need for education and understanding?

**Cassie Hersee:** I just—*[Inaudible.]*—what Viv Dickenson was saying there. Most of my residents who are admitted to the nursing home come in because it is a crisis situation. It is very rare that anybody comes in in a planned way. It is usually a crisis; it is usually an emergency. It is a request for

immediate support and we do everything possible to enable them to come in and calm things down a little bit. The fact that everything is becoming a crisis before people arrive reflects what is not happening in the community. That information needs to get out there to the general public so that they know what to do at each stage, so that we are not firefighting all the time.

**Emma Harper:** Joanna MacDonald is working on adult social care services and looking at how we roll services out. I presume that we will be able to assess which local authorities are doing great on streamlining and making sure that people have choices and the ability to get the package that they want. Is it part of the role to take the best practice in areas and look at how it can be shared?

I heard an example yesterday where social prescribing was being presented to a local group in Dumfries and Galloway, but many people who were attending the meeting did not know why they were even in the room learning about social prescribing. In order for a health and social care partnership to present best practice, we need to ensure that everybody is on board and knows what self-directed support can offer.

**Joanna MacDonald:** That is a really good point. As Cassie Hersee said, a number of people are coming into care homes at points of crisis. That is difficult for them and their families and it is something that we want to prevent.

There are some fantastic examples across Scotland, including in the Borders, Dumfries and Galloway and Falkirk. We have examples in south Argyll and Bute of people being able to access advice and guidance not in a traditional social work office, but in community cafes or even supermarkets. They can drop in, have a cup of coffee, have a discussion and not feel that they are being judged in any way. Huge benefits have come out of that.

At times, perhaps even at the beginning of the assessment process, budgets or the worry about budgets will drive what the potential outcome can be. When we support carers, in particular, and organisations that deliver care, it is important that they are able to say at the earliest opportunity where things are not working so well and ask what support they can access. That could be basic things such as getting their benefits maximised and making sure that they have access to funding.

As I said, it has been beneficial to have the profile during Covid, but there is still a lot of work to do across Scotland. We need to educate the public, but also, probably, re-educate our staff on the self-directed support legislation and the intention behind it.

**David Stewart (Highlands and Islands) (Lab):** Good morning. I have two main questions—one

on consultation and one on care at home. First, on consultation, how do we involve the public in the planning and commissioning of services? I am particularly interested in how we involve older people.

**Cassie Hersee:** My answer is that I do not know, just as nobody else seems to know. Again, it is about community engagement, but it needs to start at a much earlier stage, almost before the social workers need to become involved. I think that a huge piece of education needs to happen with nurses, care staff and doctors' surgeries so that they can give out the information at a very early stage. As I said, we should not wait until somebody is at a crisis point, because that will not be a time when they can absorb information. It needs to happen earlier.

**Viv Dickenson:** There are some models out there that you could look at. A lot of work was done to consult care-experienced children in the recent care review, and before that, the big blether that was run by the Children and Young People's Commissioner Scotland tried to get children and young people to engage on issues that are fundamental to them, such as how they want to live their lives and, if they need support, how they should be supported. It is not too much of a leap to ask whether we can draw on such models and engage with older people in that way.

One of the difficulties is that we do not have an older people's commissioner who is trying to pull such conversations together, but it seems to me that we need to have that debate very early on.

I think that older people are sometimes a bit frightened to talk about the subject because they think that the answer will inevitably be a care home. Care homes can enhance people's lives. My mum has gone into a care home in the past 18 months and she is thriving there in a way that she was not in the community in the latter stages of her journey with dementia there. However, people can be terrified early in the conversation about care and support that a care home will be the automatic answer, and at an earlier point than they would like.

I think that a careful conversation needs to be brokered by something like a commissioner, in the same way that children's services have organically done that and had a real intention and focus on making sure that people's voices are heard.

10:45

**Joanna MacDonald:** Our community councils and local elected members are pretty powerful advocates for their communities, and for older people in particular. During Covid, we have seen fantastic work involving their local intelligence around caring for people and the basics around

people who were lonely, who were struggling to get their prescriptions and who were struggling to look after themselves. In Argyll and Bute, I am so proud of the work with the third sector interface in particular and the way that it harnessed all those resources across communities and worked with the council and the HSCP to care for people and ensure that they had basic support.

Through that work, we also found an untapped resource around volunteering. In Argyll and Bute, we have a population of 86,000, and we had over 1,000 people volunteering to participate in caring for people, who then fed back that it really enriched their lives. The terminology around older people is interesting. When we speak to older people, they always think that the term refers to people who are older than them, but we had a number of people in their 60s and 70s participating, which was really valuable. They were picking up prescriptions, popping out to speak to people on their doorsteps and seeing their neighbours, and they have continued to develop those relationships.

