OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 4 October 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 4 October 2016

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HEALTH AND SPORT COMMITTEE
7th Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

*Tom Arthur (Renfrewshire South) (SNP)
Miles Briggs (Lothian) (Con)
*Donald Cameron (Highlands and Islands) (Con)
*Alex Cole-Hamilton (Edinburgh Western) (LD)
*Alison Johnstone (Lothian) (Green)
*Richard Lyle (Uddingston and Bellshill) (SNP)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Val de Souza (South Lanarkshire Health and Social Care Partnership)
Nick Kenton (NHS Highland)
Rob McCulloch-Graham (Edinburgh Health and Social Care Partnership)
David Robertson (Scottish Borders Health and Social Care Partnership)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 4 October 2016

[The Convener opened the meeting at 10:00]

Subordinate Legislation

The Convener (Neil Findlay): Good morning and welcome to the seventh meeting of the Health and Sport Committee in 2016 in session 5. I ask everyone in the room to ensure that their mobile phones are on silent.

We have some new guidance on the use of mobile phones. Although it is acceptable to use mobile devices for social media within the room, please do not take photographs or film proceedings—if, indeed, you were inclined to do so.

We have received apologies from Miles Briggs.

General Dental Council (Fitness to Practice) (Amendment) Rules Order of Council 2016 (SSI 2016/902)

The Convener: Under agenda item 1, we will consider two Scottish statutory instruments under negative procedure. The first is SSI 2016/902. No motion to annul has been lodged and the Delegated Powers and Law Reform Committee has made no comment on the instrument. If members have no comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

Food Hygiene (Scotland) Amendment Regulations 2016 (SSI 2016/260)

The Convener: The second instrument is SSI 2016/260. Again, no motion to annul has been lodged and the Delegated Powers and Law Reform Committee has made no comment on the regulations. If members have no comments, does the committee agree to make no recommendation on the regulations?

Members *indicated agreement.*

Health and Social Care Integration Budgets

10:01

The Convener: Agenda item 2 is our first evidence-taking session on health and social care integration budgets. I welcome our panel: Rob McCulloch-Graham, chief officer at the Edinburgh health and social care partnership; Val de Souza, director of the South Lanarkshire health and social care partnership; Nick Kenton, director of finance at NHS Highland; and David Robertson, chief financial officer at Scottish Borders Council and a member of the executive management team at the Scottish Borders health and social care partnership.

We are not expecting any opening statements, so we will move directly to questions, starting with Maree Todd.

Maree Todd (Highlands and Islands) (SNP): I represent the Highlands and Islands region and I am interested in the fact that NHS Highland is running a different model from all the other health boards. I ask Nick Kenton to tell me a little bit more about the perceived advantages and, maybe, disadvantages of that model, as he sees it.

Nick Kenton (NHS Highland): It is important to note that NHS Highland actually runs both models. We run the lead agency model for north Highland and the body corporate integration joint board model in Argyll and Bute, so we have experience of both. I guess that that puts us in a good position to have a view on the matter.

My first point is that we do not have a strident view about either model. What is important is what is best for each community, which is why we are one health board with two different models. It is important that we have a model that suits the local circumstances.

My second point is that it is easier for me to speak about the lead agency model because we are now in our fifth year of that model, whereas the model in Argyll and Bute is still in its first year of really functioning. For me, what makes the lead agency model powerful is that operational budgets, management and governance are entirely integrated into one body.

I do not know how much members know about the arrangements in Highland but, by way of background, I note that we entered the lead agency arrangements with Highland Council in 2012, which entailed a transfer under the Transfer of Undertakings (Protection of Employment) Regulations of about 1,800 staff from Highland Council to NHS Highland, along with various other

bits of non-pay expenditure, a large proportion of that being contracts with third sector providers. We inherited all of that and came to an arrangement with the council whereby it paid the health board £90-odd million to pay for the resources that were transferred over.

Once those resources came over, they became, to all intents and purposes, part of the health board's business, so there is no artificial barrier between health and social care. There is one budget for a locality and one system of governance. There is still governance that goes to the health board and governance that goes to the council at the higher level, but at the detailed operational level, it is really one just system of governance.

To give you some anecdotal evidence, one of our heads of finance told me that when a vacancy committee had a district nursing post for consideration it instantly decided to turn the post into a social worker post. The fact that it made that decision on the day without having to refer it to any other body shows in practice the power of the lead agency model. We can be very fleet of foot and respond to local needs. Local decisions can be made by local managers to respond to local need. That is the power of having one management system and one governance system.

As we implement that change, one challenge is that it becomes harder to track where the money has gone. For example, Highland Council would want to know what has happened to the £96 million that it has given the health board, but because we are starting to move things around in the way that I indicated, it is harder to track that money.

The flipside of the lead agency model is that we have delegated the delivery of children's community services to the council, so we have passed £8 million to it and transferred, under TUPE, 250 staff to the council, which is making decisions without direct reference to us. Another challenge of the lead agency model is that professional accountability still lies with the parent body. For example, if the health board decided to disestablish lots of social work posts—although it would not do that—and the chief social work officer was still with the council, that person would have a view on that decision. There is therefore a challenge around ensuring that, as we make operational decisions, we keep our professional lines of accountability in place.

For me, the lead agency model has suited NHS Highland and Highland Council. Its genesis was in 2010, so it took two or three years to get there. We know from the Torbay example in England that it takes five years to see some results, and we are starting to see some results coming through now. It is not a huge amount, but we are starting to see some change around the balance of care.

To summarise where we are in Highland, the lead agency model is a powerful one that is now starting to show results.

Maree Todd: I am interested in whether it is achieving the planned shift in the balance of care. Do you have any data around that, or is it, as you said, hard to track?

Nick Kenton: It is quite hard. I have figures that are quite hard to read out, but I am happy to give them to the committee after the meeting. We have figures that show the direction of the trends in emergency admissions from 2000 to 2004, and a regression analysis would show the same direction. We have seen the trend flatten and a reduction in expected emergency admissions. We have also seen the proportion of our spend on non-residential care increasing and the proportion of our spend on residential care, acute hospitals and care homes reducing. The spend on both is still going up overall, but the balance is slightly changing—it is fractions of a per cent but involves very big numbers.

We are also starting to see increased use of self-directed support packages: the trend has doubled in the past three years. However, it is early days and we still have lots of challenges—for example, we have quite a challenging delayed discharge position. We are not saying by any means that we have cracked this, but we are starting to see some of the indicators move in the right direction.

We have made a particular attempt to try to tackle delayed discharge related to care at home, and the figures for that have definitely come down. We have redesigned the care at home service to focus on and grow the non-statutory sector. We have a good relationship with our partners in the third and independent sectors, so that is working quite well. Because we have grown the non-statutory sector, that has released in-house capacity that we have then turned into enablement capacity. We have some numbers on enablement that show that we applied it to 300 clients in 2015-16, almost half of whom needed no further care at home. We dealt with those clients as individuals, and that was them sorted rather than drifting into a long-term need for care.

There are therefore little green shoots, but we would not pretend by any means that we have cracked it.

Alison Johnstone (Lothian) (Green): I am interested in hearing the panel's views on when we might shift the balance of care. What are realistic timescales? Perhaps Mr McCulloch-Graham can respond first.

