The Scottish Parliament
Pàrlamaid na h-Alba

Official Report

HEALTH AND SPORT COMMITTEE

Tuesday 15 December 2015

Session 4

Tuesday 15 December 2015

CONTENTS

HEALTH AND SPORT COMMITTEE
35th Meeting 2015, Session 4

CONVENER

*Duncan McNeil (Greenock and Inverclyde) (Lab)

DEPUTY CONVENER

*Bob Doris (Glasgow) (SNP)

COMMITTEE MEMBERS

*Malcolm Chisholm (Edinburgh Northern and Leith) (Lab)
*Rhoda Grant (Highlands and Islands) (Lab)
*Colin Keir (Edinburgh Western) (SNP)
*Richard Lyle (Central Scotland) (SNP)
*Mike MacKenzie (Highlands and Islands) (SNP)
*Nanette Milne (North East Scotland) (Con)
Dennis Robertson (Aberdeenshire West) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Jim Forrest (West Lothian Health and Social Care Partnership)
Elaine Mead (Highland Health and Social Care Partnership)
Julie White (NHS Dumfries and Galloway)
David Williams (Glasgow Health and Social Care Partnership)

CLERK TO THE COMMITTEE

Jane Williams

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 15 December 2015

[The Convener opened the meeting at 10:04]

Decision on Taking Business in Private

The Convener (Duncan McNeil): Good morning and welcome to the 35th and final meeting in 2015 of the Health and Sport Committee. I ask everyone in the room to switch off mobile phones, which can interfere with the sound system. People will notice that some committee members are using tablet devices instead of hard copies of our papers.

Agenda item 1 is a decision on whether to consider in private at future meetings themes arising from the 2016-17 draft budget scrutiny, as we normally would do. Does the committee agree to take such items in private?

Members *indicated agreement.*

Draft Budget Scrutiny 2016-17

10:05

The Convener: Agenda item 2 is our first evidence session on the draft budget 2016-17. I welcome Julie White, who is chief officer of the integration joint board and chief operating officer at NHS Dumfries and Galloway; David Williams, who is chief officer designate for the Glasgow health and social care partnership; Elaine Mead, who is chief executive of NHS Highland and Highland health and social care partnership; and Jim Forrest, who is director of West Lothian health and social care partnership.

I am not expecting opening statements, so we will proceed directly to questions.

Malcolm Chisholm (Edinburgh Northern and Leith) (Lab): Two of the exciting things about integration are the pooled budgets and the locality arrangements, so I was a bit concerned when I saw that Audit Scotland had flagged up both issues as areas of concern in its report, "Health and social care integration". I will start by asking about the budgets, but I have a second question about the localities.

In our briefing before the meeting, Audit Scotland told us that there has been great difficulty in agreeing the budgets and went on to talk about set-aside budgets. I suppose that this will apply mainly to Edinburgh and Glasgow: there are particular concerns about disaggregating the larger hospital budgets and deciding what will go to the integration authority. Audit Scotland found that even when agreements are reached about what is going into the integration authority, health boards want to keep control of the budgets. All that made for rather depressing reading in respect of the potential for pooled budgets. Will you comment on the concerns that Audit Scotland expressed?

David Williams (Glasgow Health and Social Care Partnership): My first response is that these are still early days in the integration of health and social care. We are expected to have a strategic plan in place and operational from 1 April; in Glasgow, our plan is currently out for consultation.

As the Audit Scotland report highlighted, many of the strategic plans express a general direction of travel rather than explicitly setting out actions and reforms that could happen. Glasgow's plan is not an exception in that regard. In the context of the aspiration to shift the balance of care, in relation to which there needs to be a shift in the balance of resource—potentially from acute and other forms of institutional care into locality planning and community-based support, to enable more older people and adults to remain in their

own homes—we must remember that it will not be achieved overnight.

From the Glasgow perspective, although we have not agreed the IJB's definitive aspirational budgets for future years, my expectation is that the broad parameters of the budgets that were set out when the health board and the council agreed, a year or so ago, what functions and services would be in scope, are the starting point for 2016-17—minus, inevitably, the budget savings that will be expected.

On the set-aside budget, the first year will be regarded as a kind of shadow year in terms of what that will mean, because the truth is that nothing will change substantially in the shape and size of acute services in Glasgow over the first year of the system.

Jim Forrest (West Lothian Health and Social Care Partnership): Many of the things that David Williams said from a Glasgow perspective are equally relevant from the West Lothian perspective. Setting up the budgets for a health board area that has—as NHS Lothian has—four partnerships, is complex. In West Lothian, most of the acute activity goes in through St John's hospital. To a degree, that makes it more straightforward to consider the set-aside budgets that will be involved in the partnerships that are being set up. That work is on-going at the moment.

The complexity in Lothian is that we have one or two hospital campuses in the city that not only serve the population of the whole of the Lothians but provide regional and national specialties; the Royal infirmary of Edinburgh and the Western general hospital serve the populations of the Lothians. Each of the partnerships—East Lothian, Midlothian, West Lothian and the city of Edinburgh—has issues around the activity that goes into and out of those partnerships.

It is early days with regard to setting up budgets. We have not fully agreed them all, but like all the services that are part of the scheme, they will be part of the devolved budgets that are agreed and which are in the process of being reappointed to the partnerships.

On localities, we have in West Lothian worked as a health and care partnership for a number of years under a voluntary arrangement, with aligned budgets. We have good relationships with and between the 23 general practices in West Lothian. We are working with them on what representation in the localities would look like and, importantly, on what sort of time commitment would be required from them and how we could accommodate that to enable them to do the locality work that we will take forward. That is being built up and will be part of a strategic plan that will be signed off by the end of March by the integration joint board.

Julie White (NHS Dumfries and Galloway): I will comment on pooled budgets, because we in Dumfries and Galloway have decided to include all the acute services in the budget from the outset. The reasons behind that are numerous. In the early days of setting up our proposals on integration, we wanted to ensure that there was transparency on the entire health and social care resource across the partnership. We recognised that the potential impact of our increasing population of older people and the increasing demands on health and social care services would be felt right across that partnership, and that decisions that are made in one part of the partnership—for example, acute services—have knock-on consequences for other parts, for example primary and social care services.

We in Dumfries and Galloway also decided to integrate all acute services, because we were committed to ensuring that we maintain the integration of health services. We maintained the integration of primary and secondary care services and did not create any unnecessary divide between them.

In many ways, we are lucky in Dumfries and Galloway in that the health board and the council have coterminous boundaries and there is one district general hospital. That enables us to make decisions around the entirety of the resource that is available to us. When we presented our integration scheme to a meeting of the full council earlier this year, we had incredible support from the local elected members for the inclusion of acute services in the integration scheme from the outset.

One of the other reasons for including acute services was that we also recognised that there was an assumption—explicitly in some areas and implicitly in others—that we could reduce the cost base in acute services and transfer that resource quickly to primary and community care services. However, with the pressures that we are currently facing within acute services—around increasing demand, access targets, medical locums or whatever—it is difficult in practice to make that shift. We felt that if we had transparency about the totality of the pooled budget and about the pressures on that resource, we could reduce the increase in expenditure on acute services over time and see an increase in the percentage of the funding that is available to primary and community care services.

10:15

Elaine Mead (Highland Health and Social Care Partnership): It is probably appropriate for

me to go last, because the model is slightly different in Highland—as committee members may be aware. The Highland lead agency model allowed us to completely integrate the budgets from the outset. That was back in 2012, when we first moved to the model. We now have a single budget with single management and single governance, which we believe works well for us.

That model has been important because it has allowed us to look across the totality of funds from acute care through to secondary care and into adult social care. As my colleague from Dumfries and Galloway has described, having the whole system within one budget allows us to look in a different way at how we deliver services.

It is a significant budget of £116 million and there has been investment in that budget from the Highland Council and NHS Highland over the past four years. It is important that we examine how we use every single penny of that budget. One of the really important things that we set out to do was to try to lose identification within the budget over time, so that it was no longer a healthcare pound or a social care pound, but a care pound, and we could move the money where it was needed.

Clearly, it is difficult to release the pressure on the acute sector and we are in the process of redirecting resources from the acute sector into the community sector—primarily into primary care to support general practitioners, in particular, to lead teams in all the localities. For example, in NHS Highland this year, we redirected £5.4 million of investment from the NHS Scotland resource allocation committee—NRAC—parity funding into adult social care rather than putting the funding into health in the first instance.