We are looking to see how we can continue that and expand it. For me, preventative services are about that initial contact and about connecting older people, who can be quite isolated in their homes, particularly if they lose their loved one. There has been loads of learning through Covid.

It is important to hear the voices of older people. I have met numerous people at lunch clubs—predominantly women in their 80s and 90s—and, when I talk about power of attorney or their home, the majority say, "Yes, I'll do that when I need it." They always see it as something that is not the priority at the time. That is a difficult one for us to crack.

As I said, community councils, elected members, the third sector interface and our voluntary sector are out there. As we have seen through Covid, harnessing all that information is really beneficial for older people.

**Cassie Hersee:** I agree with Joanna MacDonald and Viv Dickenson that sharing and disseminating information to the relevant people is important. However, at the end of the day, it comes back to having the resources available. I have people in my nursing home now who should not be there, but there are no resources available in the community for them to receive the type of support that they would benefit from. My fear for them is that they are inappropriately placed, but there is nowhere else for them to go.

**The Convener:** I think that that is an underlying concern that we are keen to explore further.

**David Stewart:** The witnesses have brought me nicely to my other question. I am interested in changing the mindset of care at home. For

example, I have been working with a Shetland general practitioner to introduce a policy of the right to die at home. That would obviously involve follow-on services, which are crucial. Joanna MacDonald will be familiar from her time in the Highlands with the fit homes project, which involves sensor-based accommodation so that movement can be monitored. The accommodation is barrier free, with sinks that can be dropped, and it has aids and adaptations.

If we get home settings right, which will involve resources and perhaps a change in philosophy, will that not cover the point that Cassie Hersee made? We might prevent some inappropriate allocation or inappropriate movement towards care homes. Care homes are important, but I think that there is an element of inappropriate allocation of individuals to residential care when, frankly, they want to stay in their homes.

**Joanna MacDonald:** I agree entirely. Their housing can be the primary reason why someone has to move out. The care is a huge element, but the house is as well, because it can become a place where they cannot live.

There has been fantastic work across Scotland, including in the Highlands, as Mr Stewart mentioned. That is good in the areas where it happens but, again, we do not have a whole-system approach. We are doing work in Argyll and Bute, again building on what worked well during Covid. There is investment in housing in many parts of Scotland, and we certainly have investment here in Argyll and Bute.

We have established a housing, health and social care group to inform the design and build of our new accommodation so that we can have accommodation that is fit for older people and accommodation that is fit for our care-experienced young people when they move out of their accommodation and into their first home, which can be a really difficult time for them. It is about harnessing the experience and knowledge of occupational therapists, physios and others, who are the first to say, when someone is moving into a care home, "If we had done things upstream and earlier, we could have prevented this."

As I said, the decision that a loved one should go into a care home is a really difficult one. As Viv Dickenson said, when people move into a care home, they inevitably enjoy it—they are well cared for, they are not lonely and they have lots of social supports—but it is a big decision. If people do not have to make that decision because the right care and the right accommodation are in place, that really does get underneath everything about human rights and supporting people to have a choice.

**Cassie Hersee:** Nursing homes and care homes are experts on dementia care, but there are many times when there is no reason for somebody with dementia to be in a nursing home. There is perhaps some scope to look at whether nursing homes could be supported or funded to provide more of an outreach service to enable community resources to manage what can be quite difficult behaviours within somebody's home environment.

Nursing homes are big places and there is room to wander and so on, but people with dementia can be managed in their homes if there is the right input. We need to use the knowledge and expertise in our nursing homes to provide that link into the community support that is on offer.

**Viv Dickenson:** I agree with Joanna MacDonald and Cassie Hersee. The availability of support is critical. I know of numbers of people who have not been able to get the support that they needed at the point when they needed it. When we see a potential crisis looming with an older person, we can go to the local authority and agree a support package, but it will often say, "You'll have to wait because we don't have carers available in the area at the moment." The family then has to make a choice about whether to fund the care privately. If the situation goes to a point of crisis and the family cannot afford to fund it privately, that is probably one of the things that precipitates an earlier journey into a care home than is necessary.

The Life Changes Trust has done quite a lot of work on dementia-friendly communities. I agree with Cassie Hersee. People with dementia can live independently and happily in the community for a long time. There are a couple of things that we should do in that regard. We should build on the work of the Life Changes Trust and its work on dementia-friendly communities, but we should also do something about the stigmatisation of dementia, which still exists in our communities. That is quite a big conversation and one that we are still to have.