Rob McCulloch-Graham (Edinburgh Health and Social Care Partnership): I will try. It is a bit of a bumpy ride at the moment. The delegation happened in April for our services in Edinburgh. We have had some traction on our delayed discharges. From October to April this year, we saw a significant improvement—we went from 183 delays down to 50. However, we are introducing some long-term changes, which will take time to bite, and we have seen that great reduction in delayed discharges actually completely reverse.

Specifically on the balance of care, we have seen a variance in the use of our care homes. We were doing very well at the beginning of this year but then the delays snuck in again and there has been an increase in the use of care homes. We saw a shift towards packages of care and care at home earlier on and we need to get back to that.

If you are asking me for a trajectory and a prediction, the new contracts that we have put in place should be up and running by Christmas this year so we should see the trajectory reverse early next year. If you want to hold me to anything, I would say that it will be spring when we start to see the changes bite, but they will take a good year or two to get embedded in practice.

The big change that we have seen is in the relationship between national health service and council staff and joint working on the major issues that we face. Prior to the IJB, there were far too many hand-offs between different sections, both within the council and the NHS and across the boundaries between the two. Because we are working hard together on that and the objective is shared between us, much more innovation is coming in, as well as much more willingness to share budgets, responsibilities and accountabilities. Again, that is a cultural change that has taken a while to embed.

The legislation was a very brave move—it was an inspired step to bring such partnerships together. We now have official forums in place—backed up by law—that we have to go through. That has provided an avenue for both parties to engage much better on a formal basis. We are able to escalate things to the IJB now, which we were not able to do previously, when there were significant impasses between NHS and council services. We now have a forum where issues can be debated and seen through to completion. We have had several examples of that over the past year.

Alison Johnstone: You obviously regard the IJB as a strength in taking this forward, and Highland has a different model. I would be grateful to hear from Mr Robertson and Ms de Souza whether they think that the IJB model has strengths when shifting the balance of care.

Also, how important is it to have a financial overview of what is going on? Clearly, a shift in finance can demonstrate what is happening on the ground. In Edinburgh, Liberton hospital and other services have been moved into the community, and that will be recorded on the balance sheet. How does that tie up with the feeling that things are moving in the right direction?

Val de Souza (South Lanarkshire Health and Social Care Partnership): I am quite happy to come in on that. I have been in post in South Lanarkshire for about two weeks so I will speak in general terms, if that is okay. I am happy to pull through any details later.

The IJBs have a really important role in shifting the balance of care. There are two aspects: the management and overview of the finances and the integrated budget; and the work that has gone on nationally around the development of strategic commissioning plans.

The strategic commissioning plans are signed up to by all partners; they have been very inclusive nationally. They are our route map for laying out our stall, if you like, and saying, “This is how we will shift the balance of care, and this is how we will finance it”—at least, we will do that as best we can, as we think that it will be a difficult road at times. With the evidence around that, we will hold one another to account.

The strategic plans are three-year plans, and one of the challenges for the IJB is that the funding can be annual. The IJB and other stakeholders might want to look at what freedom and capacity there is to bring those two parts of the agenda together for us.

10:15

It is sometimes hard to evidence concretely the shift in the balance of care, although my colleagues here and around the country can probably do that with projects. We have seen a lot of shift towards the community from hospitals and care homes. The length of stay in care homes has reduced in many places. A lot of that shift has come from initiatives around hospital at home services and integrated community support services. A lot of effort has been made, and there are a lot of really good initiatives.

The pace and rate of hospital admissions and the demographics sometimes skew things. There are a couple of issues with the demographics. Sometimes we think of the demographics as being just about the volume of people who live longer—older people—but in the past few years, we have become very aware that it is not just a matter of older people. Younger people with chronic conditions are living longer. That is a real success and is really good news, but they require different

kinds of health and social care support in their lives as they go through the different care pathways.

We are doing a lot of the right things in shifting the balance of care, and we can evidence quite a bit of that. It might be helpful if the budget and the strategy were more aligned, but dynamic things around demographics and what is presented to us can sometimes make it difficult to see real successes. They probably exist, but we always need to do more. The strategic plans will set the direction for us.

David Robertson (Scottish Borders Health and Social Care Partnership): One of the heartening things about the legislation was that it enabled us to put our partnership together in a way that meets the needs of people in the Borders. We have quite a unique situation. We have a coterminous boundary and two organisations that are largely the same size, and we serve quite a distinct geographic population in the Borders. The legislation has really allowed us to develop our integration scheme around our health and social care partnership to meet the needs of people locally.

Like others, we are, obviously, very focused on shifting the balance of care. Early intervention, prevention and keeping people out of hospital and in their own homes wherever that is possible are a real focus for us. We are using the integrated care fund to do that focused work and we are really starting to see some traction, in line with our strategic plan, in shifting the balance of care and keeping people out of hospital.

A very good example that we have recently taken forward is the refurbishment of Waverley residential home, which is one of our care homes, to provide a transitional care unit. That allows us to keep the focus on delayed discharge, to provide an appropriate care setting for people in a non-hospital setting, and to try to ensure that we get people back home as quickly and safely as possible.

The Convener: One of the priorities for the committee is a reduction in health inequalities. What concrete examples can you provide of shifts in the balance of resources—maybe not the balance of care—to address that issue? Is it happening? Is it a high priority in your strategic plan, or are they just warm words?

Rob McCulloch-Graham: They are more than warm words. All of the strategic plan is directed towards reducing inequalities across the board.

The IJB and shared budgets give us more opportunity to get into earlier intervention. Early identification of people who need support or healthcare and much earlier provision of services reduce the draw on acute and specialist services, which are obviously more expensive. Getting in more functionality and real support programmes earlier on is reducing inequality.

You asked for hard facts: we do not have them at the present time, but we measure the reduction in health inequalities in our overall strategic plan, and we expect to see that gain traction over the forthcoming years. All the work that we are doing is highly focused on inequalities right across the board. We are working not just within the IJB but under a wider remit with other services—third sector services and wider council services. We are ensuring that inequality is a feature within the overall vision for the city of Edinburgh. We will be using other services that are not within health or the IJB but which can deliver.

One of the biggest drivers around good health and reducing inequalities is employment. We want everybody to have access to good education and good employment, which will reduce health inequality more than a lot of the stuff that we are doing elsewhere. Our influence on that, through public health and through our engagement on the council, is a real strength of the IJB. The fact that the chief officer sits on both senior management teams, in the NHS and in the council, is an added strength, so we can influence the wider agendas, too.

The Convener: Is it just that you do not have the hard facts at the moment, but you will do, because you are going to measure things?

Rob McCulloch-Graham: There are facts at the moment—for example, we can measure life expectancy. There is a range of factors with which we can measure inequality at the moment. We have started with a baseline within the strategic plan—the commissioning plan. We expect the position to improve over time, but the plan needs time to bed in. It would be a really high expectation to expect to have delivered significantly within 10 or 11 months. We acknowledge, however, that health inequality is one of our major priorities within the strategic plan. That is where we wish to see a difference.

The Convener: Would anyone else like to say something about what their organisation is doing and how much of a priority health inequality is?