Highland is organised into nine localities that are overseen by district partnerships. We are considering—under the Community Empowerment (Scotland) Act 2015—how we want to build on that experience. It has been successful in some areas, but it may not have gained quite as much traction in others. However, the clinical and social care teams are now fully integrated in localities, with a single point of access for each locality for healthcare and social care, and for the public to access services in those areas.

Malcolm Chisholm: Thank you for that. The budget seems to be easier to manage under the lead agency model, which begs the question why Highland is the only authority in Scotland that has gone down that route, but let us just leave that sticking to the wall.

On the locality issue, we are really interested in what Dumfries and Galloway is doing, but we accept that Edinburgh and Glasgow cannot take that approach because the hospitals serve various local authorities and so on. I am still intrigued about how the set-aside budgets will be determined, but we will leave that aside as well, since you have given an answer on that.

My locality question springs from the Audit Scotland report on health and social care integration, which says that

"arrangements for localities are relatively underdeveloped".

I accept that West Lothian is ahead of the game, but I am interested to hear more about how the witnesses view the localities arrangements. When we were working on the Public Bodies (Joint Working) (Scotland) Act 2014, many of us thought that the localities element was one of the most important and exciting parts of it. It is concerning when we read that

"arrangements for localities are ... underdeveloped".

How do you envisage the scope of those arrangements—for example, would they include locality budgeting and so on?

Perhaps David Williams wants to comment: I think that Glasgow was criticised last week in the Parliament debate on health and social care integration by at least one member—not me—for having a bit of a top-down approach rather than being locality focused.

David Williams: We plan to have three localities in Glasgow. We are endeavouring not to create tiers of bureaucracy and governance as a consequence of the 2014 act, so we need to be fleet of foot. Part of the approach to integrating health and social care is about how we can build on the existing community planning arrangements in the three localities, including area partnership groups, and taking into account the Community Empowerment (Scotland) Act 2015.

We are clear that we do not want to establish additional planning functionalities specifically and solely around health and social care. I am clear that mere integration of a significant part of a health board's functions and services with a significant part of council provision will not, in and of itself, deliver the aspirations of the health and social care legislation in respect of national health and wellbeing outcomes. That is the key to the word "partnerships", in terms of health and social care partnerships.

On the construction of IJBs—in relation to voting members and, more important, non-voting members and all the stakeholder groups that are represented in IJBs at the point when decisions are made about delivery of health and social care in their area—partnership has to mean much more than just bringing together two workforces and two budgets, because the resource will substantially be located, in people terms, in local communities.

If we are serious about transforming how health and social care are delivered in Glasgow or anywhere else—that includes impacting on the health improvement and health inequalities agendas and the shift in the balance of resource from acute services to early intervention and prevention—our aspiration has to involve improved engagement of neighbourhoods and communities and better support for carers and families. That does not relate to a top-down approach but is much more organic and built in to the system of how the city works in the three localities.

We will work closely with our community planning partners to deliver on that agenda. That should allow the integrated arrangements to focus on clear and particular need that is identified for people who require health and social care services at different points in their lives.

Julie White: Our four localities in Dumfries and Galloway are built around natural communities, natural localities and historical arrangements through the old district councils. An important aspect of the localities is that our communities really identify with them. We say in our strategic plan that health and social care integration must lead to staff and local communities feeling that we are smaller and much more responsive to local need.

Integration is not about developing new structures and monolithic bureaucracies. It is important to note the arrangements that we have developed within localities, whereby we look to delegate our budgets to them so that the budgets are as close as possible to the communities. We are also introducing joint integrated management arrangements for health and social care across our four localities.

As David Williams highlighted, one of the key things that we have learned is that successful integration is based not on us just bringing two organisations together, but on genuine engagement with our communities, on changing our relationship with them and on development of those four localities. In our public engagement groups, we are engaging with members of the communities and involving the third and independent sectors in development of our locality plans. We are consulting on our four draft locality plans, which describe how we will deliver against the priorities that are set out in the strategic plan. In Dumfries and Galloway, there is a strong commitment to devolving as much decision making as possible to local communities, and the locality plans will reflect how they will deliver on the aspirations that are set out in the strategic plan.

Richard Lyle (Central Scotland) (SNP): Julie White has grasped the issue with a passion.

I come back to a point that Jim Forrest made. Do you think that we have missed a trick? I am all for local democracy—I was a councillor for three decades. North Lanarkshire and South Lanarkshire have two IJBs and East, North and South Ayrshire have three, although I understand that they are starting to work together. We used to have what was called Strathclyde fire board as the joint fire and rescue board for Glasgow, South and North Lanarkshire and other authority areas. Have we missed a trick by having too many boards?

David Williams: There is certainly a challenge for—dare I say it—the smaller partnerships in relation to their ability to deliver what sits behind the legislation, which is about transformational change in how health and social care can be delivered. In Glasgow, we have an opportunity to substantially change the way in which health and social care are delivered. That will not happen overnight, but we hope that it will have a bigger impact on how health and social care are delivered.

That is because of scale—the Glasgow budget for integrated arrangements will be just short of £1.2 billion. There is a workforce of 9,000 involved in that and, broadly speaking, another 20,000 are involved in the care environment through the commissioned provider sector, the voluntary sector, the independent sector and other bits of hospital care that are not linked to integration planning. We know that there are probably about 50,000 unpaid carers in the city. That is a workforce of paid and unpaid carers of about 80,000 people. That is a significant volume of influence if we get the culture and the approach right in relation to how we want to address the issues that are significant to Glasgow. We have the ability to deliver on that and achieve that because of scale. That potentially sets us apart from other parts of the country where it might be more challenging to achieve that level of change.

Elaine Mead: We have a once-in-a-lifetime opportunity to transform the care sector, and I am not sure that it is particularly dependent on scale. My view is that it is built on trust and relationships, and maximising the use of the resources and capacity in organisations and in the community.

That means that we have to redirect the way in which we use our resources. For example, the additional investment that we have made in acute geriatricians, who would normally have been working in hospitals, so that they are working out in the community as part of integrated teams has already had an impact and reduced the number of older people who are being admitted to hospital. They are maintaining their independence. We will start to see the shift when we find that we can change the way in which we deliver care.

The Convener: I have a couple of questions based on your earlier comments. For a period of time, we have been searching for a shift of finance and people from the acute sector to the community sector. I do not know whether you can describe some of that, given that you have had it in place for a considerable time. When the committee visited at the start, the hospital was almost being left alone to get on with it. I presume that things have progressed since those early days.

How much of the budget has shifted into the community? What is the acute sector budget now compared with what it was then? Has there been a significant shift? Can that be measured?

10:30

Elaine Mead: It is very difficult to measure that shift, which colleagues have described as a shift in the balance of care, because of the continuing requirement for us to deliver care in the acute sector. We need to deliver all that emergency care as well as the elective care. That consumes a huge amount of resources, and that is very difficult, given all the things that we are asked to deliver. It is hard to switch that off with an increasing population.

However, as I have already described, when we had additional NRAC money, we made the active decision to invest that directly in adult social care. That has given us some immediate benefit, by increasing the number of care-at-home workers. Having a single tariff across the providers in Highland has meant that they are now working together in zones. That keeps people closer to home and in their homes for longer.

That shift in resource—although resource has not technically been taken out of the acute sector—has moved money that could have been invested in the acute sector into adult social care instead. There is no doubt that just having the acute geriatricians working in a different way is a shift in the balance of care.

The Convener: I understand that. It is a good example but, as an example, it is the exception rather than the rule. There is a perception among us all that we need to shift resources and finances into the community, and the health service has an opportunity to shift that budget, but that would not be your experience, would it?

Elaine Mead: That is not yet our experience, but it is coming.

The Convener: How long have you been doing this?

Elaine Mead: We have been doing it for four years.

The Convener: So you are four years ahead of everyone else.

Elaine Mead: Indeed.

The Convener: There has also been some criticism about the slowness of the process, the impact, and whether and when it will make a difference to people. I am just trying to gauge the situation. Four years in, you are unable to describe that shift in budget, because it is difficult and demand is increasing.

Elaine Mead: We could have invested the NRAC money directly in acute care and taken out some pressures in that sector, but it would not have helped the whole system. In considering a whole system of care, we have to look at where every penny is invested and how every penny is spent. Our approach to looking at how we can genuinely shift the balance of care involves not having people who do not need to come into hospital coming into hospital and looking at how we spend every penny of the health budget.

We are looking to take out the waste, harm and variation in health care in the acute sector, with the view that that will allow us to invest more of that resource—

The Convener: But for those of us who think that the integration process will shift money from the acute sector to preventive and community services, it will be a long time coming.