**Donald Cameron:** Good morning. It is great to see and hear from the panel. My question is an overarching one about integration. Will each of you give a frank health check on what you think of integration, given that we have now had it for five or six years. How is it working? Particularly given the Covid pandemic in the last nine months, how has it withstood the stresses and strains that have been placed on the system?

**Viv Dickenson:** Our experience of integration has been pretty mixed. I think that something about the value of social care has got lost in the middle of integration. My sense is that we are getting quite a health-led approach in a lot of areas. I see that coming down in a number of

ways, but principally to our staff, who are being directed to care in a much more clinical way than they did previously. That is tricky.

Integration should be about holistic support that gets medical support to people when they need it, but recognises that people are people and not patients and that, even when they are living in challenging circumstances and have disabilities, the primary thing is to treat them as people and give them as much choice and control as possible.

I think that integration has stalled a bit. I do not think that it has delivered what we hoped it would deliver from the start. It still has a bit of a journey to make, but I think that it still holds the key to that holistic approach if we can get the implementation right across the board.

**Cassie Hersee:** I totally agree with Viv Dickenson, although I think that she is being a little too kind. I worked in social work and commissioning before I moved into nursing home management. I know what health and social care integration was supposed to be, and I do not think that it has happened. I think that we are all still operating as separate entities. That agenda needs to be revisited.

**Joanna MacDonald:** It is a mixed picture. In Argyll and Bute, as part of integration, we have adult services, children's services and community justice in the health and social care partnership, which has meant that, particularly over the past eight months, we have been able to be more flexible and work with our communities differently. We have all of health and social care, including acute care, which we commission with Glasgow.

It is probably fair to say that the profile of healthcare has risen during Covid. That is understandable, as it is a pandemic. However, as I said earlier, I am not sure that there is a complete understanding of the role of social work and social care. Some of the best work that we saw during Covid was where people did not have any direct care and support services, but they had mental health services, children and family social workers and adult social workers supporting them through the real concern and isolation that they experienced.

There is still a lot of work to do on integration, on self-directed support and on how we protect and promote the rights of the majority of people, who live not in care homes or hospitals, but in their communities. That focus on the community has not been there.

On care homes in particular, it was a supportive measure—and we welcomed it in Argyll and Bute—when the directors of public health and of nursing were asked to come in. However, there was an initial feeling of, almost, “What have we done wrong and what do we need to do

differently?” We all recognised the need for improvement, but the approach came in very quickly and, from a chief social work officer perspective, it felt like someone was saying, “Perhaps you need that additional support to manage care homes and ensure that you manage them through the pandemic.”

As Cassie Hersee said, our care homes are the homes of individuals. That is where their life is and they should be able to have things like carpets and opportunities and friends. During the pandemic, people who live in care homes have been brilliantly supported by the staff there, but they have been vulnerable in relation to the prohibition on access to friends and family. We are now in a situation where families and friends are anxious to visit. However, the staff have been outstanding during the pandemic.

11:00

**Donald Cameron:** Thank you for those frank answers, which are much appreciated.

Looking forward, the committee is considering the prospect of a national care service. In some regards, that seems to be if not reversing the process of integration at least encouraging us to think of the health service and the care service as separate entities. What are your views on that? Would you like the process of integration to continue and be sped up? What do you feel generally about the future?

**Cassie Hersee:** The idea of a national care service was probably first mooted in the early 1970s or the late 1960s—I know, because I go back that far. It is a brilliant idea, but it will require a huge amount of funding. If we go down that road, we must be careful that we do not lose the expertise that is already out there by thinking that we can get rid of it now that we have a national care service. We should not forget about all the good stuff that is going on at the moment. The knowledge and the skills that we have now must be at the forefront of developing any national care service, and the funding has to be there. If the funding is not there, it will not work.

**The Convener:** It is about resources, resources.

**Joanna MacDonald:** I agree with Cassie Hersee. I think that, when the Social Work (Scotland) Act 1968 came in, there were moves around a national care service. It is important to have national overview and oversight, so that would be welcomed. On local authorities' roles and responsibilities on commissioning, although I manage an HSCP, I would not want that to be taken away from local authorities. However, national providers have to negotiate every year with up to 31 HSCPs or 32 local authorities on

commissioning and are paid at different rates, which seems inherently unfair and a huge amount of work for them.

As a chief officer, I probably spend too long on finance, if that is the right way of phrasing it. I spend an awful lot of time on finance. We are already looking at what next year's budget will be. The one-year funding does not help us with innovation and working differently. It would be welcome to have a national overview through a national care service, but I would hate to see the expertise and skills in the voluntary and private sectors not being welcomed into that fold.