Val de Souza: I support what my colleague Rob McCulloch-Graham said about development of the strategic plans being at the embryonic stage and about their direction. Health inequality is a real priority for the South Lanarkshire partnership. There probably is some hard evidence that we could produce about a shift in terms of integration or of the wider agenda.

I support the idea that this is about the work of the integrated partnership, but it is also very much the job of the community planning partnerships

and of the corporate bodies. The health and social care side will be core, but with housing, employment, employability and corporate parenting there are many crossover issues that we need to be sighted on in order to be successful. I am sure that I could dig deep and come back with some concrete examples of progress.

David Robertson: I would echo those comments for the Borders. We are very focused on inequality in our communities. A specific example of what we have been doing recently is on our recognition that transport and access to healthcare can be major problems in isolated rural communities. One of the projects that we have been pursuing through the integrated care fund has been to look at our integrated transport hub and join up our transport arrangements using the council's and Borders NHS's fleet in order to ensure that can that people can access health services locally or at Borders general hospital as and when they need them.

Nick Kenton: I echo what David Robertson said about access to healthcare and care services in remote and rural areas. NHS Highland is focused on that to ensure that as much equality of access as we can provide. We are trying wherever we can to use technology, including smart technology in newly designed houses, as well as linking with transport. That is the sort of thing that might help.

As Rob McCulloch-Graham said, employment is also crucial. We have tried to reassure the independent care sector about incomes and encourage providers to pay the living wage, and so on. We have tried to make that employment more sustainable in the Highland region.

Alex Cole-Hamilton (Edinburgh Western) (LD): One of the broadest and most stubborn frontiers of health inequality in Scottish society is still alcohol and drug misuse and the wider effects on our communities.

I am sure that many committee members will share my horror at the most recent Scottish Government budget, which saw a 20 per cent reduction in funding for alcohol and drug partnerships. My question is directed particularly to Rob McCulloch-Graham and relates to the efficiency savings that you have identified for 2016-17. The Edinburgh alcohol and drug partnership is set to lose £1,380,000. Is that a reflection of the 20 per cent cut in the Government's block grant, or is it a further cut to the ADP's funding? How does that help Edinburgh in its wider approach to tackling drug and alcohol misuse?

Rob McCulloch-Graham: It is a very difficult budget settlement. The cut is part of the 20 per cent—it is our share of that—and there will be reductions in some of the services that we are providing. However, we are trying to mitigate the reduction in resource by being more efficient and by managing demand. I will give you a quick example of that. In conjunction with the City of Edinburgh Council we have removed all legal highs from shops in Edinburgh, so we have seen a reduction in the number of people presenting at hospital as a result of those. Such fundamental changes help. There is no getting away from the fact that I would like to have more money to spend on services, but we live in the real world and must operate within a budget. The cut is painful, but we are trying to mitigate it as best we can.

Alcohol is a particular problem for us. We have some fantastic projects in Edinburgh that have very high success rates in helping people to stay sober and to regain access to a lifestyle that is appropriate for them, and we will seek to protect those projects. We are being careful about how we are supporting them and how we are introducing reductions in services. Being part of a wider partnership helps with that. If the cut was limited to one particular area, it would be a severe cut, but because we can wrap other services around in a wider partnership, we can take some of the sting out of it.

The Convener: On the point that Alex Cole-Hamilton made, NHS Lothian told me a week ago that it is not putting in the share of the drug and alcohol money that the Government expected it to put in because it does not have any. Is that correct?

Rob McCulloch-Graham: The cut was meant to be covered by the uplift that would have been passed on to us, but the uplift is not sufficient to mitigate the cut.

The Convener: How much was NHS Lothian's contribution, which is not now being made because it does not have the money?

Rob McCulloch-Graham: The contribution would have been the amount that I quoted—those are the savings that we have to make.

The Convener: That is fine.

Clare Haughey (Rutherglen) (SNP): I would like to return to the shifting of resources. Each of the health boards gives examples in the survey that you kindly completed for us before the meeting, and I would like to explore some of those. Perhaps you can elaborate: how exactly are the health boards shifting money from in-patient settings to community settings?

Rob McCulloch-Graham: The main way of shifting resources from acute to primary care is by closing beds, which reduces capacity on the acute side, and transferring that funding directly to the partnership. In Edinburgh, we are reducing capacity in our hospital-based complex continuing

care, and that money will be made directly available to primary care. For example, at the Astley Ainslie hospital, we are reducing the ward base and expect a transfer of funds this year to support the work that we are doing in primary care.

Alison Johnstone mentioned Liberton hospital; we are looking at a different way of using Liberton hospital. We have a step-down facility in the north of the city and we are looking to provide something similar in the south of the city. That will be a shift in use of the hospital, so there will be a shift of resources to support that. A reduction in size will shift some of the funding to enable us to do that.

Nick Kenton: Before I give examples, I will say that in 2015-16 NHS Highland received a £6 million increase in funding from the Government because it was below its funding target, and the health board took a strategic decision to invest that almost entirely in social care. I do not think that that would have happened before integration; it would have gone into health services. We have increased our spend on community and social care services; it is not a shift, in the sense that it has not come out of the hospital, but we have targeted that investment, so it is a statement of intent.

10:30

On specifics, I reiterate that I do not view a shift in the balance of care as being purely about a shift from acute care to community care—it is also about a shift from residential to non-residential care. For example, in our social care sector we have real pressure on care home beds, so we are trying to grow care at home so that we can keep people at home.

On hospital beds, we have a business case out for a new hospital in the Badenoch and Strathspey valley, which would entail closing two hospitals and building a new one in Aviemore. That would mean an overall reduction in beds, but it would allow investment in community services. Part of the business case is about release of resources from in-patient beds to be invested in community services.

Val de Souza: I will give two examples from the South Lanarkshire partnership and from NHS Lanarkshire. The hospital at home service has been developed over the past couple of years from the integrated care fund. It is basically about keeping people out of hospital. If there is any suggestion that a person might need to go into hospital, the clinicians, the nurses and the allied health professionals go to their home. Individuals who in the past would have needed in-patient care are now being cared for in their own homes. The service is quite innovative and different and has proved to be quite successful. There are quite a lot of evaluations of that project going on at the moment. An example of a cost saving from it is that we are no longer transporting individuals from their homes to hospital by ambulance.

That is just part of it: the greater gain from the hospital at home service is that individuals are not moving out of their home environment into a hospital environment—which can have the knock-on effect of their needing to have their package of care restarted, and maybe with different carers. That type of disruption can happen if somebody has even a short episode in hospital. That project is being undertaken in three areas in the Lanarkshire partnership area at the moment.

The other example is integrated community services teams, of which there are eight around the South Lanarkshire partnership. They are integrated partnership teams of occupational therapists, physiotherapists, nurses, and social care workers who work with individuals to keep them at home. That, too, is completely supporting the shift in the balance of care for individuals for whom it might in the past have been suggested that they move into a care home or another residential setting. It is about trying to support people and keep them as independent as possible.

Clare Haughey: Thanks for that.

AHPs are a particular topic in the information that you provided. I have had concerns raised with me about the role of occupational therapists within integrated services. There are concerns that they are seen as a generic workforce although they are specialist practitioners. Will you comment on that and on how occupational therapists are being utilised across the IJB in South Lanarkshire?