Elaine Mead: It will certainly take time, because we have to change the model of care—people are sometimes unnecessarily admitted to hospital and we need to manage those cases in a very different way.

The Convener: So how far are you into that journey?

Elaine Mead: We are about five years into that journey. Before integration, we were already looking at removing waste, harm and variation from our system. We think that we can already see parts of the system coming back into balance. That has been helpful but, as yet, we are not ahead of the curve and able to say that we can take a certain amount of resource and move it into the community. However, we have not had to extend our acute sector to provide more care. Had we not been working across the whole sector, we might well have found ourselves under the same pressures that other health boards are currently experiencing.

The Convener: If I look at Lothian and Glasgow, where there are different organisational circumstances—that is an issue in itself—are there greater opportunities to disinvest from some parts of the acute sector and transfer that resource to the community?

Jim Forrest: Yes, there are opportunities, but there is also a challenge that is not just about moving resources and spend. We also have to examine the current job profiles and roles. We are considering and starting to move on the medical roles. Instead of someone being hospital or community based, they will have a role in both parts of the services, particularly in relation to older people's services. For older people, who come in through medical wards and assessment units, admission to hospital sometimes means that they get stuck in the system and it does not do the best by them. As well as having hospital-at-home services, we are looking at geriatricians and physicians playing a dual role both in the medical wards and in leading some community services to ensure that we have more integration of the whole service right across the pathway.

An analysis of our frailty programme that is going on just now is looking not only at social care but at admissions to hospital and the blockages in the system and, as a result of that, we will be able to change the service that we offer. We have used the integrated care and daily discharge funds almost as pump priming for additional capacity in the community and social care elements of the services to gear ourselves up for looking at how we deliver the outcomes that are really necessary across the board.

With regard to the preventative aspect, we are looking at preventing admission in the first place and bringing hospital-at-home services straight into somebody's residential setting. We are also analysing the effectiveness of that approach, whether it actually prevents admissions and disruption to the person and, if so, what effect it has on hospital services over time. That ensures that once we start to bed these services in, we can start to transfer some resources into sustaining them in the longer term.

I should also stress that we need to change the demarcation of the roles right across a number of the professions to ensure that, particularly at the interface, they have a role in both elements. As a result, they will start to understand what actions are needed to ensure that there is no detrimental effect on one side or the other.

As part of that process, we are also looking at a new framework agreement for social care providers for care at home and the metrics in that respect. The whole system needs to take people much more quickly, particularly those who require what we would call higher-tariff care packages, which involve two carers four times a day. How do you respond to that as quickly and in a way that supports the whole service, improves the quality of care for people who are receiving it and ensures that they get it on time?

The Convener: More people are being cared for at home than has ever been the case, but we still have 90 per cent bed occupancy and bed blocking. David, how is health and social care integration going to deal with that?

David Williams: You are right, convener. The shift in the balance of resource from acute services to community-based provision provides more opportunity in areas such as greater Glasgow that have multiple numbers of hospitals and so on.

With regard to the ability to develop an evidence base, I think that it is almost a chicken-and-egg situation. Jim Forrest is correct to reference our use of the integrated care fund, which is the additional funding stream that the Government has provided as part of the transitional arrangements. You cannot just shift resource from acute services to the community without really knowing how people are going to be supported at the point at which, previously, they would have pitched up at accident and emergency and expected a service to be provided. There is therefore a need to develop not just an evidence base but a range of appropriate provision to ensure that alternative forms of support and care are provided and that better connections between community and acute services, particularly A and E, are made, especially at the point at which individuals and patients turn up at such departments.

Over the past 12 months, we in Glasgow have completely flipped our approach to delayed discharge and bed blocking. Instead of focusing on delivering the two-week delayed discharge deadline, which came into effect on 1 April, we have gone beyond that to look at getting as many older people out of hospital as close to their fit-for-discharge date as possible, and preferably within 72 hours. By doing that, we immediately do not hit the two-week problem or the delayed discharge issue. We have had significant success in delivering that and have thereby significantly reduced the level of bed days lost in the acute system in Glasgow.

That has significantly reduced the number of people over the age of 65 who have been delayed unnecessarily in hospital. It has been a case of moving individuals back into their own homes and communities and supporting them there. We have done that by substantially changing the approach and the principle, which is about getting people out of hospital more quickly rather than waiting for things such as assessments to happen. Assessments of need take place in a more community-based environment in something called intermediate care beds, the number of which we have significantly increased over the past 12 months. We have used the integrated care fund to deliver on that.

The strength of that approach has been that, for every 100 people who have gone through those intermediate care beds on a four-weekly turnover basis, 30 have gone home. Until a year ago, the chances were that all 30 of those individuals would have gone permanently into a residential nursing care placement directly from their hospital beds. We are shifting the resource, not necessarily from the acute sector in the first instance, but from the residential nursing care sector.

Implicit in that—to a certain extent, this needs to happen more explicitly—is a re-evaluation of what we would call the threshold of risk and an empowering of individuals to take different decisions about where they want to be and how we enable that to happen. Most older people tell us that they want to be in their own homes; that is where they want to see out the rest of their days. There has to be a re-evaluation of the threshold of risk in that regard.

We have established an evidence base. We have been able to sustain the performance on delayed discharges over the past number of months—we touch lots of wood all the time. We are aware of the pressures that winter can present, so we are working really hard on sustaining that performance. If we can sustain that continuously, that will give us an opportunity to look at what we can do, jointly with acute care, on front-door provision and accident and emergency presentations.

Part of our challenge and our responsibilities in the health and social care partnership is to consider how we look at anticipatory care, how we prevent things from happening and how we avoid unnecessary admissions at the front door. We are working on things that can assist with that right now, particularly in the area of communication—including information and communications technology systems—between A and E departments, GP practices and local authority social work provision about an individual patient. One of the changes that we have made already in Glasgow is to do away with the single unique identifier that social work has historically always given to service users as they have come through the door. We have switched to using the person's community health index—CHI—number, which allows an immediate connection to be made there.

We are working to create the technical bridge that will allow A and E departments to understand who else is involved in an individual's life, which might enable a different decision to be made by the A and E departments about whether to admit somebody or to divert them back home with an amendment to the support arrangements around them. That is the next challenge or approach that we need to take in Glasgow. If we can tackle both ends of the hospital system, what should necessarily follow from that is clarity on what use—and I do not mean that in a pejorative sense—needs to be made of acute functionality in future. That might realise efficiencies that can be delivered somewhere else.

Elaine Mead: Building on David Williams' comments, which I fully endorse, I think that the use of intermediate care beds and changing the place where assessments are undertaken are absolutely critical. As far as that whole-system approach is concerned, I think that what David was describing was how we can ultimately reduce the occupancy of acute beds. That is where we need to get to and the long game that we are looking for.

Increasingly, we are recognising that we need fewer beds in our hospitals, but at the moment they are full of people whom we are struggling to move through the system. We need to use intermediate care beds so that we can assess people, change the threshold of risk that David Williams described and support people at home. There has been a reduction of more than 80 per cent in the care needs of people who have been through our reablement system. That is significant, because it means that we can redirect some of the care-at-home support to people who really require it and move others out of hospital.

We are involved in a long game here—we cannot change things immediately. At the moment, the resources are tied up significantly in acute beds.

10:45

Bob Doris (Glasgow) (SNP): I want to look at the balance between the acute sector and primary and community care and how that fits in with integration. If someone presents at A and E with sight problems—for example, because they have cataracts—or because they have had a slip, a trip or a fall as a result of needing a hip replacement, there is a cost to the acute sector, and the on-cost of enablement back at home is higher.

In a private session that we had with Audit Scotland before the meeting, I raised that issue in relation to the £200 million that is going to be spent in the acute sector at the Golden Jubilee hospital and in four designated surgical units across Scotland. We want to make sure that, with an ageing and increasingly frail population, we have the capacity in the system to maximise the time for which people can be fit and healthy at home and thereby reduce the risk of their presenting at A and E as a result of injuries.

As that £200 million is investment in the acute sector, it would seem in budgetary terms to go against what we are seeking to do in shifting the balance of spend from the acute sector to primary

and community care. That is why I thought that it was interesting that NHS Dumfries and Galloway decided to include acute spend as part of its spending on an integrated approach to health and social care integration. I do not want this to be a dry and dusty accounting discussion in which we argue about where the numbers should sit—even though I and Audit Scotland would probably love that—but how can we become a bit less one-dimensional in looking at investment in the acute sector and how it can drive improvements in health and social care integration and the community agenda that we all support? I would appreciate some thoughts on that, so that we can determine what is good and what might be slightly more short-sighted acute spend.