**Viv Dickenson:** I would like to know a bit more about the national care service proposals, because I do not think that we have yet had a definition of what it will look like. If we had that, I would probably be more able to comment.

I agree with Joanna MacDonald that there are benefits to doing things nationally, but there would also be challenges. There would be benefits through national collective bargaining for the staff on conditions. The staff are wonderful. In what the committee heard last week, there was lots of talk about the processes and the systems, but there was a universal regard for the way in which people are supported by social care staff. It is right that we look after and value the staff. If we do not do that, we will not get it right for supported people.

Given the experience with implementation of the living wage, there would absolutely be a benefit if we did not have to negotiate with local authorities 32 times on the terms and conditions for staff or think about whether we can implement them with the provision that we get. Staff training would probably benefit from that overview and there might be an effective voice for the workforce within a national care service.

I would, however, be worried that pathways for support would become homogeneous and that people would not have so much choice. Those barriers would have to be overcome. I also wonder how a national care service would sit with the principles of self-directed support.

Those are some of the questions that I have. As I have not seen anything outlining the principles, it is tricky to comment, but I think that it would provide as many challenges as opportunities.

**Joanna MacDonald:** To come back in on integration and the national care service, as a chief officer, it is difficult when we get to commissioning and looking at next year's budget to see differences nationally in relation to how healthcare and social care staff are valued. As a chief officer, I manage health and social care staff—I have 1,500 health staff and 770 social care staff as well as the services that I am commissioning—and it is difficult when there are

proposals on salary protection for healthcare staff but that protection is not in place for social care.

We have a real opportunity in Scotland to stand above that. However, whenever we try to integrate and say that all staff are equal and are valued, there are issues with wages and salaries, national negotiations and with clapping for the NHS but not for social care. All of those things have the right intentions, but I am afraid that they can make the social care sector feel devalued.

**The Convener:** You have opened up an important line of thought. I want to hear again from Cassie Hersee and then from Viv Dickenson.

**Cassie Hersee:** Joanna MacDonald has hit my bugbear on the head. As a nurse who trained in the NHS, worked in the acute sector in the NHS for years and then moved into nursing home management and care in nursing homes, I feel like a second-class citizen. I think that most of my nursing colleagues would agree. Our role in dementia care, which to me is important and valuable, is not perceived in the wider population as being as important as front-line nursing in accident and emergency. That is demoralising. Our pay is less, because the funding is not there, and our esteem needs to be given back to us, because it has very much been taken away.

That has been highlighted through Covid. The NHS has very little contact with us normally. The most contact that we would have would be when a resident is admitted with a hip fracture and the hospital will be on the phone to us within 12 hours saying, "Can you take him back? We cannot cope with him." That is the normal amount of contact that we get from the NHS. Now, during Covid, it is suddenly throwing all this information at us as though it is an expert in dementia care and telling us to do things that we know are not possible, such as isolate people with challenging behaviour in their rooms, and treating us as if we do not know what we are talking about.

We know what we are talking about. We are as qualified as any NHS staff. That perception of nursing and caring in a care home needs to change radically, because otherwise we will not attract nurses and good care staff to care homes, because of the perception that it is somehow second class.

**The Convener:** Thank you. It sounds as though we should all dedicate our efforts to changing that. That is one of the issues on which I am sure the committee will want to draw some conclusions.

**Viv Dickenson:** We have 17 care homes, but it is not just in care homes where social care staff feel undervalued. The issue runs through the heart of the report "Fair Work in Scotland's Social Care Sector 2019". Social care staff report that they often feel valued by their organisation and the

individuals who they support, but not at all by society because, on the whole, society does not understand what social care is about. I am sure that the committee is aware of the recommendations in that fair work report.

I agree with Cassie Hersee that social care staff are highly trained, highly skilled and highly experienced, but they are not well paid, and they are not well recognised or well protected by terms and conditions. Even in the coronavirus legislation, hospitals are protected from decisions that they take in terms of coronavirus deaths and the way that they work with coronavirus in hospitals, but that has not been extended to social care and it certainly has not been extended to care homes. Care home managers across the country are absolutely terrified at the moment about prosecution. On that ground alone, we can see the inequality that exists. That makes integration hard, and it makes the lives of care staff very hard.

It would be great if the committee spent time and energy on thinking how we can get things right for staff, both on the front line and for progression. The differentials have been squeezed for care staff. Who in their right mind would progress at the moment to take on massive responsibility in a care home or anywhere else? I take my hat off to those who do so, but the conditions under which they work are very tough. A bit more recognition of that has come about during the pandemic, but I am frightened that it will go again just as quickly. Time is of the essence in tackling some of those issues.