Val de Souza: I suspect that as we go further and deeper into integration, a lot of the allied health professionals and other professionals, including social work professionals, will start to look at their roles in terms of the generic tasks that they undertake and the very specialist tasks that they undertake. Occupational therapists have very specialist tasks that they undertake and they will continue to do those tasks; they will be professionally supported in that and directed on governance around their tasks.

However, the skill sets of a lot of the professionals and paraprofessionals in the community will overlap. As we go further into integration, we will look at our workforce to see whether individuals can undertake their specialist core functions and other tasks. That will be part of the multiskilling and multitasking that we will undertake as we develop really joined up teams, and it will be about reducing the number of

individuals who go into a person's house daily. Last week or the week before, I heard about an example of two OTs—a hospital OT and a community OT—being in a person's house at the same time. I guess that our job is to work out whether we need two OTs to be involved in one person's care just because the world has always had hospital OTs and community OTs. We need to explore where the overlap might be, and integrate their tasks a little more.

Clare Haughey: I have to say that I find that a very unusual way of looking at the issue. For example, you would not say that we should not have two doctors going into someone's house. For hospital at home, we would have a geriatrician and a general practitioner going in. I am concerned that some of the allied health professionals' skills are perhaps not being recognised or are being merged.

Val de Souza: I do not have any information to suggest that skills are not being recognised and acknowledged, but we are looking at different ways of delivering the best-quality care, whether from the medical or the care point of view, from all of the professionals. I take your point about medics, but even some functions of the medical profession are starting to be done by advanced nurse practitioners. That is a challenge in terms of professional identities and the way that we have always been established and organised. We are looking at those areas across the board; I hope that it will be done without any threat to people's professional identity and governance.

The Convener: Richard Lyle has a question, after which we will move on to budgeting and financial issues, which are probably the main issues.

Richard Lyle (Uddingston and Bellshill) (SNP): I was going to come on to that.

The Convener: Good. Perfect timing as always, Richard.

Richard Lyle: One reason why the Government introduced the legislation was to reduce bed blocking to make things better for patients and to deliver savings. Edinburgh has not yet finalised its budget for 2016-17, although we are six months down the road and we should now be looking at 2017-18. With the greatest respect to Rob McCulloch-Graham, I say as a former councillor that that astounds me. As David Robertson said, it was maybe easier for Edinburgh because there is one council and one health board, whereas in Lanarkshire there are two councils and one health board. If you have a council budget book and an NHS budget book and you decide what services you are going to integrate, you extrapolate the costings and budgets from those books, join them together and—hey presto!—you have a budget. Why, six months down the road, do you not have a budget, when you should now be looking at 2017-18? Has the process been very hard for some councils and easier for others?

Rob McCulloch-Graham: That is probably the case. I can give you chapter and verse on where we are in Edinburgh. The council went through due diligence and through the process that you just described—we looked at the spend in previous budgets, which formed the basis of the forthcoming budget. We took a fair share of the savings target, as every council service was doing. Then we had the advent of the social care fund, which introduced a change to the mix, in that the council no longer met the stipulation from the Scottish Government—it came up short in the test that was set relating to the social care fund. The IJB was unable to accept that, so until very recently we were in negotiations with the council and the Scottish Government on how to fix that gap.

I can report that we are ready now to sign off the council's budget. I would prefer to do that before March in any financial year, but we are in that position now. The IJB could not accept the situation because it was following the guidance that we had and there was a disparity. NHS Lothian set a budget with a £20 million gap. Within that, there was a £5.8 million additional savings target to close that gap, which was passed on to the Edinburgh IJB. The three other IJBs in the Lothians were given smaller targets but had to make their savings. We could not accept that we would run services with a gap in our budget that did not pass the due diligence test because of an additional shortfall. We have been in continuing negotiations with NHS Lothian and have been assured that the gap will be closed. We are waiting to find out whether the £5.8 million savings target will be reversed. If it is, we will be in a position to sign off the budgets.

Having said all that, we have not stopped working. We have very close working relationships. The NHS board, the council and the IJB have been cognisant of the challenges that we have been facing and we have worked closely together. Nothing has stopped. The strategic plan is in place and actions have been taken. We are right in the middle of a restructuring that will achieve some of the savings targets that we have to hit, and some of the projects that we are doing are gaining traction now.

Nothing has stopped; we just did not sign off the budgets. There was a gap but it now looks as though we are very close to closing it. It looks as though we will sign off both budgets probably in the coming months and definitely before Christmas. The director of finance in the IJB was not in a position to accept the budget previously,

but she is very close to being able to do that now because of the continuing relationships that we have.

Richard Lyle: We have heard from a couple of boards and associations that a number of councils and IJBs have reduced the number of delayed discharges. That immediately throws in savings, surely. Some areas are tracking that and say that it does make savings. Other areas—for example, Glasgow—have not tracked it. When I served on the Health and Sport Committee in the previous session, the Government said that we would make savings of roughly £130 million or £140 million. Some boards are now predicting that they will not make savings and will go into the red. Is that the case?

Rob McCulloch-Graham: A number of factors impact on delayed discharges. We would make savings from reducing them if we were able to close some hospital beds. If a board has significantly reduced the number of delays, it does not need the same capacity in the hospitals so, under the legislation, we can shift moneys from acute services into the community and make a saving. However, we need first to have succeeded on delayed discharges.

I started to say what has been happening in Edinburgh. To begin with—between October last year and April—we successfully brought delayed discharges down from 183 to 50, so there was a more than 50 per cent improvement. However, we need a long-term solution.

I will try to keep this short. In moving to using localities, we want to try to reduce travel time for people who provide home care, for instance. We had a set of contracts with external providers that was not fit for purpose; those agencies were able to refuse a request for a package of care if it was not economically viable for them, so we had to change the contracts. The time to do that is not in winter; it is in summer. Therefore, we started that process in May and it is finishing now, so the contracts are being transferred. In that transfer, we have dropped capacity, so more care workers need to be employed to lift us up. At the same time, we have dropped capacity within our reablement function because we have changed the nature of our reablement, which was blocked earlier.

Those two factors have had a negative impact on our ability to keep on the trajectory that we had for delayed discharge. We expect to return to that and have set ourselves a trajectory to get back by the end of November to the level that we had in April. That is a very challenging target for us, but we need to gain that traction before we get into winter.

That was a long answer, I am afraid. We will make savings once we have started to reduce delayed discharges to a level such that the hospitals can start to close beds and reduce capacity. That is necessary.

The Convener: I urge people to give brief answers and ask brief questions, but I welcome any further comments.

10:45

David Robertson: In the Borders, we were able to set the budget on 30 March so the IJB had its budget for the start of the financial year, albeit that it was subject to final confirmation from Government about the overall level of NHS finance. We put a lot of work in at the front end to ensure that we did the due diligence and had a sustainable budget for the IJB. That is not to say that that budget is without risks—any budget has an element of risk—but it was very important for us that the first year of the partnership started in April with a budget for the IJB to operate to. Without that, we could not have effectively planned the shift of resources and the deployment of services. We were focused on getting the budget in place and moving forward. Of course, there are savings to be made by NHS Borders and Scottish Borders Council—£7.7 million this year—but we felt that it was important for our planning to have the budget set and to move on with what the Scottish Government had tasked us to do.

