OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 6 September 2016

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 6 September 2016

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HEALTH AND SPORT COMMITTEE
3rd Meeting 2016, Session 5

CONVENER

*Neil Findlay (Lothian) (Lab)

DEPUTY CONVENER

*Clare Haughey (Rutherglen) (SNP)

COMMITTEE MEMBERS

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

*attended

THE FOLLOWING ALSO PARTICIPATED:

Tim Eltringham (South Ayrshire Health and Social Care Partnership)
Stephen Fitzpatrick (Glasgow City Health and Social Care Partnership)
Councillor Matt Kerr (Glasgow City Council)
Rita Miller (South Ayrshire Integration Joint Board)
Liz Moore (NHS Ayrshire and Arran)
Catriona Renfrew (NHS Greater Glasgow and Clyde)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 6 September 2016

[The Convener opened the meeting at 10:00]

Decision on Taking Business in Private

The Convener (Neil Findlay): Good morning everyone and welcome back after the summer recess. This is the third meeting in 2016 of the Health and Sport Committee in the Scottish Parliament's fifth session. I ask everyone to switch off their mobile phones because they can interfere with the sound system.

The first item on our agenda is to decide whether to take in private item 4, which relates to the implications for the committee's work of the European Union referendum. There is an approach paper for future work, and such items are usually taken in private.

Do members agree to do that?

Members *indicated agreement.*

Subordinate Legislation

Foods for Specific Groups (Scotland) Regulations 2016 (SSI 2016/190)

10:01

The Convener: Item 2 is subordinate legislation. We have three instruments that are subject to negative procedure to consider today, the first of which is Scottish statutory instrument 2016/190.

No motion to annul has been lodged, but the Delegated Powers and Law Reform Committee has commented on the regulations. It has noted that the regulations omit to make further consequential amendments to the Foods Intended for Use in Energy Restricted Diets for Weight Reduction Regulations 1997, which are required as a result of the changes to the 1997 regulations that will be introduced by regulation 6. The Scottish Government accepts that the change that will be made by regulation 6 has led to insufficient clarity in the 1997 regulations, and undertakes to amend further the 1997 regulations at the earliest available opportunity.

Are there any comments from members? No. Somehow, I did not think that there would be.

Does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

Food Information (Scotland) AmendmentRegulations 2016 (SSI 2016/191)

The Convener: The second instrument is SSI 2016/191. No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has made no comment on the instrument. I invite comments from members.

There are no comments, so does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

National Health Service (Free Prescriptions and Charges for Drugs and Appliances) (Scotland) Amendment Regulations 2016 (SSI 2016/195)

The Convener: The third instrument is SSI 2016/195. No motion to annul has been lodged, and the Delegated Powers and Law Reform Committee has made no comment on the instrument. I ask for comments from members.

As there are no comments, does the committee agree to make no recommendation on the instrument?

Members *indicated agreement.*

Delayed Discharges

10:02

The Convener: Item 2 is two evidence sessions on delayed discharge. I welcome to the committee Stephen Fitzpatrick, who is the head of older people's services in Glasgow city health and social care partnership, Catriona Renfrew, who is the director of planning and policy at NHS Greater Glasgow and Clyde, and Councillor Matt Kerr, who is the executive member for social justice on Glasgow City Council.

We are not expecting opening statements from the witnesses, so I will move to questions. We have a large committee, so brief questions and answers would be appreciated so that we get through as much as possible. I will open the questioning.

Yesterday, we heard from the Cabinet Secretary for Health and Sport, who praised Glasgow City Council for the reductions in delayed discharge that it has achieved and the progress that has been made. Can you give us an indication of how that progress has been made over what looks like a relatively short period of time?

Stephen Fitzpatrick (Glasgow City Health and Social Care Partnership): I had not appreciated that—it is nice to hear.

There has been a short but intense period of change in Glasgow. The story goes back four or five years, when the delayed discharge numbers were at their worst—from memory, they were running to around 300 cases being delayed more than six weeks. The first stage in the process, which was really important, was that the health board and the council acknowledged that that was a strategic priority that we had to address together. That was a key point in making the change.