**Brian Whittle (South Scotland) (Con):** I want to ask about innovation and flexibility, which the pandemic has highlighted. At a previous meeting, I was struck by a comment from Eddie Fraser when he stressed the importance of activities, including intergenerational activities, and said that the absence of such opportunities has had a profound effect during the pandemic. It seems obvious that the pandemic will have led to a greater incentive to innovate and be creative.

As we have Viv Dickenson on the panel, I want to highlight the work at Morven day services in Kilmarnock, which is a mental health drop-in centre. Of course, that relies on people and integration, but the centre has not been able to do that during the pandemic and has had to think of other ways to communicate. I ask the witnesses to give us some examples of how the pandemic has driven innovation.

**Viv Dickenson:** The two pivotal points for us throughout the pandemic have been keeping people protected and keeping them connected. Protection is very important. We want to keep all our valuable people as safe as possible, but at the outset we recognised that that would be challenging for many of them, because it would

mean isolation. We have worked to do everything digitally as far as possible. That is what we have at Morven day services. We have put informal support in place and we have been feeding communities from our schools and working with vulnerable families. We have put iPads and digital devices in every care home in order to keep people connected with their families as much as possible. All our counselling services have gone online.

The staff have been remarkable in responding to the needs of individuals and innovating as far as possible. Joanna MacDonald talked a bit about that. It has been wonderful to see the support from the voluntary sector and community councils and people reaching out. It would be great if that can continue.

The constraints were moved. The commissioning barriers were suddenly moved a bit and, instead of saying to people that they needed 15 minutes of support to do something, it was more important to ensure that their wellbeing was being looked after. We have learned a lesson about removing some of barriers that standard commissioning puts in place and working with people to support them in the best way possible.

**Cassie Hersee:** In the nursing home, we have been very locked down because we have very vulnerable people but, where possible, we have utilised information technology systems—there has been FaceTime with families and so on. However, some within our nursing home have missed out—the people with advanced Alzheimer's disease or types of dementia that mean that technology is too much for people. For some people, iPads and FaceTime are too confusing. They just want somebody who they know and who is familiar to them to hold their hand, but that has not been possible.

11:15

**Joanna MacDonald:** To add to what Cassie Hersee and Viv Dickenson have said, during Covid I have heard the most heartening stories but also the most heartbreaking stories about people not feeling connected. The longer we have restrictions in place, the harder it is for families. Initially in lockdown, a number of families did not want social care staff coming in to provide support and wanted to do it by themselves. We have worked with them to encourage them to continue to have social care, but many of them, particularly those with caring responsibilities, are really struggling.

I heard from a number of people that the gap in their being able to visit their loved ones, particularly husbands and wives, in care homes meant that, when they made their first visit, even

though they had been trying to meet virtually, the person did not recognise them. People had to rebuild their relationships, and then there were further restrictions. We felt that in Argyll and Bute probably as much as anywhere else, because south Argyll and Bute borders Greater Glasgow and Clyde, where the numbers are significantly greater than those here in Argyll and Bute. That heartbreaking story of love and relationships, which underpins what social care is about, probably has not been discussed enough publicly.

The heartening story is that our staff, particularly our care home staff, who had such a spotlight on them for many months, have been absolutely incredible. They cared about the people who passed away in their care homes. Our care home staff are often families or surrogate families for our residents.

The innovation has been heartening, but the impact of the pandemic has been heartbreaking.

**Brian Whittle:** I thank the panel for those answers. A couple of things stuck out for me in relation to removing barriers and constraints. How do we continue that innovation and improvement? What lessons can we learn from the creativity that has been forced on the sector by the pandemic? Secondly, following on from what was just said, how do we ensure that fragile and crucial services can get up and running again post-Covid? Are we set up to do that?

**Joanna MacDonald:** We have spoken about health and social care services being different and about the value of health. When the pandemic started, the removal of barriers was an issue. If someone goes to the doctor, they get a prescription and they get that medication straight away. If someone is looking for social care, it is common that they will have an assessment—quite a complex assessment. They might have to wait for funding to be agreed, and when the funding is agreed, they might not have that resource. There are differences in the universal services that are provided.

Innovation at the beginning of Covid, when we were not questioning the cost of social care, because we were going through a pandemic and it was about keeping people safe, was invaluable and helped, across Scotland and certainly here in Argyll and Bute, to move us away from having a complex process. We have built into social care quite complex assessment and funding allocation processes. We moved away from that approach to one in which we asked, “What does that person need now to keep them safe?” That applied to personal protective equipment and to people’s social care and support needs. I think that that was huge.