Colin Smyth (South Scotland) (Lab): The budget process as Richard Lyle described it sounds relatively simple for this year because if you extrapolate what the health board and the local authority spend on adult services, that is the budget. Despite that, there have been significant problems across Scotland in determining IJB budgets.

For the benefit of the committee, please describe the process that you will follow to set the budget in future years. It will not be a case of the councils and health boards just extrapolating what they spend, because it is now over to you guys. It is not entirely clear to me what the process will be. Also, what will happen if there is a conflict between what IJBs think they should receive and what health boards and local authorities are prepared to hand over?

David Robertson: It is very important that we develop budgets in partnership. It is probably fair to say that in informing our IJB budget this year, the council undertook its exercise, the NHS undertook its exercise, then the partnership brought those together. Moving forward as one IJB with three partners, we will need to make sure that we work closely on identification of efficiency savings and cost pressures. We also need to build

in demographic factors to reflect the increasing numbers of older people that we are managing. We need to make sure that we are doing all that in a timescale that allows the IJB to have its budget in place for the start of the financial year, so we need much more close working, a closer understanding of the challenges that everybody is facing, and a timescale that allows budgets to be set by 1 April.

Colin Smyth: Ultimately, a local authority will set its budget, by and large, in February because it has to set the council tax in February. In effect, it will agree a figure for the IJB in February. How will you engage with the local authority and what process will you go through between now and February, notwithstanding the fact that you will not know what the local authority funding settlement is until, probably, December?

David Robertson: We will go through a process of negotiation and agreement. I am looking at the projections for pressures on the IJB. Councils set their budgets in February. I think that legally they have to set their budgets by 11 March every year. Largely, councils set their budgets in February for council tax billing purposes so that they can get bills out on 1 April.

It is quite clear that there is an on-going process around budget development. It would be very helpful if we could get information from Government earlier in that process. As Colin Smyth said, local government tends to get an indicative settlement in December. That is before the health boards tend to get their finance. We are just going to have to work through the process and ensure that we set up the IJB budget as robustly as possible for 1 April, taking into account what risks we can manage.

Nick Kenton: I will give the lead-agency angle on that. In 2013, NHS Highland entered into discussions with the Highland Council. Of course, the situation is slightly less complicated because there are only two partners—there is no IJB. We discussed the concept of a three-year budget, taking into account exactly what Mr Robertson described—expected demographic changes, cost pressures, expected funding and so on. We reached a three-year budget for 2014 through to 2017 and that is what we would like to go back to.

Two things happened in the year that we are now in. First of all, the council settlement was much lower than had been expected when the three-year settlement was made. Secondly, the announcement of the £250 million investment turned out to be an extra complication. As a result, we had to renegotiate with the council, which we still managed to do by 1 March. That said, the principle is still that we would like a mutual three-year budget to be agreed, but that would inevitably be subject to any change that had a material impact on any of the assumptions.

Rob McCulloch-Graham: Edinburgh has set a three-year budget for itself and for when it passes over to the IJB, but that is subject to other factors that might arise. Indeed, the settlement from the Scottish Government will impact on it. As my colleagues have said, the same is true in the NHS. The non-alignment of those two budgets has not been helpful; in other words, having budgets that were decided by 1 June for the NHS and in March for councils did not help with setting an overall budget for the IJB. We expect things to be simpler next year, but those two factors will always be there. It all depends on that—although we have predictions and savings targets rolling on for the next three years, they will change subject to the settlement that the council and the NHS get from the Scottish Government.

The Convener: Social care funding seems to have been very badly addressed when it was passed over to the authorities. Things seem to have been taken right up to the last gasp; indeed, we still do not know today whether the living-wage element is going to be implemented—all sorts of debates and discussions are going on about whether it will happen. Can each of you give us your experience in that respect? Were things handled well or badly? Did you get the money that you expected to get? What contribution did your authority have to make, and what did that mean for you? Finally, is this move going to deliver what it is supposed to deliver?

Val de Souza: The social care fund is very welcome, but initially it was difficult to work out how to apply for it and how to work on it. That was a challenge for the partnerships.

From a South Lanarkshire partnership point of view, I am comfortable that the money has been used well and that the living-wage element has been applied; we are one of the partnerships that can actually say that we will deliver that from 1 October. Again, it is all about detail, but I think that there was a six-month allocation for the living wage, and I suppose that there needs to be some reassurance about continuation of that funding. Some of the rest of the spend was for demographic activity, some of it was used to further support projects that are being taken forward under the integrated care framework, and some of it was for shifting the balance of care, particularly with regard to care at home.

The Convener: What finances did your authority have to come up with to make the living-wage element work, and where did that money come from?

Val de Souza: I do not have that detail for the partnership, but I can find it out for you.

The Convener: Will you forward that to us?

Val de Souza: Yes, I will. No problem.

The Convener: Can the other witnesses respond to the question?

David Robertson: In the Borders, we received social care funding of £5.267 million from the Government, and we are confident that payment of the living wage can be accommodated within that overall funding. However, the problem for us is that the funding is expected to accommodate a lot of other issues—in particular, demand pressures around demography.

We can say that we are making progress with the living wage and that we will have it implemented for 1 October. We have been negotiating with all our external care providers across the council area, and we think that we will reach agreement with them on implementation of the living wage. In short, yes—the living wage will be funded within the money that we got, but a whole lot of other issues also have to be accommodated, which will be much more difficult.

The Convener: What was your contribution to that?

David Robertson: We saw the £5.27 million as internal to the overall budget. The council was already paying its own internal staff in the care sector the living wage. With the funding, we were trying to ensure that everybody operating in the care sector was paid it. In effect, the council has made a significant contribution to the overall package and the Government's aspirations for that funding.

The Convener: Did the additional money come from the private providers who employed social care staff?

David Robertson: No. On the back of the move to implement the living wage in the care sector, we have had some difficult negotiations with our care providers and costs have increased as a result of the retendering. In many cases, that has been directly driven by the impact of the living wage. Care providers have simply come back and said that they cannot deliver services within the funding with which we have previously provided them and that we will need to provide additional resources to sustain those services. We have done that largely within the budget.

Nick Kenton: You asked how the social care funding was handled, convener. It would have been helpful to have had the guidance about how to use the £250 million earlier than we did, particularly on the extent to which the local authority would expect a share of that money to help with its pressures. That was not entirely clear to me and it was one of the matters on which we entered into negotiations with Highland Council.

There is sufficient money in that funding to deal with the living wage but, as Mr Robertson indicated, there are other pressures that would be a charge to that budget. Therefore, we will spend more than our share of the £250 million when we take account of some money going back to Highland Council. NHS Highland is contributing more than £1 million of health money to balance the difference.

We had already implemented the living wage with our care-at-home providers and we are now implementing it with our care home providers. We have followed the Convention of Scottish Local Authorities guidance. A percentage uplift on the national care contract has been negotiated nationally with providers to allow for the living wage. We will apply that to our national care home contract providers and those that are not on the same contract. Our view on the sector contributing its share is that using the COSLA percentage uplift means that the onus is on the sector to do that because that was part of the negotiation.

The Convener: Edinburgh said that it failed to comply with the guidance. Will you elaborate on that, Mr McCulloch-Graham?