We then spent a couple of years working closely in partnership with social work, as it was pre-health and social care partnerships, with the community health partnerships and with the acute system to try to improve the existing system and its performance. A lot of managerial attention was given to trying to improve performance. We saw in the period from May 2011 to about the middle of 2014 an improvement in the level of delays from 300 delays over six weeks to about 150.

However, we recognised at that point in 2014 that we had exhausted the potential to improve system performance through a managerial approach, and that we had to reform the system fundamentally. One of the issues that we had to deal with at that time was that there was what we described as almost a tail of people who had been

delayed in hospital for quite a long time. The only way to deal with that was to make a one-off investment in care-home placements. The council agreed to find in the region of £3 million to create, in effect, a steady state, so that we were dealing only with demand as it came through rather than the residual demand that had built up over time through that historical challenge that we faced.

However, as I have said, we recognised that there was a need to reform the system fundamentally. We decided to introduce intermediate care at scale in Glasgow so that, wherever possible, no one was being assessed for long-term care from a hospital bed, and that if they were fit for discharge they could move to an appropriate environment where that long-term assessment could take place. One of the key underpinning principles was that all the system pressures meant that assessment in hospital tended to lead to poorer assessments than would otherwise have been made. Intermediate care and the provision of that space at scale across the system were therefore key.

Alongside that was the introduction of a target of 72-hour discharge for older people—excluding some categories of people whose needs are more complex, including adults with incapacity. However, for the typical older person coming through the system, we would apply that 72-hour target and move them into intermediate care. The numbers will bear out that we do not always achieve that, but the target has certainly made a huge difference in throughput from acute care to social care assessment for long-term care.

You asked us to keep answers brief, convener, so we will probably go into some of the detail, as we go through questions, about what underpinned that fundamental cultural change in the system in terms of pathways, processes and so on. Again, we principally needed investment for that to happen, because it could not be done with existing resources. The integrated care fund and, before that, the change fund that the Scottish Government allocated to local partnerships were invested, with the priority being to develop a system that would affect delayed discharge and throughput. We have seen a significant reduction in delays involving older people across Glasgow since we introduced the 72-hour target. At its introduction on 1 December 2014, 117 people who were aged 65-plus had been delayed for more than 72 hours. The numbers fluctuate, but the lowest number recently was in March 2016, when that 117 had reduced to about 14 or 15, which is about an 80 per cent reduction.

The Convener: What does “intermediate care” mean? In what type of settings does it take place?

Stephen Fitzpatrick: It is step-down care for people who are deemed fit for discharge and no longer require acute medical care.

The Convener: Where do those people go?

Stephen Fitzpatrick: They go to a number of care homes in Glasgow. We have—I think—six at the moment, across the city. One of the key features of intermediate care is that for families and patients to co-operate with the move, it must be to somewhere in their local community. We therefore need geographical coverage across the city, which is why we use care homes in different locations. There is also an optimum size for the approach to work because, by definition, it applies to the people with the most complex needs who cannot just go home for short-term home care or lower-level packages of support; they tend to be the people who are most likely to be assessed as needing long-term care at home. There is therefore an optimum number, beyond which the care homes struggle to cope. All the care homes that we use in Glasgow are in the independent sector and are privately provided.

Alison Johnstone (Lothian) (Green): I have a question about the submission from the integration joint board. It gave an interesting response to question 8, which asked:

> “What do you identify as the main barriers to tackling delayed discharges in your area?”.

From my experience in Lothian, the main barrier is often lack of a care package or the fact that home adaptations have not been carried out. I was interested by the response from the Glasgow IJB, which mentions:

> “Continuing professional and community culture of risk aversion rather than risk management in relation to the care of ... older people.”

Could anyone on the panel flesh that out a little?

Catriona Renfrew (NHS Greater Glasgow and Clyde): I will take that and give Stephen Fitzpatrick a break.

There is a range of cultural issues surrounding whether people can go home; for example, families have expectations. Once somebody who has had a pretty significant hospital admission is, in our view, ready for discharge, the family’s expectation is often that the patient will not go home or will go straight to a long-term care placement. What intermediate care has done for the city is create a space between an acute hospital episode and a decision on final discharge from in-patient care. In other words, a patient can move into a care home environment without the expectation that they will be there for the rest of their life.