The Convener: Julie, you have not said anything for a wee while.

Julie White: Thank you, convener. You have raised an interesting point. As you have said, we decided to include all of that spend on acute services to ensure that there was real transparency in resources and what they were being used to address.

In Dumfries and Galloway, a number of changes have been made to investment in acute services that are about supporting people to be maintained at home for longer. For example, we have introduced an ambulatory care approach in our medical admissions unit, which basically means that when someone is reviewed in that unit, instead of giving them a hospital bed, we are looking to provide rapid assessment and diagnosis of that person within acute services. That means that we can turn that patient back to community services as quickly as possible and thereby avoid their making use of a hospital bed. Although that might be seen as investment in acute services, it is aimed at shifting the balance so that people are not admitted to acute beds. They might have a short-term assessment in hospital and then be returned to the community setting.

Investment is also being made in things such as out-patient antibiotic therapy, for which, in the past, patients would have been admitted to acute services. That investment is intended to allow such therapy to be delivered to people as day-case patients, which avoids the need for them to be admitted to hospital and supports them in remaining at home for as long as possible. That is another area in which, if you looked at the figures, you would see an increase in the resources for acute services, but it has a positive impact in delivering the aspirations of health and social care integration.

A key area that we need to focus on in shifting the balance of care is reducing the rate of emergency admissions to secondary care. In NHS Dumfries and Galloway, we have undertaken a range of tests of change that were supported originally by the reshaping care for older people fund and then through our integrated care funds, and which are about supporting the use of technology to allow for the remote monitoring by acute services of individuals remaining at home.

One example of that is the provision of telecare to people with chronic obstructive pulmonary disease and supporting them to remain at home. We are also considering community early warning scores for respiratory patients, which would alert the patient and our teams in acute services to any changes in the individual's condition that might require some interventions. There have been some significant shifts in our resource and in the use of the integrated care fund moneys to develop new models of care and ways of supporting individuals to remain at home for as long as possible.

Bob Doris: I would be interested in knowing whether other witnesses have a perspective on the use of acute moneys, what is good acute spend and why they did not put in for part of that overall pot of cash.

Elaine Mead: On your comments about investment in elective care centres, Mr Doris, my view is that, if we think about it a little laterally, we will see that it has for sure a long-term benefit for older people. Clearly it means more investment in the acute sector, but it is more than that. As cataract surgery prevents falls, there is no question but that that is a significant investment for older people; moreover, hip replacements allow older people to maintain independence. Both things support the models that we are trying to describe to you and separate day cases or short lengths of stay from the acute hospital streams.

David Williams: As far as I can see, the acute system tends to work in a crisis-response mode. Inevitably, as our experience sadly shows, the challenge is that whatever money goes into that system tends to prop it up. That is the point of integrating health and social care. The perverse outcome or unintended consequence is that less money ends up going into the early intervention and prevention model, which reduces the potential to develop the models of care and the opportunities that Julie White described. That sort of financial squeeze at the wrong end of the system is contrary to the health and social care partnership's aspirations.

We need to be careful about the money that Government makes available to the acute system or to health boards. If we really want the 2014 act to make a change, the money needs to be directed at the integration of health and social care.

Jim Forrest: Like Elaine Mead and the others, I think that the investment in the regional surgical centres will make a difference. Part of the answer is contained in your question, Mr Doris, in that, if somebody has to turn up at A and E as a result of having a cataract or has fallen because they need a hip replacement, we can say that other parts of the system have not worked properly for them. Having the regional centres will help because that will enable us to manage people and book them in appropriately for their ophthalmic surgery or planned orthopaedic surgery, for instance.

However, the other part of the package needs to be that, once such patients have had their acute procedure, their rehabilitation takes place in their own residential setting. Therefore, we will have to discharge people to assess their rehabilitation needs, rather than cover all that in expensive hospital beds. If we invest in that part of the service and use our integrated care funds to manage people much more appropriately, deal with any acute exacerbations and plan people into the services in a managed way, there will be less of a demand for other hospital beds and the community resources will be based in people's own residential settings. Resourcing the kind of intervention that Bob Doris mentioned is a staging post along the way to where we need to get so that we can see these things in the round.

We need to be careful to talk to all the community resources. Moreover, given that primary care is under pressure as a result of the limited recruitment of GPs, we need to look at the primary care model, make it much more multiprofessional and ensure that it takes on all kinds of different roles so that we target GPs, for example, exactly where we need them instead of making them do a range of other things.

We should not underestimate the need to invest in models of social care to support all these activities; after all, they have a significant effect on individuals' lives and even a small social care package can make all the difference in maintaining someone at home. We need to see these things in the round, and the investment in surgical centres will be key to managing the whole pathway. People in Lothian can access the Golden Jubilee, but for those who are already medically compromised or who are older and frailer, it is a major upheaval not only to go in for a procedure but to have to travel that distance, with everything that goes with that. Of course, they get a very good service at that hospital, but we should not underestimate the effect on people of having to get there. In fact, it puts people off doing things in a managed way, and then they have an accident as a result of medical compromise and you face a much more expensive and difficult process in managing them.

Bob Doris: Mr Forrest has come close to identifying what I was trying to tease out. You have all fleshed out why we should not be one-dimensional in discussing acute versus community and primary care, and it is really helpful that you have put that on the record.

However, the question that I had in my head is: what happens if a health and social care partnership realises that it has 50 or 100 clients who would significantly benefit from a cataract operation now but who, although on a par as far as clinical need is concerned, are subject to other social dynamics? How would it seek to increase capacity in the acute sector to get those people through the system quicker and get the social benefit of reducing slips, trips and falls and so on? I do not want to do the accounting thing, but I wonder whether bringing some of the acute budget into the gambit can drive change.

The Convener: Perhaps I can add another aspect to that. Looking at the £200 million for the acute sector initiative and the £100 million for the A and E initiative, I have to wonder what that £300 million would have done if it had been invested in the community. Given your responsibilities, the tightness of the finances and so on, if you had had access to some of that money, would the priority of the integration boards for your communities have been more hip or cataract operations or would it have been the transformation of services? One of the better examples, which made us all scratch our heads a wee bit, was the investment in A and E services. After all, we all know that the solution to that problem is not having more doctors and nurses in those services but preventing people from going to A and E departments. Had that money been available, would you have used it in that way or would you have set other priorities?

David Williams: This relates to where I think Mr Doris was going, but our experience of flipping the two-week delayed discharge target on its head and asking whether we could do better has proved to us that we could do more in a preventative sense by taking an early interventionist approach and tackling at an earlier stage illnesses or accidents—or, indeed, frailties such as hips that need to be replaced or cataracts that need to be removed. That sort of approach has a positive social impact.

I would certainly have considered using that money for a range of things in that kind of context, but we would have to have done a little bit of work to identify the big-impact issues.

We used the integrated care fund specifically for delayed discharges, because that is a big national priority at multiple levels. In terms of the balance between cataract replacement, for example, and cancer treatment or whatever, in relation to scheduled care, we would have to do a bit of work

to understand what would be the big impact and how that could release more opportunities for the use of the acute system further down the line.

11:00

Elaine Mead: It is all about balance. If you want us to deliver the waiting time guarantees, we need the elective capacity. It is as simple as that. Choices are made and our job is to put those choices into practice and operationalise them as best as we can.

Of course we want to be able to put more resources into the community. I think that we would all agree on that. However, we also need to deliver the other requirements that are expected of us as a health and care system.

Julie White: The on-going financial pressures in acute services, such as the delivery of access targets, means that, faced with that prioritisation around a budget of £300 million, there would need to be some investment in capacity for us to be able to deliver those access targets.

I think it is important to flag up to the committee that the majority of the performance metrics that are used to assess the performance of national health service boards are focused around our access targets and delivery of unscheduled care. You can see how that means that a decision would be made around investment in things such as the elective centres to deliver against those access targets.

If, through integration, we start to look at a different range of performance metrics that consider how well we deliver health and social care to achieve those nine national health and social care outcomes, that may lead to different investment decisions. While we are measuring performance against a range of indicators that are focused on acute care, elective care or unscheduled care, that will drive investment decisions.

Within Dumfries and Galloway, in our partnership, and looking at the totality of the resources across the health and social care system, we have identified a range of pressures in acute services that we must address. That includes things such as our use of medical locums, which is about sustaining safe clinical services on the ground and creating the capacity to deliver against those access targets. We also see increased financial challenges in terms of delivering the waiting time guarantees and so on.