Rob McCulloch-Graham: It was open to interpretation. It was possible to take a couple of perspectives on the guidance that was produced. That was the difficulty that we had with the council. We have now redressed that and are able to clear the issue, but it has taken us time to get to that stage.

We have implemented the living wage for our council staff and contractors. The annual cost for us will be £8.8 million.

Colin Smyth: In the four areas that the witnesses cover, does payment of the living wage include payment for sleepover shifts in the deals that they have done with providers?

Nick Kenton: We follow the COSLA guidance on that, so I do not know the detail on it.

David Robertson: We are looking at that at the moment. The impact of the living wage on our night-time support sleep-in service has been substantial. We have gone from having a rate of around £36 a night for somebody to provide a sleepover in a social care setting to a cost of around £153 a night, so there is a significant financial impact from the living wage. However, we are saying that, if we are paying somebody to work, we will not pay them £153 for a sleep-in; they will provide a waking shift, which will give us the ability to redesign services. We are currently working through a number of technicalities on the implementation of the living wage with regard to sleepovers, but we are absolutely implementing it.

11:00

The Convener: We had a session a few weeks ago with 25 or 30 social care workers and, frankly, the evidence that some of them gave us about how they were employed was shocking. They were not paid for travel time. Some of them had to purchase their own uniforms. Some of them were using their own mobile phones. Some of them were not paid for any gaps between visits during the day. Frankly, the conditions that some of them were employed under were unacceptable. Some of those who were making the claims were employed by local authorities—not directly but through contracts. Will you comment on the overall package and value that we put on social care in our country? Do you, as people who are managing a service involving some of those workers, think that it is acceptable?

David Robertson: I will comment only from a Borders perspective. The issues that you have outlined regarding travel time and non-payment between contact visits absolutely do not happen in the case of those who are employed by—

The Convener: Directly employed staff.

David Robertson: Yes.

The Convener: But I am talking about staff who are employed by local authorities on contracts to provide social care.

David Robertson: I believe that we are very clear in our contract specification for external care providers about what is acceptable and what is not acceptable. We are working through a process of ensuring that all staff are paid the living wage—that people are remunerated appropriately and paid travel time where that is appropriate. We are trying to ensure consistency across the care sector.

The Convener: That is very welcome to hear, and I hope that that is followed through.

Val de Souza: I support what David Robertson is saying. The difference is to do with the internal and external market. Given the newness of the post that I am in, I will be going back to check out what the relationship with the external providers of commissioned services is. As local authorities, we have been good over the past few years at trying to mitigate any of the particular issues that you have raised but, with the external providers, that sometimes relies on very good relationships and a lot of monitoring. I will be alive to that and I will report back, too.

Nick Kenton: I can only answer your question generally rather than specifically. This group of staff is crucial to the health and social care economy, both those who are directly employed and those working for contractor partners. We have done some work to increase the payments that we make to care providers so as to allow them to pass on benefits to staff. Part of our contract monitoring will be around that, although I do not have the detail to hand. I would have to check exactly what the arrangements are for monitoring how staff are treated.

Rob McCulloch-Graham: I do not have a lot to add to what my colleagues have said, except to go back to what we have been saying about a living wage for what is quite a challenging and difficult job. All of us would want to be in a position to remunerate all those staff at an appropriate level. However, that is eating into the budgets, and we have to share that and put in priorities.

In Edinburgh we are competing against the likes of the supermarkets on wages. Care staff carry out a vital, very difficult and very skilled job yet, if we do a straight comparison with the retail sector, the level is the same. Our providers are finding it difficult to recruit at that level. We may have to go back into the debate to see whether we need to consider whether the wage is sufficient or not. It is a very difficult question that we have to face within that.

Looking at standards across staff in Edinburgh, we would expect exactly the same as what my colleagues here have said. We cannot provide the services without the staff. They are vital to what we are doing across the whole of the sector, not just in home care. If they fall down, our hospitals fall down, primary care falls down and we all do. There is a great emphasis on getting this right. We might have to challenge what we are offering.

The Convener: Given the evidence that the committee has heard from people, could I suggest that each of you and your colleagues across Scotland might wish to do the same exercise as we did? We heard from people on the front line, and the perception—indeed, the evidence—appears to be quite different from what the witnesses are telling us today. It might just be that the four local authorities that are represented here are doing things right, but we heard powerful evidence from social care staff that was quite different from what we are hearing today.

Does anyone else want to ask about the financial elements?

Ivan McKee (Glasgow Provan) (SNP): I want to shift gear and focus on the outcomes framework and the witnesses' understanding of how effective it could or should be. As I understand it, there are nine national health outcomes, below which sit 23 measurable indicators.

First, are those the correct things to measure? If we get those 23 indicators right, will we be covering all the bases? Secondly, will you talk about the relationship between budget lines and the indicators, both on the input and the output

side? What I mean is, will achieving the indicators lead to spending reductions in certain budget lines because you are doing things better from a preventive care point of view, and are you focusing on input, that is, the spend on activities that will deliver on the indicators?

Val de Souza: I am happy to kick off and see whether I can make some sense of the issue. It is really important to have the national outcomes. Over a number of years, we have had different legislation and policy without there being such a framework. The framework is helpful, because it gives us a sense of direction and focus.

The indicators that lie underneath the national outcomes are also helpful. I think that we will probably get meaningful information when we start to look at our local indicators. We are currently undertaking work to develop indicators that will measure local progress on local issues, whether they are to do with health inequalities, delayed discharge or whatever.

The exercise that we faced in summer, which was about allocating the funding to the outcomes, was particularly tricky, because a number of activities that we undertake might have a range of outcomes. Some are difficult to track from input to outcome and some are very tricky to allocate funding to. The exercise was tricky, and from a local and detailed perspective we could spend time putting funding against the indicators.

Overall, the national outcomes are going in the right direction and we have the freedom to put in place a performance framework that will make a difference over time and give us something that we can measure and monitor progress on.

David Robertson: It is notoriously difficult to budget for outcomes. When we are dealing, as we often are, with people who have multiple conditions and require multiple interventions in a healthcare setting, what we are interested in is how quickly we get them out of hospital and whether they come back. I sometimes worry that we are too focused on delayed discharge. What is also very important to us is keeping the person out of hospital. Readmission is a huge issue for us. We need to be careful about spending too much time trying to align budgets and outcomes, when what matters to a person is their quality of life and how good the care that they receive is.

Ivan McKee: That is true. Delayed discharge is only one of the 23 measures; I think that 10 measures focus on what you are talking about, which is the quality of the care. I suppose that I am asking whether you think that the 23 indicators are the right ones.

Val de Souza talked about local indicators. I would have thought that it would be possible to have indicators that were applicable nationally because, at the end of the day, the outcomes that we want nationally are the same everywhere. Are you saying that those are being tweaked locally or that you need additional ones? Edinburgh has inputted a number of additional indicators and I am intrigued why it needs to do that.

David Robertson: We have enough indicators, to be quite honest.

Ivan McKee: That is good.

Rob McCulloch-Graham: The nature of the IJBs is that they serve local areas, which will be different, so there will be different drivers within each of the different places. Some of the additional targets will be because of the different nature of the places in which we operate.