The risk issue is often to do with the fact that there are differences of opinion among the various

professionals on when it is suitable to send a person home with a care package. If someone has come from difficult home circumstances or has issues with their physical health, the social care view is often that they should be able to make a decision to go home, so we try to put in place a package to minimise risk. However, the family's expectation might be quite different, and the expectation of hospital staff might be quite different. Intermediate care has, for us, delivered a bridge between the two, because a patient can go into a care home without the expectation that they will be there for the rest of their life. Further intensive rehabilitation and further assessment will be carried out to assess whether they can be at home.

I would like briefly to emphasise the numbers, if that is okay. We count our delayed discharges in lost bed days, because what is significant to the hospital sector is how many beds are consumed every day by delayed discharge. At the peak, in 2011-12, 109,000 bed days in Greater Glasgow and Clyde NHS were taken up by patients waiting for social care outside hospital. Those delays did not relate only to Glasgow City Council—we deal with eight or nine local authorities. By April 2016, the figure had gone down to 31,000 bed days, so the change has been dramatic. From my point of view, and from the point of view of the national health service's acute sector, there is still a long way to go; those 31,000 bed days are still a big issue for us in respect of how we run the throughput for acute care. However, in four or five years there has been a transformational change for patients, for acute services and for what the social care teams have been able to do.

Alison Johnstone: I would like to ask a follow-up question. Are you optimistic that you will be able to tackle the remaining 31,000 bed days that are lost as a result of delayed discharge through education and stakeholder engagement—which you mentioned in response to the next question in the survey—or is that a resource issue? Mr Fitzpatrick pointed out that the private care homes are sometimes full. What happens then?

Catriona Renfrew: The 31,000 figure will be to do with a mixture of issues. Resources are extremely important. When we talk about funding for the health service, if social care services are not funded at the level at which they need to be funded, the health service cannot function; therefore, the balance of investment and resources across the whole system is absolutely fundamental. Hospitals cannot work without social care services, community services and general practitioner services, with which they are funded and integrated. Resources are an issue.

In addition, there are still issues to do with some of the more complex patients—for example, finding non-hospital solutions for people with acquired brain injury and people with more complex physical disabilities, who account for a chunk of the 31,000 bed days. There are also still challenges to do with getting patients who do not have capacity out of hospital.

You asked me whether I am optimistic. We are working with our partners in the HSCPs on all those areas, and one thing that has changed—as Stephen Fitzpatrick highlighted in his introductory comments—is that we are all on the same ship in trying to address the problem. In the five or 10 years over which we have improved the situation, people have come together to a much greater extent to view the issue genuinely as a shared problem. However, resources are a huge worry, because if there is no money in community services, hospitals cannot function.

The other caveat is the need to reduce the acute sector. If we shift the patients, the money that is in acute beds needs to be shifted into supporting them better in the community. That is a major issue for us; we are trying to reshape our acute hospitals to reflect the change in delayed discharges, which is very challenging for us not only politically, but publicly. For the public, the denominator of a good health service is still hospital beds, and not necessarily some of the services that Stephen Fitzpatrick talked about that are being provided in the community but which are much less visible. Is that fair, Stephen?

Stephen Fitzpatrick: Yes. I absolutely agree with that.

10:15

Councillor Matt Kerr (Glasgow City Council): I guess that we are now straying a little bit into the political. I have to say that this has been a bugbear of mine; this is my second stint in the social work job in Glasgow, having left the post at the end of 2013 just as integration was getting moving under the Public Bodies (Joint Working) (Scotland) Act 2014.

When I came back to the job six months ago, I found that a lot had changed. Some aspects—resources and so on—have stayed the same, but the cultural change over the period has been fantastic. When I first came into the social work post in 2010, the community health and care partnerships in Glasgow had just broken up. That approach had failed, and it was a very difficult moment for all of us. The two guys beside me here were very involved in things at the time, so they will know far more about them than I will, but I walked into a situation that was very difficult indeed.