In our partnership we see that that has to be balanced against the real financial and capacity pressures that we are experiencing in primary care and social care services. For example, we know that in Dumfries and Galloway we have a much higher number of GP vacancies than we have previously experienced. When we forecast the number of retirals over the next few years, we see that that is also increasing considerably, so we have to think about how we invest in a different shape of primary care, in order to support more people in the community setting and at home. That is critical for us.

We also know that we are experiencing extraordinary increases in demand for social care services for older people and younger adults with complex physical or learning disabilities. As a partnership, in recent days and weeks when we were identifying some of those difficult financial pressures, we have looked at the totality of the resource available through the integrated care fund and the delayed discharge moneys to establish how we can reinvest some of that money in the community setting to support more care at home to avoid unnecessary admissions to hospital.

When we look at the availability of resources, we have to look across the totality of the health and social care system but prioritisation of resources is often directed by the performance metrics that partnerships are working to. There is a real opportunity through integration to change those performance metrics so that we start to see shifts in priorities and shifts in the use of resources.

Rhoda Grant (Highlands and Islands) (Lab): I have a couple of supplementaries to ask before I move to my main question. On the face of it, the elective care centres appear to be a good idea, but I wonder how they will work. The centres will be there, they will be staffed and they will not deal with emergencies—will that not require more investment in acute care?

My assumption is that elective care is put off at the moment because an emergency case comes in and takes up not only the theatre space but the time of the surgeon who would have been doing the elective procedure in the first place. Am I right to assume that we will have elective care centres staffed with surgeons and then we will have another pile of surgeons sitting and twiddling their thumbs because they do not have elective procedures to do, waiting for that emergency case, or will the surgeon who is working at the elective care centre receive a phone call saying, “Get yourself over here quickly—we have a theatre waiting for an emergency case but there is no one to perform the operation”?

Will having elective care centres really make much of a difference unless we make a huge investment in acute care so that we are double-staffing elective care centres and unscheduled care?

Elaine Mead: Streaming out the two services and separating acute and emergency care from elective care allows for some economies of scale and allows us to organise our work differently. I would not expect surgeons from one area to be called to run across to another area.

At the moment, we are inefficient in the use of one of our most expensive resources—the surgeon. By having an elective centre where we can protect beds and resources, we can identify people who will benefit the most from those elective care centres and move them through those centres quickly.

Rhoda Grant: Sorry to interrupt, but who will be carrying out the emergency surgery—the unscheduled care?

Elaine Mead: We will have to look at how we organise the surgical capacity and the nursing capacity but there is no question in my mind that we can be more efficient if we run—as Golden Jubilee national hospital does now—dedicated elective care cases without the interruption to the process and the system that sometimes happens when people are in beds and then surgery is cancelled and our surgeons are stood without work to do. We need to work out the logistics, but the way in which we are proposing that the elective care centres should work should be effective.

Rhoda Grant: I just do not get how you are going to staff the centres. If you are going to pull out the staff who currently do the unscheduled care and put them somewhere else so that they can beaver away and get through all those elective procedures, who will be there for the unexpected cases—the emergency care? Who will be waiting to deal with that?

Elaine Mead: There will definitely need to be some additional recurring resource to go with the capital investment.

Rhoda Grant: Okay. So it is a shift in the opposite direction?

Elaine Mead: There will need to be a shift in order to resource and manage those elective care cases. We could not run elective care centres in my area without additional capacity.

Rhoda Grant: Okay. I have another supplementary. People are talking about fast discharge, fast turnaround, rehab in the community and getting people home. It takes me back to when we were looking at the Carers (Scotland) Bill. We heard some horror stories about people being discharged in the middle of the night and people on oxygen being discharged when they had gas central heating and a gas cooker and being left for a fortnight without any heating or cooking facilities.

Assessment in the community is fine, but sending people home without the correct support is not only doing them a disservice; it is doing a disservice to the people who are looking after them. How do you square that circle?

Jim Forrest: I do not think that I was giving the impression that we would send people home without the appropriate support. In my partnership, I manage the allied health professionals in both the hospital and the community, across an integrated system. I manage a number of services that are already on the St John's campus and I manage all the community and social work services. As part of the programme to assess people when we are going to discharge them, we will mobilise those services to make sure that people receive rehabilitation and assessment in the community, rather than sitting in the hospital waiting for it.

We aim to have discharges on a managed basis, so that people have an appropriate discharge time with appropriate back-up facilities in place, from their discharge prescription right through to any health and care packages that they require when they go home. Clearly, if people are on oxygen, as a number of our clients are, that needs to be managed in the appropriate way, with checks, risk assessments and precautions being taken.

David Williams: The key to it is managing the discharge, whether individuals need a fairly low level of support or a complex assessment. There is the need for a risk assessment, if you like, rather than a community care assessment. It is a risk assessment of where an individual can go—whether they can go home or need to go to an intermediate care bed, to use Glasgow terms. That assessment is carried out jointly by ward staff and, in the main, our homecare provider organisation, which will be the first port of call for the delivery of additional support if that is in place. The whole point of integrating health and social care is to develop that partnership working between not just community and acute services, but also other services and support that are in place.

Rhoda Grant: What is the role of the unpaid carer in all that? What support is there for them and what is their involvement in that process?

David Williams: I have been very public with my comments about this in the last year and a half in Glasgow, and I have already mentioned the 50,000 unpaid carers that we have in the city. The reality is that most, if not all of us in this room will at some stage become carers, because of the demographics of the country and the state of the health and wellbeing of too many of our people, related to long-term conditions. Most of the country's population will be carers or, if they are not carers, they will be the recipients of care from

a loved one. That is an unpaid workforce that we have to value, cherish, nurture and support much better than we have historically been able to.

Part of our responsibility in health and social care partnerships, which is certainly a priority for Glasgow, is how we encourage and support the people of Glasgow to get used to the idea that, because of things such as demographics and health and wellbeing, regardless of how well or otherwise we are able to impact on things such as health improvement, there are still certain trends that clearly tell us that there will be a demand that paid services will not be able to deliver exclusively. We will need to rely on unpaid carers.

We need to support and encourage the people of Glasgow to get used to the possibility—perhaps even the probability—that they will become carers and, in order to support them to do that, we need to ensure that they feel confident and competent to carry out that task with dignity, respect and the appropriate level of care. They can only do that if they know that the support will be there for them at the time that they need it.

That is a step change from where we have been. In Glasgow, over the course of the last three or four years, we have done an awful lot of joint work with health and with carer organisations to get to a better place than where we were about five years ago. We are not halfway through that journey for support for carers and we still have a long way to go, but that is where we want to get to.

To go back to the question from Mr Chisholm about locality planning and whether there is a top-down approach, I would say that there is nothing more bottom up than supporting the multitude of carers and looking at the local resources that are in place for the provision of human services—not just health and social care—so that carers can feel supported and are able to carry on the important work that they do.

11:15

The Convener: People want to come back in for other questions, so we need quicker questions and sharper answers, please.

Rhoda Grant: Given that we are looking at the budget, what would you ask the Parliament or the Government to change to allow you to deliver services better and more appropriately?

Elaine Mead: Ideally, I would like some protection for the adult social care budget. That might sound strange coming from someone in a health board, but the whole model of care now needs us to be able to plan into the future with certainty. Even with the lead agency model, we anticipate significant reductions to this year's adult social care budget as resources to Highland Council have been reduced by potentially 5 per cent, so it is very difficult to plan into the future and develop long-term models of care. We would like some protected source of income—accepting that those resources might be subjected to known reductions, but without having to compete with other council priorities. In health, we have benefited from having a protected budget, but we would also want protection for the adult social care budget.

Jim Forrest: It is clear that we are in difficult financial times and we all understand that. Health and social care are now inextricably linked and, following on from some of the answers that I gave earlier, I would like some recognition of that in the budget, so that money comes directly to partnerships to look at how they would invest in health and social care across the pathway.

I would also like to see some money coming into the partnership from primary care, so that we can look at how we invest money in primary care in its broadest sense. We could then address some of the outcomes that we are looking to deliver—and that you are looking for us to deliver—through the transformational change that we are trying to make. We would also use that resource to empower local communities and work on local capacity building so that people take much more responsibility for their own health in a way that gives us the generational change that we want.