We are trying to continue that approach, but, as I said, it is very difficult when we look at next year’s budget and the potential for social care funding not to be what we will need it to be. The approach during the pandemic was so refreshing; it put social care on a level playing field with health services, so that we were able to assess someone and provide a service straightaway, if we had the staff, without focusing first on the finances. The financial process has become too dominant in social care services. We do not see that in health services; as I said, someone goes to the doctor and gets a prescription, and no one questions how much that costs.

**Cassie Hersee:** I sound like a long-playing record, but it comes back to resources and funding. The situation in my home is that most residents are NHS funded, but we have some private residents and those residents are supplementing the care that the NHS-funded ones get. The amounts that we are receiving to support people are insufficient. I think that that has been highlighted throughout Covid.

**Viv Dickenson:** Removing the barriers is an interesting question and Joanna MacDonald spoke to it very well. We are a large voluntary sector provider, and in our case people just said, “Get on with it. Do what you can, support people as best you can and find ways of keeping them connected.” We have stopped competitive tendering during the pandemic, which has been a huge support and has taken a level of uncertainty out of the social care field. We could all learn from that. Is there something better than competitive tendering that we could do? I am concerned that that is all about to start again; we have seen signs of that.

We have also looked at funding more holistically. We have been freed up from treating people as packages and saying, “You can have this or you can have that”, and we have been able to say, “What is most important to you at this time in your life, in the middle of a global pandemic?” and deliver that. That has been incredibly refreshing. Working alongside families where we can, to make sure that things are rationalised and make sense, has been good.

That whole issue of the care home contract, which Cassie Hersee raised, is important. I do not know that that will change as a result of coronavirus, but it needs to be carefully thought about. In the third sector, we are being pushed to develop a more commercial model and take more and more private clients to balance the national care home contract. I have raised with Government that it should not be pushing the voluntary sector into that place; we should be there to support people regardless of their ability to pay or whether they come in under the national

care home contract. That is material to the longer-term discussion, although it is perhaps not central to the conversation about how we can remove barriers to care in future.

**The Convener:** Thank you very much. I want to address some of those issues, too.

**Brian Whittle:** Joanna MacDonald highlighted that the system is complex and that you work in a sector that is highly regulated. How do we balance that with the introduction of creativity, innovation and fairness, particularly between local authorities and providers? Quite a conflict is created when we try to put innovation and creativity into such a highly regulated system.

**Joanna MacDonald:** Social care is a highly regulated system. That is a huge advantage for us, which we recognised at the beginning of Covid. The staff who work in social care are registered with the Scottish Social Services Council, and the services that are delivered are, in the main, overseen by the Care Inspectorate. We can have a level of trust in the delivery of services because of the oversight that is in place.

The system is very complex at the moment, which makes it difficult for the public to understand. When people go through the process of assessment of social care entitlements, they have to evidence why they need that care and support in a way that is often then reviewed by others before funding is allocated. Such an approach does not respect our values and particularly our older population, who are vulnerable and often have less of a voice than people with no care needs.

The Scottish Government could do work nationally on that. Work is also needed on the national performance indicators, which are very much about hospitals, hospital discharges and A and E performance; in comparison, we see very little about social care, and very little investment in that regard.

If people are to understand social care, we must all step up and take responsibility for articulating what it is and what it does. As I said, the spotlight that is currently on social care, which means that everyone is looking at it, is really valued—so thank you.

**Emma Harper:** Our briefing paper mentions the Buurtzorg model. I am interested in whether health and social care partnerships are looking at home teams or other team models. For example, Dumfries and Galloway has developed a home teams model. According to the information online about Buurtzorg:

“Buurtzorg is a pioneering healthcare organisation established 12 years ago”,

which revolutionised community care in the Netherlands. The site gives statistics on how staffing is funded at ground level and the substantial savings that have been made in delivering care.

In East Lothian, ELCAP is looking at a self-management model and creating much leaner management structures. Do the witnesses have experience or knowledge of the development of self-managing teams or the Buurtzorg model?

**The Convener:** I encourage witnesses to address Buurtzorg, by all means, if it is something with which you are familiar. Please also address some of the more general points to do with the different approaches that Emma Harper highlighted.

**Viv Dickenson:** We have looked at self-managing teams, particularly in our community services, but we have some hesitation about how the model works in relation to regulation. There is quite a lot of work to do to unpack the staff registration and the regulation that are involved in health and social care if we are to develop that sort of model further. However, it is certainly of interest. It pushes power down as far as possible in brokering the relationship between the individual and the person who supports them and it allows people to support individuals in the best way possible. There is a lot in there.