What happened was that slowly but surely we had to rebuild certain relationships at a higher

level. A lot of the working relationships were okay: if we are being honest with ourselves, the problem was really at political level. It was difficult to patch that up, but getting that side of the culture right helped us as we moved into implementing the 2014 act.

The other cultural challenge that has been mentioned—which is as much about the public as it is about the professionals—feeds into Catriona Renfrew's final point about how we look at things. If we are being honest with ourselves, we will see that this is a collective problem for the political classes, in that politicians of all parties—and as a result the media, although such things might have a tendency to feed back on themselves—tend to look at the NHS and care as being about hospitals. We measure success by the number of beds we have or the number of nurses and doctors we employ instead of by the health of our population. That is a really challenging thing for a politician to say out loud, and I understand better than many—although I am sure that many members will have come across such difficulties in their communities—that there will be difficulties with that remark. This is not an easy discussion to have with the public, but we need honest discussion on the matter. We also need a genuine transfer of resources not just into social care but into community care in the round because, after all, we want to break down the barrier between health and social care properly, and to start talking about building an integrated service from the ground up.

I should point out that in our consultation response to what became the 2014 act, we in Glasgow raised a specific concern. Although we said, "Fine—we get and support the principle of moving to integration", we felt that it would be better to start at the very beginning in the communities—to ask where our GPs and community nurses are based and where our social workers and other care professionals could be based, and to build things up from there. That is not to say that such an approach is impossible now. It is very possible but, quite frankly, we need to build political consensus around that and to think very carefully about how well funded it will be in the future. It is a tricky issue.

Ivan McKee (Glasgow Provan) (SNP): I thank everyone for coming along. I want to focus on some of the numbers, but first I thank Catriona Renfrew for her clarifications and for answering some of my questions. I believe that the 31,000 figure that you mentioned is an annualised figure.

Catriona Renfrew: The figure was for 2015-16—in other words, the financial year that has just ended.

Ivan McKee: That was the total for that year.

Catriona Renfrew: Yes.

Ivan McKee: Great. I want to talk about the financial implications of that. A big part of the justification for the integration agenda was £150 million—or whatever the figure was—in savings across a number of areas, one of which was delayed discharges. The information that we have received from NHS Information Services Division suggests that £214 per day is the average cost per bed in the acute sector. I do not know whether that number reflects what you have seen. I suppose that my question is this: compared with that figure, what is the cost if you move someone into intermediate care? Given the substantial reduction that you have seen, have you seen those numbers flowing through? If not, why not?

Catriona Renfrew: I will start with hospital bed numbers. We have fewer acute beds now in Glasgow than we had in the early to mid-2000s. Part of the financing for opening the new Queen Elizabeth university hospital was to increase efficiency and, therefore, to have fewer acute beds. I do not have the figure to hand, but I think that there are about 150 fewer acute beds.

There is a flow through from having fewer delayed discharges to less acute care. The challenge that is coming for us now is that reducing the number of beds in big acute hospitals is not a particularly economical way to deliver care, so we need to look at our sites. We want to achieve maximum transfer into community services—Matt Kerr was right to say that that includes not just community care services, but GP services, community health services and social care services—by looking at the costs and the whole of our estate right across NHS Greater Glasgow and Clyde. We still have acute services for older people on seven or eight sites, but we do not see that as being a viable model as we start to develop further the kinds of services that we are talking about. I am not making a political—with a capital P—point, but a public political point, and that is a very challenging discussion.

The counter side to the reduction in delayed discharges is the pressure on admissions in a number of our hospitals. Unfortunately—as is often the case with the health service—nature abhors a vacuum and, as quickly as we have cleared delayed discharges, more patients have presented themselves for emergency care. That is not true across the piece, but it is true on parts of our patch. You can probably see that from the ISD data.

Ivan McKee: Do you have the comparable number for the cost of a bed in care homes? Does £214 sound right?

Catriona Renfrew: The general rule of thumb is that a hospital bed costs twice as much as a social care bed.

Ivan McKee: Have you seen those savings coming through? They come to £8 million to £10 million or something.