David Williams: There are still many of us who do not get health and social care integration. Although the new legislation has been put in place and we have gone ahead and introduced integration joint boards, there is still a large element within local and national Government and health boards that does not see integration as important and central to the change process that was the aspiration behind the legislation. The comments of my colleagues on the focus of resources for health and social care partnerships reflect that.

My own personal ask is twofold. First, it should be recognised that integration joint boards have a lead place in the transformation of health and social care provision in and across our communities. Secondly, and linked to that, decisions should not be made at a national level about how certain levels of new resource that might come to us are spent, because that limits the opportunity to make local decisions and priorities. The £200 million investment that Mr Doris highlighted is one example of that. Another is the new money that is coming to health boards to provide 500 health visitors throughout the country to deliver on the getting it right for every child arrangements. We should have a degree of flexibility about how that money could and should be used rather than the Government simply saying

that it needs to be invested in a certain grade and certain tier of health visitors who must provide a universal service.

In Glasgow, we have huge numbers of children and young people. The integration arrangements in Glasgow cover children as well, but I have no ability to influence how the money for health visitors is spent. It could be spent in a much more targeted way to support the most vulnerable children. We need to have a degree of flexibility about how local partnerships can use the increasing amounts of money that come from Government.

Julie White: First, I request recognition of the pressures throughout the health and social care system, from acute services to community health services, primary care and social care services. I also have some specific requests.

In Dumfries and Galloway, we have undertaken a huge amount of learning from some of the tests of change that we have initiated through the use of our integrated care fund moneys, for example. We have invested in services such as step-up, step-down care in care homes to avoid admissions to acute services and in reablement services to support people to maintain their independence at home for as long as possible. We have also considered forward-looking care plans, which are about identifying people's anticipated care needs and how we should respond to them so that we are not always reacting to crises. I talked earlier about some of the other tests of change that we have introduced. When the pots of resources are identified over a short period, one of the challenges that we have is the sustainability of services. If the pots of resources that are identified are recurring, that enables us to make significant improvements in reshaping care for people in our communities.

I echo the comments that have been made about the bundling of resources. Often, resource allocations are bundled together so that, although there might be a significant investment in a particular area, how those resources should be used is clearly identified. It would be very much appreciated if local partnerships could have a greater degree of flexibility about how those bundles can be used.

I would also really appreciate focus on the challenges in primary care and our sustainable models of primary care. I am obviously aware of the negotiations about the future general medical services contract, for example. It is important that we make that contract as facilitative as possible to support GPs to have the capacity to become much more involved and engaged in the integration process.

Nanette Milne (North East Scotland) (Con): Where in the patient journey does discharge planning currently start?

Jim Forrest: Discharge planning should start the day someone is admitted to hospital. The various teams that I have in the St John's campus in West Lothian—I have district nursing and social work teams there—should liaise with the ward-based staff and ensure that we have identified when discharge is likely to be and what will be needed to do it.

Elaine Mead: If possible, anticipatory care should prevent admission and then we would not start discharge planning. That might sound a bit flippant, but significant numbers of people end up in hospital because they do not have effective anticipatory care plans, so our focus needs to be there.

Julie White: I absolutely agree with Elaine Mead. For elective admissions, we should be planning discharge even before the person has arrived at hospital. For unscheduled care, we should be planning discharge on admission to hospital.

Historically in the NHS, we have often looked at bed management within acute hospitals. We have shifted the focus in Dumfries and Galloway and introduced what we have called patient flow co-ordinators, who are nursing staff or occupational therapists, for example. They are focused on patients and not on beds, so they are focused on what happens at every step in a patient's journey through acute services in order to minimise delays from the minute that person is admitted to hospital through to their discharge. They focus very much on patients with complex needs who have multiple interventions. We have shifted from focusing on managing beds to focusing on managing that whole patient flow right across the system.

Nanette Milne: I am glad to hear all that—it sounds like an ideal situation. However, I do not think that that is the case throughout the country at present, unfortunately.

I am glad that you have put the focus on primary care because I have felt, right from when we started talking about integration, that GPs have to be pivotal at locality level. West Lothian is some way down the road in involving GPs in locality planning, and it sounds as though Dumfries and Galloway is as well. Are other areas that witnesses know about in the same position? I am hearing anecdotally that GPs in a number of areas do not feel particularly involved. I do not know whether the witnesses have any experience of that.

Julie White: The position is variable, certainly across our localities in Dumfries and Galloway. We have identified GP clinical leads in each of our

four localities and they are working closely with the multiprofessional, multidisciplinary team in developing the locality plans that I talked about earlier. However, we have a number of GPs who face considerable pressure in their day-to-day activity, and freeing up capacity so that they can engage in discussions about health and social care integration has not been achievable in some areas because of those capacity constraints.

In our integration work, we have to think about how we support those GPs through new models of care, including primary care. We need to look at using extended primary care teams and at using advanced practice—advanced nursing practice, advanced AHP practice, and advanced pharmacists—to support general practice. It is all about supporting general practice so that GPs are focusing on what only the GPs can do.

I absolutely recognise the challenges of having that true engagement with the wider general practice community. We have taken some steps towards that engagement in Dumfries and Galloway with our clinical leads, but I recognise that we have a long way to go.

One of the ways in which we are using our integrated care fund moneys in our localities is to support practices to free up time for GPs to become involved in the discussions about health and social care integration and the development of locality plans. We are specifically using our funding to address that issue. However, I appreciate that we have a long way to go before we have consistency of engagement right across the patch.

Elaine Mead: In Highland, GPs are key to leading the multidisciplinary team based in the locality, as I described earlier. I agree with Julie White that a new model of primary care is required. In my view, GPs are best placed to co-ordinate and provide support to frail older people who have complex needs. Getting back to that sort of work may well ultimately aid the recruitment of general practitioners.

David Williams: I echo some of Julie White's comments about how great a challenge it is to engage with all GPs when they are so busy—particularly in the city. We have a number of arrangements in place and we hope to develop a systematic engagement at locality level. We are at the early stages of putting that in place but it is a big challenge. As I have already said, we also recognise the importance of locality. Central to that is what we call community anchors. GP practices are community anchors, as are housing associations and faith-based communities. We can engage all those community anchors in a broader partnership approach, and GPs are essential to that.

11:30

Colin Keir (Edinburgh Western) (SNP): As an Edinburgh MSP, I am going to be a bit parochial in this supplementary question about problems relating to the involvement of GPs in locality planning. Some of my colleagues and I had a discussion the other day with the chief executive of NHS Lothian, which is facing specific pressures between Jim Forrest's patch in West Lothian and mine in the west of Edinburgh. Given the potential growth and development in the west side of the city and West Lothian and the fact that GPs in many of the practices there are already feeling under siege, how will you implement the change and take along a group of GPs who are perhaps not sold on the idea?

Jim Forrest: As Colin Keir, and I am sure other members of the committee, will be aware, there are areas of the country, of which Lothian is one, where there is population growth and there are increases in housing development. We have a number of GP practices across Lothian that are under pressure because of that population growth and because of the premises that they are in at the moment. There are plans afoot. We have had an audit of all the premises across Lothian and we have prioritised those that are due for refurbishment, extension or replacement. In some cases there will be a call for additional GP practices and centres to be provided, some of which have been mentioned. The idea is to liaise closely with our GP community, to involve GPs as much as we can in the locality approach, in some neighbourhood type approaches and in the design or extension of other services, and to be as up front with them as we can about what will be available and possible.

The Convener: On that point, what planning is there on what the workforce is going to look like? There is the report on the redesign of primary care services and there is Lewis Ritchie's review. What impact will that have on your flexibility to operate and on your budget? Alongside that there is, according to their representatives, a significant bid for GPs to have a larger part of the budget.

Are we getting into a situation where, to create an opportunity to address an issue with GPs, we are overinvesting? Is there the right balance in relation to the role of GPs? We heard earlier that if GPs are not confident in the services that you are providing—I am talking about those carers who are in five times a day, and who are looking after people directly—they will continue to refer patients into the acute sector. I am trying to understand the balance here, because who can argue with the importance of the GP's role as a gatekeeper and so on?

The GPs are going to require some of your funding; they are going to be bidding for that and

they are negotiating a new contract. Where are the integrated boards and health boards in all that? Where is the proportionality in considering how important GPs are and what you are prepared to pay for them as against looking at the development and shape of the workforce in 10 years' time? GPs on their own are not going to deliver any of this, are they?

Elaine Mead: Our GP colleagues understand completely the complexity of the system and recognise that they sometimes put pressure on the acute system because there are no alternatives to admission at the time when they need them. If you get right to the front line, people understand the pressure that the system is under.