I think that only one IJB made an attempt to split its budgets according to the outcomes. It is impossible to do because the outcomes are interrelated. The actions that we fund will cover a range of those outcomes, so doing the exercise that splits up £1 million being spent on prescribing or whatever is not useful. There are different impacts. If we are successful in prescribing properly, we could reduce the number of visits that are required in a package of care, so our delayed discharges would be impacted by the £1 million that was spent on prescribing. It is too simplistic to expect us to divide up our budgets according to the outcomes. We just hit all the outcomes.

The national outcomes are definitely a driver for us, but there is a need to be cognisant of what the locality's needs are and to have some drivers for them as well.

Ivan McKee: You are right that it is complex. If it was easy, anybody could do it, but it is difficult, which is why we are asking you guys to do it. However, does it not bring clarity of thought to have to go through that process of saying that you expect the £1 million that you are spending to influence five, six, seven or 10 of the indicators in a particular way? Surely there is value in that. Otherwise, you are simply pumping cash in and continuing to do what you have always done and get what you have always got without any thinking being done about what the result will be.

Rob McCulloch-Graham: The outcomes of the strategic plan drive the budget, so we do that exercise. We prioritise the funding and consider the consequences of investing money in one area and not the other. I am sure that that is done in all the IJBs.

There is a nicety around sticking to a national reporting line. It makes life simpler for sharing information, for example, and we do that to quite an extent. However, we would not go down to the level of detail that was requested of us for each of

those outcomes. It would not serve your purpose or ours to do that.

Richard Lyle: Are the joint boards getting too much thrown at them at once? The North Lanarkshire joint board has now taken on the care alarm system and is sending out a bill for it to people who are quite shocked. The boards were set up to remedy delayed discharge and now they are taking on other things. Are councils and NHS boards throwing too much at them at once? I am interested in comments from the four witnesses.

Rob McCulloch-Graham: The governance is right. I could answer the question in two ways. The essence of the legislation was to bring accountability into the one place. That is right. We have individuals with quite a big span of responsibility, but that means that we can move funds easily, redirect staff, consider the professions and decide that, if we have enough health professionals, we can invest in something else. If we did not have that span of control, we would not have the ability to do that now.

The other side of that is how much we are doing. I have never been busier in my life, but that is a stage that we are at. Remember that the services exist now in the council and the NHS. It is not that we have created new services yet, but I think that we will in future. The board is sharing the governance and accountability and the situation will evolve over time.

11:15

If expectations of change and the rate of change were higher than they are now, that would be problematic. It is a matter of people having some patience with the way we are going, because it is the right way to go. Any of the partners across the country—definitely in my partnership and in Lothian—will agree that this is the right way to go. In the past, we got stuck with the silos, the arguments across budgets and the allocation of staff. We were duplicating left, right and centre; we were also missing some major areas and blaming one another for missing them.

The legislation is right and the span of control is right. There is some variance in what we have at the moment, but that comes down to local needs. I think that we are on target with the progress that we have made. We have a huge number of difficulties—I am dealing with several crises in Edinburgh—but I think that I have the wherewithal to deal with them, because the legislation gives me the levers to pull; in the past I did not have those levers.

Nick Kenton: We do not have an IJB in north Highland to throw things at, so the feeling is slightly different. To put it in perspective, looking back to when we became integrated, it has been a matter of managing expectations. When we became integrated in 2012, our initial year was really about stability. It is a matter of trying to ensure that the services that we have inherited are still being provided at least as well as they were being provided before, rather than having expectations that are too ambitious. We wanted to ensure that the transition, which was quite risky, went well. Expectations need to be realistic.

Richard Lyle: You are now four years down the road.

Nick Kenton: Yes.

Richard Lyle: Are things getting easier? Are you making—I will not say, "making savings" because you have to reinvest. Are you doing the job with the money that you have? Some boards are saying that they do not have enough money.

Nick Kenton: All boards would always say that. We are all under financial pressure. We are in a period of sustained financial pressure, which we are feeling, but we are more likely to find the way out if we have this integrated approach than we would be if we were working separately. We have to find a way to relieve some of the pressure on the acute sector by investing and growing social and community care. We have used that flexibility by redirecting our resources towards that sector when we can.

Richard Lyle: Val de Souza has been in post for only a couple of weeks. How are you feeling?

Val de Souza: Fine. I agree with my colleagues: I think that integration is the right way to go. From a national perspective, it is a matter of trying to keep things as joined up as possible. I come from a social work and social care background, and I have my eye to childcare and criminal justice. From a local authority point of view, I also have my eye to housing services. As my colleagues have said, the real synergies will occur if we keep all those things together. Some of the risks arise if we create boundaries and barriers between them.

From the IJB point of view, we have adult and older people's services in the partnership in South Lanarkshire just now. Up and down the country, there are different elements of services in the IJBs. That is a question for the future.

I do not think that we have too much. It is a question of how we do it. It is important that we have the connections across the different public bodies if we are to go forward with the levels of efficiency and effectiveness that we are challenging ourselves to maintain.

David Robertson: Integration gives us significant challenges, but it also provides us with huge opportunities. Our challenge is to make it work and to do so as effectively as possible. Before we put anything into the health and social

care partnership, we want to be absolutely convinced that it is the right thing to do and is the best business model.

You gave the example of an alarm system. We are delivering that through SB Cares, our arm's-length external organisation, and my council debt recovery team is responsible for recovering all the charges associated with that and for debt recovery. Before we move to put anything into the partnership, we want to ensure that that is absolutely the right thing to do under our business model. If there is a better way to do that outwith the partnership, we will do it that way.

The Convener: I bring in Donald Cameron to ask a final question.

Donald Cameron (Highlands and Islands) (Con): My question arises from Clare Haughey's question about occupational therapy, which seemed to get to the nub of integration. Is integration about the merging of health and social care or is it, as I have understood it to be, about health and social care working alongside each other? In future, will integration be seen as a merging or will it really be about people working alongside each other, where roles might be duplicated?

Val de Souza: I will say a little and then let my colleagues in, because I have had a bite at this one.

I see integration as neither, in particular; I think that it is something in the middle. It is not about just being co-located—it cannot be—and it is not about losing our identities and being completely merged. It is about co-existing and having a function and a reason for doing something. The outcome for our customers must always be core, and then we can work out what our functions are—specialist and generic—and find a way of working so that we are not duplicating roles or overpresenting ourselves to members of the public who need our assistance with health and social care.

Rob McCulloch-Graham: I agree that it is somewhere in the middle. The question sounded like a simple one, but the issue is quite complicated. There is a definite need for some merger of provision, and we should be ambitious enough to carry that through.

On the one hand, we are talking about individuals who have spent a career in a profession and people who have chosen to be trained in a specialism. On the other, we have situations in which four specialisms go into one household. If we stand back and look at such situations, we can see that there needs to be a bit of blurring between the professions sometimes, so that we deliver.

When we talk to clients, patients and residents, we find that they do not really care what integration is. What they care about is getting good-quality healthcare when they need it, which is delivered in the right place and by the right person. We have to give consideration to how we move to that. There will always be a need for specialisms, because of the nature of our needs, but there is also a need for generalist workers.

We are considering how GPs function. We will always need general practitioners, but they need support in a changing world. Demand is greater and people are living longer with more complex needs, and we need to be cognisant of that when we consider our model for GP practices. It is more than a GP that we need to serve a community. We have started to talk about advanced nurse practitioners and pharmacy support in surgeries; I think that we need a new model.