Stephen Fitzpatrick: For intermediate care places, we pay roughly £740 a week for a bed, though we have not done the exact comparison in terms of ancillary costs and so on. It is also important to say that the overall efficiency idea of the approach has been motivated not just by more efficient discharge from hospitals, but by trying to shift the balance of care in terms of the number of people who go home. By definition, those whom we place in intermediate care are most likely to go into long-term care—I think that 99 per cent of the first cohort did so. In the most recent two four-week periods, 38 and 42 per cent of people have gone home. That has been a big shift for us. We expect to see the economic benefit of that further down the care pathway for those individuals. It is quite a complex picture, but we think that we are moving the right way.

Catriona Renfrew: Our model is moving towards trying to get out of acute hospitals anyone who does not require acute care. That will require a smaller hospital base.

Again, to put the matter in context, it is not just about delayed discharges for HSCPs. We are trying to address all sorts of other delays in systems in acute hospitals; for example, people waiting for imaging, waiting for results or waiting for the ambulance service. We are working really hard across the acute system to get people out quickly and also to shift unplanned care to planned care—for example, a patient who has an urgent outpatient assessment is not admitted, but comes back the next day. Trying to change the system of care and delayed discharge for community services is just one component of that.

Alex Cole-Hamilton (Edinburgh Western) (LD): At our residential away weekend, we had a presentation from the national clinical director, who walked newbies, like me, through the idea of what causes delayed discharge. It was very useful. He gave the example of an elderly woman who had taken a fall and spent 10 days in hospital. She required only 10 days of care but, as her normal social care package at home had been stopped for the duration of her hospital stay, she had to stay in hospital for a further nine days while the care package was reinstated. In a nutshell, that is the cause of delayed discharge. He went on to explain that hospital at home had been introduced to deal with that. When the patient was in similar circumstances further down the line, she had the same standard of care without having to leave her house or experiencing the problems associated with delayed discharge.

Can the panel give us their reflections on innovative practices such as hospital at home? They are obviously not for everybody, particularly in very acute cases, but where do they fit into the mix?

Catriona Renfrew: Such practices are part of creating a much broader spectrum of care. I have worked for the NHS for more than 30 years. When I first started, you were either in hospital, not in hospital or in a care home. It was a pretty short algorithm, but now the algorithm across Scotland and across the UK has a whole number of modes of delivering service.

We can continue to develop new models of care. One of the critical pivots is the role of GPs, which is a pressure point for us at the moment. GPs face huge demands in their own practices just to keep on top of their daily work. There is then the issue of GPs' willingness to be part of some of the more innovative models of care, because most of those patients still need some kind of medical oversight. If it is not being done in the hospital, we need GPs to be a core component of such services. One of the worries for us is GPs' time capacity and their interest in being part of such teams and models, which are essential to making the models work. I do not know whether Stephen Fitzpatrick agrees with me on that.

Stephen Fitzpatrick: I absolutely agree with that. As we shift the balance of care, people still have needs and if those needs are to be met in a more efficient way, our whole system needs to change around that. That is not always straightforward—it takes time and there is risk involved. It comes back to the point that we need, as a system, to be willing to embrace that change and the risks that come with it and to manage those risks.

Councillor Kerr: It comes back to my earlier point about how GPs feed into the system more widely. They are overworked; I do not necessarily want to say that they are overpaid, but they are certainly overworked.

GPs are not rationally distributed either. If we are talking about tackling health inequalities, there is an issue with how our GPs are distributed around the country and what the NHS can do to influence that. It is not always a straightforward exercise at all. If we are trying to rebuild this as a truly integrated service, we need to think a little bit about where GPs are and how we integrate services around them. The ideal is to have a one-stop shop with different disciplines for people to visit.

Alex Cole-Hamilton gave an interesting example about somebody going into hospital and being

delayed in coming back out because their home care service had gone. I would hesitate to say that that would never happen in Glasgow, but it would be less likely to happen there. I am proud to say that that is partly because the council's company, Cordia, which provides the care service, has about 96 per cent of the work. Its scale gives us a huge advantage. First, the size of the organisation means that, in dealing with new cases coming into the system, it can respond quickly; sometimes you hear stories about large organisations not being able to react quickly, but in this case it works because we have well-trained and well-paid staff who are properly resourced and who can take on that extra case when required. Secondly, it means that, in a situation such as the one that Alex Cole-Hamilton described, we could get the home care service back in place relatively quickly. I would therefore hope that such a scenario would be less likely in our area.