I had the privilege of being at a multidisciplinary team meeting with the director general recently. It was clear from listening to that team, which had an acute geriatrician sitting in the same room as the local GPs, a social worker and a multitude of team workers, including care workers, that they were focused on what was important for the individual and recognised that what they needed to do was to get the individual in front of the right person at the right place and the right time. That may well have been at hospital for a short period of time but, ideally, the aim was to keep individuals at home. GPs understand that an element of what they are doing is compromising what ultimately we want to do to keep people out of hospital.

The Convener: Are you suggesting that that sort of grouping will deal with every individual case that presents in the community?

Elaine Mead: There should be an anticipatory care plan for every individual. GPs oversee those individuals.

The Convener: But you just described a situation in which there was a senior social worker, a geriatrician and all those people discussing an individual.

Elaine Mead: Indeed.

The Convener: How many cases does that apply to?

Elaine Mead: They will be picking off the most complex cases and the ones that most need that expertise.

The Convener: We need to be careful in our evidence and make it clear that what you are describing is not the norm.

Elaine Mead: It is not the norm for every person. This is really my point about having an integrated team: the integrated team would segment the population and identify the people whom it can support most, as a team. That is important, because the GP has a critical role in that. Our GPs are fantastic at keeping huge numbers of people at home; we want to ensure that they are supported to continue to keep people at home.

The Convener: The point that I am making is that the GPs do not do that on their own.

Elaine Mead: They do it as part of a team.

The Convener: When we talk about the GP contract, we have to talk about the role of the social worker. We also have to talk about how we value carers, who are the people who are going in five times a day, and about what we pay them and how we train them.

Elaine Mead: Absolutely.

The Convener: If GPs do not have confidence in what is being delivered on the ground, they will continue to refer patients to the acute sector, will they not?

Elaine Mead: They will. That is why having GPs working in localities as part of a whole team means that they can understand the issues, redirect resources and support keeping people at home.

The Convener: How much will that cost? How much of your budget will we need to give to GPs? Have you worked that out or been consulted on that?

David Williams: In Glasgow, we have not worked that out—negotiation on the GP contract is national and IJBs are not substantially involved in that. We have been variously consulted, and presentations have been made to chief officers by representatives working on behalf of GPs nationally. The language that is used is very much about partnership working and engagement with health and social care partnerships. We have to take that in good faith.

The convener was right to highlight the level of intervention relative to need that would be required for individuals becoming patients of GPs or being required to have more frequent consultations with GPs.

In Glasgow, we want to reduce bureaucracy and the approach that ties people up in the system. The whole point of integration is the creation of a seamless journey and throughput of people. For some people, and we hope and expect that to be many and most people, we ought to be in a position to provide what we in Glasgow would call a purposeful intervention—whether that is a GP, nurse, pharmacy or social care related provision, or something that just happens in the community—with the intention of avoiding things spiralling up to higher-cost, higher-level intervention for the lack of something else. That is where we are going.

The Convener: We see workforce costs in our evidence on the workforce—there is the 1 per cent increase or whatever. What has been factored in for additional costs of the new GP contract and their impact?

David Williams: We have not factored in anything for the new contract.

The Convener: I presume that the Scottish Government will pay for that and that it will not come out of your budget.

David Williams: I have to be honest and say that in Glasgow we have not given that issue that level of consideration. My assumption is that additional costs for the contract would be provided for nationally.

Julie White: As I said earlier, part of the review of the GMS contract has to be about how we create capacity for GPs to engage in integration in a more meaningful way than they have to date. Demands may be placed on health and social care partnerships to find resources to facilitate some of that GP engagement, which would be justified.

More broadly, the convener asked how we are planning for the future workforce. In Dumfries and Galloway, we plan to publish our first workforce plan for our partnership in March next year. A step that we have taken is to look not only at our traditional health and social care workforce that is provided via the local authority and the NHS, but at our colleagues in the third and independent sectors, and at the need for changes in roles as we move forward. For example, the convener talked about GPs having confidence in the standard of care that is provided through home care. We have supported and continue to support independent sector providers on training and the principles of reablement, for example, so that when we support individuals in their own homes, no matter who does it—home carer, district nurse or GP—we focus on the principles of reablement and encouraging the person to become as independent as possible at home.

I appreciate that the challenges in our care-at-home provision in Dumfries and Galloway might be different from those of the cities, but we certainly need to make the care-at-home sector attractive for people to enter and we need to ensure that care at home is seen in the community as having professional standing. We are looking at career pathways: as we integrate health and social care, is there an opportunity to develop new career pathways for home carers that will give them opportunities to develop and which will attract people into the sector and retain and develop them?

The convener asked about the role of GPs. I absolutely believe in the centrality of the role of GPs in health and social care integration, but they have to be part of the wider multidisciplinary and multiprofessional team. I talked earlier about advanced practice roles that we need to develop in primary care to ensure that we have a sustainable model of primary care in the future. Whether that is in-hours care or out-of-hours care, we need to think about that. GPs are absolutely central, but they cannot be the only answer. When we look at our projections in Dumfries and Galloway for retirements in the future and our recruitment challenges, which I talked about earlier, we see that we really need to think about the wider multidisciplinary team.

As I have said, we know that patients are becoming more complex, there are increasing demographic pressures and people are living with multiple long-term conditions in the community. The role of the wider primary care team is essential to support those individuals to remain at home and to avoid unnecessary admissions to hospitals. As I have said, work is in progress, and a host of workforce issues will be reflected in the workforce plan in March next year.

11:45

Richard Lyle: Julie White and Jim Forrest talked about GPs, as did Elaine Mead. It is about having fewer beds in hospitals. Most people are telling us that we need more beds, but we need to ensure that people can stay at home, with their bed at home basically becoming a hospital bed. The Scottish health budget is now £12 billion: more than a third of our budget is spent on health.

Prior to becoming a member of the Scottish Parliament, I had the great honour of driving for the out-of-hours service for two and a half years. The doctors were very committed and very able, but on any Saturday when I was driving with them they might admit four or five people to hospital, so I say to Elaine Mead with the greatest respect that planning went out the window at the weekend. That is a problem.

What can we do to upskill our out-of-hours service and enable doctors to cope with what comes at them locally? In just over a week it will be Christmas. I was in several hospitals a few years ago, and things have not changed since then; maybe they have got worse. Accident and emergency departments were absolutely choked on Christmas day and Boxing day, and the out-of-hours service would become a second A and E, with people realising that they could use it at 3 or 4 o'clock in the morning or whatever. I was there at those times. I admire what was done in the hospital and I admire the service that all the doctors provided, but how can we ensure that we cope at Christmas? How can we ensure that our doctors can relieve the pressure on hospitals and contain people at home?

I also have a follow-up question.

Jim Forrest: The issues that you raise take us back to a number of things. We have to give GPs, in particular, confidence that the wraparound services can respond within an appropriate time—that is, within hours rather than days. The response time is important.

Let me give you an example. In social care circles in West Lothian we have implemented a crisis care service, which is staffed seven days a week, 24 hours a day. If someone is in receipt of a care package and is on the GP case load, they can phone the crisis care service, which will pick them up without the GP having to admit them.

What often happens is that the health service admits an individual and then decides what to do with them. That dynamic has to change. People should be admitted only when it has been decided that admission is really necessary and the wraparound services are unable to cope. Avoiding admission might be about crisis care, adjusting someone's social care package or implementing a hospital-at-home service within a few hours, so that the service can be brought to the individual.

Such approaches offer a significant step forward and might be quite different from Richard Lyle's experience of driving with out-of-hours GPs. However, GPs have to be confident that there can be a response within hours, and it has to be as simple as possible for them to make the call so that services kick in.

We keep mentioning anticipatory care. It is also important that everyone who is in a care home or who is living at home with a care package should have an anticipatory care plan, so that if their acute underlying condition is exacerbated it is clear what needs to kick in and we do not just disrupt their lives and take them to hospital.

There are a number of challenges in that regard. We have to consider the workforce of the future in primary care and in community care, in its broadest sense. We can recruit a limited number of GPs. Although GPs are very important, they are also quite expensive, so we have to look at how other professions will fit in to the multidisciplinary team: nurses, pharmacists and allied health professionals have to work within that team. We have to manage the public's expectations such that someone seeking an appointment in primary care might not necessarily see a GP, but one of the other professionals. It might be done in a different way.

If we are truly going to shift the balance of care, we will have to take things from our hospital campuses; that is what it will mean, rather than just having the status quo plus. We will, with the best will in the world, also have to manage political expectations. There is therefore a challenge within the resource framework with regard to how we are going to move things around, and we are at a very early stage in that journey.