My plea for the future is for us to be ambitious, because if we are not ambitious, I think that needs will overtake us. We need to be planning for what we will deliver in the next five or 10 years. In a number of places across the country we have slipped behind on delivery, because the population's needs have changed more rapidly than our services have done. We have to be brave, courageous and ambitious about what we are doing. We must also remember that we are taking the workforce with us, and staff must have time to develop with the new models.

Nick Kenton: Structural integration is about removing barriers to make it less difficult for people to work together, but it does not of itself force people to come together in a different way—that is a cultural thing. By integration we make such working possible, but it does not happen unless we change and grow the culture.

As Rob McCulloch-Graham said, putting the client or patient at the centre is powerful, because it helps to bring the professions together. If the professionals think that their ultimate aim is to serve the client in the best way, that will automatically start to break down false professional barriers.

The Convener: Tom Arthur has a question—this must be the final question.

Tom Arthur (Renfrewshire South) (SNP): I will be brief, and I ask for a brief answer, if possible. Nick Kenton talked about the business case for reducing beds and freeing up resources for primary care. At the same time, a main financial motivation of an IJB is to ease pressure on the acute sector. Given that we are talking about a five-year timescale before we see the benefits coming through, there will be a gap. How do we effect the transition without reducing acute

services at a time when pressures continue to exist?

Nick Kenton: That is a good question. We have time to plan ahead. It is a business case that takes some years to implement so we are already redesigning the teams in those areas to try to manage people at home as best we can and reduce the pressure.

The hospitals that we are talking about are community hospitals so they are not under quite the same pressure as acute hospitals and it is easier to make the transition but, as you say, there is a point at which we need to make the step change. Therefore, we need to plan for that and ensure that, if possible, we manage the bed numbers down before we get to the transition by investing up front in the community. However, that makes it difficult to make the transition. We do not have spare money sloshing around so we need to ensure that we can redesign services within existing resources to put more emphasis on keeping people at home rather than putting them in hospital in the first place.

Tom Arthur: My fundamental question is whether it is possible to achieve that without a one-off transition fund of some sort and whether you feel able to do it. I do not understand how it is possible if you do not have a transition fund. There has to be a loss at some point.

David Robertson: I suppose that we have a transition fund through the integrated care fund. Of course we would like that to be larger, but we recognise that resources are tight.

This is a personal view, so forgive me, but I have always struggled with the concept of taking resources from the acute sector and moving them somewhere else. If we take the Borders general hospital for example, I really struggle to understand where we can take money out of the acute services without closing a ward. However, we can make big inroads in the linkages of our community services with social care and the interface with the patient outwith the acute setting. The notion that we can take resources from general hospitals and shift them out is a significantly challenging concept because of the operating models for those hospitals. Perhaps that is just my little hard-wired accounting brain talking.

The Convener: We received financial information but only the Western Isles provided information to demonstrate the financial scale of the planned shift over the next two years. There is clearly an issue with how we report such matters. I am not asking you to comment on that.

One thing that frustrates me is the response of the four authorities that are represented here to the question that we asked about the savings that are to be made. Some gave us a block figure for the savings and others gave us some detail. For example, we were told that there would be a saving of £1.3 million in the Edinburgh drug and alcohol partnership budget. That is not a saving; it is a cut.

Why are we reporting cuts as savings? Surely they should be divided and be absolutely clear. If you are saving on paper clips, that is all very well and you can tell us that you are doing that but, if you are cutting the drug and alcohol partnership budget, people want to know that you are doing that and the reasons behind that, which Mr McCulloch-Graham has already explained. They are perfectly valid reasons but I do not want that reduction to be called a saving, because it ain't a saving.

Rob McCulloch-Graham: Any reduction in resources has implications. We can mitigate the impact on the public as much as possible within that. I did not want to reduce any of the funds that were going into the drug and alcohol partnership—I do not think that any of the professionals who are present would—but we recognise that we have to operate within the budget that we are given and prioritise the spend. Therefore, some of the savings fall directly on services and others fall on other areas. You talked about savings on paper clips and I wish that that were the case.

The reduction has a direct impact on setting priorities, which impacts on services. However, we manage a lot of services because of the scale of the IJBs, so we have the ability to mitigate impacts on individuals. On the reduction in costs or the cut—whatever you want to call it—in the drug and alcohol partnership, we are working very closely with the provider and users of services to predict how we might mitigate some of those savings.

11:30

I will give you a quick example. We have a service called Penumbra milestone, which is for alcohol-induced brain damage, so it deals with mental health issues that are related to alcohol. It had a three-year budget that was coming to an end. It is a further pressure on our budgets of about £600,000. We know that the service saves in the region of £1.5 million to £2 million, given that people would turn up at accident and emergency if it was not there. There was no budget for that service to continue, and we needed to create a budget by moving things around. If we were to prioritise the service, we had to stop some services elsewhere.

If we are receiving criticism about cutting services, we are probably saving services elsewhere. The picture is complicated. I completely understand the public's frustration when they see that budgets in particular areas are

being reduced, but we have to juggle things in the complex arena of the services that we fund.

At the bottom of all that is the convener's first question about equalities. We must ensure that everyone has equal access to healthcare and equal opportunities to have good health, while balancing our budget.

The Convener: I raised the issue only because you reported it. Some authorities just gave us headline figures, and I can almost guarantee that if we delved into them we would find similar cuts. It is frustrating when cuts are reported as savings.

I apologise to Maree Todd. I said before the meeting that I would bring you in to ask a final question. This really is the final final question.

Maree Todd: As a Highlands and Islands MSP I am keen to share some of the innovations in our area, which has particular challenges to do with geography and the vast distances that must be covered. The situation is perhaps different from the situation in some parts of Scotland, in that people do not want to go into hospital, which can be very far from their community. It is also difficult to provide specialist rehab, for example, throughout the vast area that we cover.

I think that members will be interested in hearing from Nick Kenton about the new tech-enabled houses that I have been hearing about in my constituency. They tick a lot of boxes for us, by using technology to improve healthcare, provide equity of access, tackle delayed discharges—you might go on to talk about the proposed care campus—and address workforce issues.

Nick Kenton: We are in discussion with a social housing provider, and we hope that a first pilot will go live in April, in Invergordon, with a new kind of modular housing, which has been designed with input from potential tenants. The concept is technology-enabled housing, with a smart hub, which can monitor all sorts of indicators, not just when doors open and close but ambient temperature and so on, so we will be able to tell when the heating goes off, for example.

The clever thing is that the system can send messages to a respondent, so if something happens to a client in the house, the respondent—it might be one of us or a member of the family or community—can go round and see what has happened. It is very eco friendly housing, too. The concept is to try to keep people in their own homes and communities.

A care campus on one of our hospital sites is also a possibility, but it is still early days on that and I am not in a position to talk much about it. If the concept is proven to work in Invergordon, it might work in one of the hospital sites to provide a step-down facility and fill the gap between residential and nursing care. It is an innovative proposal and we will be excited to see how it turns out.

The Convener: I thank the panel for their evidence. As agreed, we now go into private session.

11:33

Meeting continued in private until 11:52.

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