Catriona Renfrew: That is fair. We were talking before the meeting about the problems that local authorities or HSCPs outside the urban areas have in providing home care services. That is a real issue for us because we are distributing patients back from acute care all over the west of Scotland and we have noticed the contrast between the reliability and durability of home care in the city and the more urban authorities and the position in the rural authorities. There is much more of a challenge for rural authorities.

I think that Matt Kerr is right. If I went through today's list of delayed discharges, I would not expect to find patients—certainly not those from the city or from our more urban areas—who have been delayed because they are waiting for home care. There are some issues for authorities outside Glasgow, but that is not necessarily due to an unwillingness to provide home care; it is a recruitment problem and it is a problem of scale.

Maree Todd (Highlands and Islands) (SNP): On the issue of delayed discharge, I am interested in the idea of preventing admissions in the first place. I imagine that that is where you are focusing to try to reduce the last 30-odd thousand lost bed days. Can you tell me a little bit about what you are doing to avoid admissions? Are you using your interim beds as step-up beds or are more flexible palliative care packages and so on being delivered at home? What sort of things are you doing to avoid admissions in the first place?

Catriona Renfrew: More care is being delivered at home. If we look back over the past three or four years, we see that the investment in rehabilitation at home is significantly greater than it was. Our geriatricians are doing more outreach so, rather than being solely focused on acute care, they are now working with Stephen Fitzpatrick and his team. They are looking at intermediate care models and are part of the team in the way that old age psychiatrists have traditionally been for a longer time. A lot of patients in nursing homes would still have some oversight from an old age psychiatrist. Our acute geriatricians are beginning to develop that model.

At the front door, we are looking at a range of different things such as assessment on discharge, urgent out-patient appointments, ambulances doing triage and so on. However, we must ensure that older people are not deprived of acute hospital care that they actually need—that anxiety always needs to be on the table—and we are always very wary of talking about unnecessary admissions; it is about different ways of managing the need at the time rather than about trying to stop older people getting acute assessment and the top-quality acute care that we need to deliver.

10:30

Nevertheless, when older people are admitted, we must get them back out quickly. Where Stephen Fitzpatrick and I probably part company—and where I probably part company with the Government, which is unwise—is the idea that someone leaving hospital after 72 hours is a success. For me, success is when somebody leaves hospital when they are ready to go. If they are ready to go on Tuesday, that is what we should deliver for them—not their going on Friday. To be fair, although we talk about the target of 72 hours, when we have detailed discussions we talk about getting people out on the day when they are medically ready to leave, not on the day of their admission plus three.

If I were to set targets, I would be much more focused. We use bed days because they are a measure of the resource that is lost, but we need to get people out on the day when they are ready—we need to change that culture.

Stephen Fitzpatrick: I do not think that we disagree too much about that. The 72 hours is a notional target for getting people out rather than the aspiration. We recognise that, once older people have had their medical needs attended to, hospital is not a healthy place for them to be, and that has driven a lot of the changes in our practice and system.

On Maree Todd's specific point, we have step-up beds in the city and we are now progressing with a tender. We developed a proof of concept in procurement terms and we are now moving to implement a tender for our intermediate care, and those beds will be used flexibly for step-up and step-down. We have systems and processes to ensure that the right people are going in, because someone who is stepping up tends to have different medical needs—it is much more about

acute medical intervention for those people. We have developed that initiative over the past couple of years, and it will be rolled out across the city.

In strategic terms, the big focus—which we have talked about over the past number of years—has been on reducing delays and the number of delayed discharges. Notwithstanding the 31,000 bed days that are being lost across the board area, which will continue to be a priority, our strategic attention is now increasingly on unscheduled care, diversion and preventing admission in the first place. There are a whole load of different initiatives around that, and we are trying to build on the momentum that we have built up around delays. We hope to apply the appetite that exists for change and doing things differently to our unscheduled care strategy. We have some new statutory duties around strategic planning for that, which we are working through with partners in the acute sector and other HSCPs in the board area. Step-up will be part of that, as will anticipatory care planning, how we configure our multidisciplinary teams in and around the hospital, trying to divert people who turn up at accident and emergency departments and our work with care homes, which are big referrers to acute hospital care.