We will deliver hospital care at home and work with people who have dual roles because they work in the hospital and in the community, so I would like in some of our hospital campuses a set number of beds being funded by partnerships, with those primary and community care-type beds having the back-up diagnostic facilities that they need. We would have only a small number of those beds and there would need to be quick turnaround in their use. People would not go through A and E, but would go directly to one of those beds and be back out again once they had treatment for acute exacerbation of their condition. The process would be as quick as that and everything would have to kick in quickly.

So, we are on a journey. I know that people keep saying that, but we do need to develop the process and refine it, and develop the workforce that will complement it. We also need to look at the patterns of care over 24 hours, seven days a week, to see what is required; we need that evidence base in order to target our support.

The Convener: Does anyone disagree with that or have anything to add?

Richard Lyle: We have had an out-of-hours review, the outcome of which we will see soon. With the greatest of respect to doctors, they do not get the living wage or the minimum wage—they get between £80 and £120 an hour, although I know that they are worth it. However, they work during the day in their own job, then some of them have to come out and do out-of-hours work at night-time or overnight—bear with me on this, because I have been there. Some doctors are employed by the out-of-hours service, but most are not. Has that system changed in the past couple of years?

Jim Forrest: Yes, it has changed significantly in the past couple of years. Quite a number of doctors are now employed by the out-of-hours service. We do not want the old system where co-ops managed the out-of-hours service and doctors would work through the night, then go into their surgeries during the day. We do not have that aspect at all now. If a GP decides that they want to put their name forward for out-of-hours work, it has to be for a time that is outwith the time when they are contracted to work for their partnership.

The Convener: Does that apply to all the witnesses' partnerships?

Elaine Mead: Yes. If a GP doing out-of-hours work is not familiar with the locality and the systems, sometimes the easy option is to admit the patient to hospital, which means that they are

not the GP's responsibility on Monday when the GP goes back to their partnership work.

Richard Lyle: Do you still have locums?

Elaine Mead: Yes.

Richard Lyle: Right. I have a final question. As I said at last week's meeting, it annoys me and people outside Parliament that political parties use the health service as a political football. Would you prefer the parties to leave you alone to get on with it? Alternatively, should the political parties agree with each other about what they want to do with the health service? I have to say that I think that Scotland has one of the best health services in the world. Where else could we just walk into a hospital and get treated? Okay, we might need to wait a couple of hours, but where else—

The Convener: I think that there could be a question about that.

Richard Lyle: There might be. If you had a wish list, would it include political parties not making the health service a political football?

The Convener: You do not need to answer that.

David Williams: Essentially, NHS healthcare provision is a public service, so it must be publicly accountable, and that accountability is to democratically elected members.

The Convener: Does David Williams speak for all the witnesses?

Jim Forrest: Yes.

The Convener: Good. I call Bob Doris.

Bob Doris: I have a question about budget scrutiny. In the brief time that we have left, I am interested in looking a little bit more at the role of GPs. Some aspects are relatively certain: we know that GPs must be central to the process, that they are valued and that they have to be consulted to help co-produce the budget.

However, we are talking about the budget flow—how money comes through the system. Money goes to health boards and local authorities, and both bodies give money to the integration joint boards, although, of course, the situation is different in NHS Highland.

At the same time, the new GMS contract is being negotiated, as the convener said. Another aspect to put into the mix relates to a constituency case that I received this morning. I do not want to localise the issue, but the case highlights that some practices have a minimum practice income guarantee, which brings security to the practice. The practices that have the guarantee like it; the British Medical Association likes it, too, but it is not so keen on localised contracts.

At this point, I will have to use the terminology in order to make my substantive point. GPs can sign a contract under section 17C of the National Health Service (Scotland) Act 1978 that is bespoke to the health board and slightly separate from the nationally agreed contract or a section 17J contract. I did not know that that differential existed.

I am sorry to put all that out there, but given that the issue is how cash flows through the system, it is important, for budget scrutiny, to consider the different contracts. Some GP practices employ practice nurses and contract in pharmacists—and they are given money to pay for much of that. Other GP practices will have co-located health board employees, or whoever, in the health centres. How it is organised is like spaghetti; I am not sure how co-ordinated it is. Clearly, that set up works exceptionally in some cases, but perhaps it does not work as well as it could. Will health and social care integration bring order to the situation or is there strength in that spaghetti-type approach, if you like, at local level? How can we use the money to drive change?

I am sorry that that was a bit long-winded, but there is a heck of a lot to consider in terms of how we scrutinise and shake down the cash flow and whether we want to see the budget drive GPs to employ more people or whether we want to free them up to refer patients on to the people whom you guys employ.

I know that I have asked a lot, but I would welcome even brief comments.

The Convener: Jim, you seem to recognise some of those issues.

Jim Forrest: There is a differential in the existing contract. In a practice with a contract under section 2C of the National Health Service (Scotland) Act 1978, the GPs and the staff are employed by the health board—they have a health board contract. There are various reasons for that. Some practices have elected to have such a contract. If a partnership is in trouble or in distress and cannot get partners, we will intervene and put in place that contract, and salaried staff, until we can advertise the practice as a going concern. There are choices to be made there in relation to the existing contract and the legislation.

What can be influenced in the existing contracts for health boards and partnerships that are at the margins depends on the new contract, how it will be negotiated and what we are able to do under it. In my patch, there is a mixed economy where a number of GP practices elect to employ their own staff, while others would rather have staff employed by the NHS and based in the practices. I guess that practices would have a different view

on what the flexibility in the legislation gives them, depending on their experience.

As I say, the situation will depend largely on how the new contract will be negotiated and implemented and the conditions around that, including whether we will have the flexibility to work with practices or whether they will continue to remain completely independent and make their own decisions.

David Williams: Given my background in social care, I am still in the relatively fortunate position of getting to understand the whole health system, which allows me to ask what are probably daft questions of my own. Of course, I am not suggesting that any of the questions that have been asked here are daft. [*Laughter*.]

Bob Doris: Given all the questions that went before, I thank you for your candour.

12:00

David Williams: What I see in Glasgow is probably not dissimilar to the experience of variability that you described. From a budget management perspective, for a significant chunk of the health budget that will be part of the health and social care budget infrastructure, there appears to be very limited scope for manoeuvrability in the way that it is used.

For instance, in Glasgow, there are significant numbers of singleton GP practices. From a basic management perspective, that tells me that there must be issues of efficiency and that efficiency could be driven into the system if that was managed differently. I hope that there is an opportunity for the IJB to have a greater degree of influence over how the funding that goes to GPs can be used, although not in any directional way—the aim would be to recognise that there are differences between localities. The needs of different parts of Glasgow will be very different from the needs in Dumfries and Galloway or Highland. We need the ability to have localised influencing of how the money is spent.

Bob Doris: Does it actually matter who employs the practice nurse, attached pharmacist or advice support worker? When we are designing services, does it matter whether the practice employs those people or the integration joint board does so via the council or the health board or whatever?

David Williams: It probably does not matter, but that is entirely on the basis of having the right culture and expectations of what health and social care will deliver and a drive towards delivering on national health and wellbeing outcomes. If, as part of the whole strategic plan approach, we are talking about having genuine partnerships based on equality with the voluntary sector and the independent sector and if we place in those sectors a trust that they will deliver what we ask them to deliver and what they are signed up to deliver, we must take the same approach with GPs. Some GPs might choose to take the responsibility of being employers and some may not. In my view, that has to be acceptable.

Jim Forrest: If things are going well and are negotiated and everybody sees things the same way, it does not matter. Clearly, if a partnership is having difficulties with a particular area and it employs the people and has more influence over the resources, that gives it more leverage to negotiate its position. It largely depends on the circumstances. Broadly speaking, in an ideal world, it should not matter, but there are tensions to do with how we target resources and what outcomes we want to deliver.

The Convener: I thank the witnesses very much for the considerable time that they have given us and the evidence that they have presented. We also have written evidence from some witnesses.

I should have said earlier that we received apologies from Dennis Robertson. As previously agreed, we will now go into private session.

12:03

Meeting continued in private until 12:32.

Published in Edinburgh by the Scottish Parliamentary Corporate Body

All documents are available on
the Scottish Parliament website at:

www.scottish.parliament.uk

Information on non-endorsed print suppliers
Is available here:

www.scottish.parliament.uk/documents

For information on the Scottish Parliament contact
Public Information on:

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