There are other models. We are part of an alliancing model in Glasgow. There are alternative ways of commissioning that are worth exploring, but at the heart of them all—whether we are talking about Buurtzorg, alliancing or anything else—is collaboration. Collaborative commissioning, by which I mean working collaboratively with commissioning partners, the third and independent sectors and supported people, could be done much better in the future.

**Joanna MacDonald:** Buurtzorg and other neighbourhood ways of working have been a huge strength of integration. Approaches that bring together our health and social care staff—particularly to support older people—to work with and within communities, and nurse-led models, are now in place in many parts of Scotland. There are fantastic neighbourhood teams across the whole of Inverness, which provide 24/7 community support. Here in Argyll and Bute things look a little different because of our rurality, but we too have the neighbourhood team approach. As Viv Dickenson said, Buurtzorg and “neighbourhood team” are different ways to describe very similar models.

11:30

The approach is very empowering, because it takes us away from looking at whose budget we

need to spend on what—that relates to what I said about having to go through an adult social care assessment and look at the budget setting within the team. It is definitely the way forward. The evidence from Holland is unquestionable. The Buurtzorg teams have been in place there for nine years, I think. It is certainly a model that NHS Highland, NHS Argyll and Bute and other parts of Scotland have embraced.

**Cassie Hersee:** I do not have a lot to add, but it just occurred to me that the approach reflects some of the models that are used in acute NHS services, such as midwife-led units. I can see the value in it. It sounds great. Where do I sign?

**The Convener:** Thank you. Do the witnesses have thoughts on what needs to be done in communities to ensure that people are able to have access if they live independently in the community?

**Joanna MacDonald:** In Argyll and Bute, we were working hard on access prior to Covid, and we have been doing that more during Covid, which has given us a greater understanding of who are the more vulnerable people who live alone. We have been looking at meals, prescriptions, collections and so on. It has given us an understanding of our communities.

This goes back to the earlier point about how we get the public messaging out there about resources and services being there for people when they need them, at the earliest possible stage. Many people do not access support until they feel that they really need it. Covid was a real leveller, because we all had to be in lockdown and remain in our homes unless it was absolutely necessary, so it was about access to food parcels, support and phone lines to combat loneliness. That was a real opportunity.

We are building on the approach here in Argyll and Bute, but we have a long way to go, because if people are to have access to services they need to understand what support is out there. They also need to believe that they can expect support and that it is their right to have support when they need it. I do not think that we are there yet in our communities and our society.

**Sandra White:** I thank the witnesses. This has been an excellent session. I had a couple of questions, but you have answered them very well.

I want to mention access to information. The information is out there, but it is sometimes very difficult to get it to people—families who have not quite come to terms with the dementia issue, for example. When they read articles and so on, they become worried that their loved one will perhaps be taken into care. I think that, with dementia and Alzheimer's, it is difficult to explain that people do not want to take the person away, but want to give

as much help as possible. I wonder how we get around that—particularly, as has been mentioned, with regard to care homes and people not necessarily having to be there. I think that it is about finding very careful way of putting it across; it is a very delicate subject. I know from experience that families sometimes have not come to terms with the matter enough, and do not want to.

**Cassie Hersee:** It is a societal thing; there is fear of dementia. People forget, or do not recognise, a lot of the time that it is a disease. It is like having leukaemia; it is a terminal disease, but it is a disease. That increases fear in some people. There is a lack of understanding, so we need to change society's perception of what dementia is and how it affects individuals. Not everybody will reach an advanced stage at which their behaviours are unmanageable, and not everybody will become incontinent. There is not enough knowledge out there in society so that people genuinely understand what dementia is. There is fear.

**Viv Dickenson:** That is absolutely the case. Stigma also still exists, and not just for people with dementia, but for numbers of other people who are supported.

It is partly about funding and partly about culture. If we see people as vulnerable, we classify them in a certain way, which can sometimes lead people to think that they are under some sort of scrutiny, "Do you want interference in your life? Do you not? Is it a service? Is it going to be more of a barrier to you living your life in the way you do?" The language is tricky. When we see people as valuable and as living with a challenge, we are much more likely to invest and to think that they can live their best life.

That goes to the heart of what we are talking about. We use very openly the term "vulnerable people", and I think we get scared about what services mean in our lives. We need genuinely to turn the dialogue around, and to make it about seeing all people as being valuable and all people as having the right to a normal life. If a person needs social support, just as they might need a bit of medical support, that should not be stigmatising; it should be normalised.