Our approach is multifaceted and we have a detailed plan that we are working through at the moment. I am happy to share that with the committee, but it will take time for it to bear fruit.

Catriona Renfrew: It may be worth referencing Maree Todd's point on palliative care. As we move away from NHS continuing care, which we are working our way out of, we are trying to transform those beds into community-based palliative care beds for people who cannot die at home. We want to offer something other than the hospice movement, which has only a tiny number of beds, for people who are in end-of-life care and who would previously have had to die in hospital because they could not be looked after at home. In the move away from continuing care, we are already seeing benefits of being able to offer more extended packages of support for patients in care homes, with the geriatricians providing input in a way that they would not have done in previous care home models.

Councillor Kerr: Key to delivering such a change is having an honest discussion with the public whose service it is. That is a recurring point. When their granny is not well, a lot of people expect her to go into a residential care home, but that is not necessarily the right thing for her, although it may be what we have all grown to expect over the years. That is not to say that it is not right for some folk—of course it is—but we have to change the mindset among a lot of people, and that is not easy to do, because we are dealing with people's loved ones and people's lives. It is a difficult conversation to have politically. I am sure that you have all had casework on such things—I certainly have. It is a difficult conversation to have with some folk to reassure them that we can genuinely give them the life and the support that they need and deserve, in a setting that we hope is more comfortable and safe than a hospital might be. I am not saying that hospitals are not safe, but I hope that members get my point. Explaining that is a wee challenge to us as politicians.

Donald Cameron (Highlands and Islands) (Con): I will pick up on those points. In the care homes that people go into—either in the intermediate system that you described or for longer-term residency—is the availability of beds ever an issue? Are you always able to place people?

Stephen Fitzpatrick: Availability is not an issue in Glasgow, but I know that it is in other parts of Scotland, such as Edinburgh. That is partly a symptom of land values and speculative building. In the east end of Glasgow, we have a high concentration of care home places, because at one time it was relatively cheap to build and develop there. As an authority, we do not commission those places; there is a marketplace.

We have never had a capacity issue. In Glasgow, capacity is running at 88 to 90 per cent across the system, which always gives us room for manoeuvre.

Councillor Kerr: I am duty bound to say that, over the past few years, Glasgow City Council has invested £100 million in new council-owned and run residential care homes for the elderly, so it is not the case that we believe that such support will not be needed in the future. Having an in-house service puts us in a good position. We are not in the position that some authorities have found themselves in—through no fault of their own—whereby they are at the mercy of what the market provides. As Stephen Fitzpatrick said, the market—so to speak—does not always provide, because of land prices and what have you. There is a strategic case for local authority investment so that councils have at least a foothold that keeps things honest.

Catriona Renfrew: One problem around care homes is that the public perception is still that they mean privatising healthcare. Years ago, when we engaged in changes that involved some of our sites—people might remember places such as Cowglen—the sense was that healthcare was being privatised, because contracting was to be done with care homes that were not run by the public sector, although quite a lot of them were run by charities, to be fair. That is still an issue when we engage with the public.

At the moment, we are debating the future of acute beds at Lightburn hospital. If we proceed with the proposals, part of the reprovision will involve local care homes. Those care homes provide a local service—much more than we could at acute sites—and have good facilities; they are good providers that have invested in their facilities. However, the public perception is still that such provision should be in the public sector and not in the private or charitable sector. That debate is sometimes challenging with patients or patients' relatives.

The Convener: You said in response to our written questions that you

"do not record expenditure as being solely for the purpose of reducing delayed discharges."

How do you know how much you need?

Councillor Kerr: This is not straightforward.

Catriona Renfrew: I am glad that Matt Kerr has started answering.

Councillor Kerr: I will leave the science bit to the guys beside me.