Dementia is very stigmatised, and there are other mental health issues through which people feel incredibly stigmatised and frightened to ask for services in their lives. The same is true for families who are struggling with poverty. We have a difficulty in the society that we have created, in that it recognises people's vulnerabilities but does not necessarily see value in supporting them holistically. That is my throw-in.

**Cassie Hersee:** I totally agree about stigma in society, but that is not recent. I come from generations of psychiatric nurses over many years; that stigma has always been there, and it is incumbent on us to do something about it. That will come through knowledge, education and understanding.

**Joanna MacDonald:** I have certainly welcomed Government investment in the post-diagnostic period, through which a person has expert support in the year after a diagnosis of dementia. Additional staffing and funding were put in place a number of years ago for that. That has been invaluable in relation to there being one person to support the person during the post-diagnostic phase.

It is incredibly difficult, especially for couples or families who have been together for many years, to accept in the first instance that there might be dementia. It is a story of grief as well, when people start to see the signs that someone is not remembering everything in the same way. Post-diagnostic support for one year around practical things, around benefits and around personal things is invaluable. I have seen it in Ireland and in Argyll and Bute; I continue to see value in it.

As Viv Dickenson and Cassie Hersee have said, dementia is hidden a lot of the time. Families are living in our communities and managing their loved ones in the most incredible ways, but that is hidden. People are entitled to privacy. However, it is difficult to raise the profile of using a whole-system approach to dementia, which is what we are all trying to do, when so much of what happens is hidden within communities. We are not even connected to it from a health or social care perspective, because families are just getting on and supporting their loved ones until there is a crisis, as Cassie Hersee said.

**The Convener:** Thanks very much. Sandra—do you want to come back?

**Sandra White:** I just want to thank the witnesses.

**The Convener:** David Stewart explored consultation. What about involving families or receivers of care more in commissioning and designing services, and perhaps in designing preventive services? Is that something that the committee could focus on, or should the Government be thinking about that kind of engagement?

**Joanna MacDonald:** One of the strengths of integration joint boards is that carers representatives and others participate in the discussions and decision making on how partnerships are working, but carers do not have the same voting rights. From an equalities perspective, that means that they do not sit on

boards on equal terms and conditions. That issue comes up for us occasionally, although the fact that they are helping us and informing our strategic plans is important.

Our strategic plan here in Argyll and Bute is now co-chaired. The third sector interface is involved to make sure that it is reflective of the ambition of integration, which is about empowering and connecting our communities.

**The Convener:** Thank you very much. I will ask a final question of all our witnesses, as no other members have more questions. I would like each of you to give a summary, in a couple of sentences. We are talking about reform of the social care system. The Scottish Government is reviewing the social care system with the same outcome in mind, and we have talked about some of the important issues today. What one thing would you want us to take away, or want the Government to focus on, in relation to the future of social care? Viv Dickenson will kick off.

**Viv Dickenson:** It is about value. There are all sorts of things that can be done underneath that, but valuing social care and seeing its distinct value allows us to see the value of supported people and to shift power, choice, control and accessibility. That also allows us to value staff by implementing fair-work policies. It is about value being at the heart of the matter, and everything fanning out from that.

**Joanna MacDonald:** Viv Dickenson has taken the words out of my mouth. It is about value and everything that underpins value. When we value something, we cherish it, we invest energy in it and we care for it.

I will come back to finance, I am afraid. In media discussion phrases are used such as “record investments in health services” and “spiralling costs of adult social care”. They are both about investing. That sort of media attention does not value adult social care, but brings the matter down to pounds and pennies. They are essential, but it is about the relationships in social care in care homes and communities, and not just between our staff and the people whom they are paid to support, but between the families who connect with each other. That is of real value. Viv Dickenson said it better, but from me it is about valuing social care.

**The Convener:** Thank you very much. Cassie Hersee will have the last word in this session.

**Cassie Hersee:** Joanna MacDonald and Viv Dickenson have both articulated that better than I will.

I absolutely value what I do and we need you to value what we are doing. It is a privilege to do my job. I recognise the need for change, but I ask the

Scottish Government, please, do not just go away and decide the changes that it will put in place. It needs to involve us: we know and we are the experts. I acknowledge that that is what the committee is doing today, but you need to continue to include us in your discussions in the future.

**The Convener:** Thank you very much. We will certainly, as a parliamentary committee, want to continue our dialogue with the Government as well, in order to ensure that the voices of carers and people who provide social care are heard loud and clear.

I thank all our witnesses for a stimulating, wide-ranging and informative session that will certainly feed into our consideration. Thank you again for your time and your contributions—they are much appreciated. The committee will now move into private session. I suspend the meeting.

11:45

*Meeting suspended until 11:50 and continued in private thereafter until 12:21.*



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