There have been two different cultures. I am sitting between representatives of each of them, so I hope that I do not get a hard time from them both. The culture of how councils run their budgets has been different from that of how the NHS runs its budgets. There are long-term reasons for that. It has not been possible for councils to run overspends in the way that parts of the NHS have done—I can feel Catriona Renfrew looking at me.

Catriona Renfrew: No—it is a fair comment.

Councillor Kerr: Over the years, the expectation from successive Governments has been that they would stand behind health authorities and bail them out. I do not mean that too negatively, as that is what needs to happen. However, that has not necessarily happened in local authorities, because the mechanisms that we work under are different.

I will give you a wee example. During my last stint in social work, a third of Glasgow City Council's spend went on social work. That is an awful lot of money—but not enough. That gives you a sense of the scale of funding that we need, certainly in that city—we could have spent that amount twice over. We got to the point that, when the city treasurer was reporting various departments' probable outturns to the executive committee—I think that it was in January—social work was to be £18 million overspent, and he gave that information at the same time as he was reporting that the council's reserves were sitting at £18 million. To say that that was scary and that the discussions that took place after were difficult would be to put it mildly.

An overspend can happen really rapidly in social care, as it can in the NHS. One secure placement for a child can cost £200,000—with a click of your fingers, that spend is gone. In an authority of a scale such as ours, such costs are not at all unusual.

Given my difficult experiences in hanging on to social work budgets, we have good officers working for us who manage to watch the spend all the time.

If I am honest, I was trying to make the point that we are not approaching this as a cost-saving exercise. In fairness, this was not the focus of the act, but the potential to make three quarters of a billion pounds-worth of savings was mentioned. However, we are kidding ourselves if we think that there will be genuine savings to the public sector in doing this work. Yes, we might get to the point where less money is spent on acute services, but money will be spent in other ways, because demand is not about to fall any time soon. We have an ageing population, and as people get older and get to the point of needing help, their needs are ever more complex and the treatments are ever more expensive.

There are a number of complex challenges, as I am sure the committee is very aware. Over successive years, we have not got to the bottom of them. We are not going to realise savings through this.

The Convener: If you free up bed space because people move elsewhere, is the space just filled up by others?

Catriona Renfrew: The core issue for the NHS is that NHS inflation runs at a very high rate. Every week in the paper, you will see articles mentioning new drugs that potentially cost hundreds of thousands of pounds per patient and new treatments being announced. The complexity of the NHS is the rate at which we could do more for patients if somebody gave us the money. If there is no stop because someone says that it is not a NHS priority or that the opportunity cost is too high, then the acute sector will spend more and more money. Therefore, where money has been saved in some areas, it will have been reinvested in other areas.

The headline figure is that this year we are probably spending £30 million or £40 million more on prescribing drugs in the acute and primary care sectors than we did last year, and that amount is not covered by the inflation uplift that we have had. It comes back to choices. Do you want really good community services, with people being looked after at home or in community settings, or do you want to spend more money in the acute sector? With HSCPs in place, that choice becomes much more explicit: the more money that

is spent on acute services, the less money can be spent on other things. In the NHS, the risk has always been to drug and alcohol, mental health and child and adolescent mental health services—those are Cinderella services, because they do not have a public profile. New drugs, new cancer treatments and new pieces of equipment create a public mood that wants the NHS to provide those things. That is an intensely difficult debate, because there is not enough money for everything.

The Convener: To pick up on that point, the drug and alcohol budget was recently cut quite significantly and you guys were told to replace the money. Where do you magic that up from?

10:45

Catriona Renfrew: We did not reduce the drug and alcohol budgets that we allocated to the HSCPs by the same amount as they were reduced nationally. The difference—the gap—between the national allocation and what we passed on has become part of our financial problem. At this time, our board does not have a balanced budget; we are still looking for savings for 2016-17, and our acute sector is overspending.

Like a number of health boards around Scotland, we are in a position where the books do not balance and difficult choices need to be made. If we get those choices wrong, we will undermine the kind of delivery of care that we have been talking about. If we take money out of community services or mental health services, we will end up with more people in hospital. Despite the fact that a number of statutory bodies are involved in the provision of those services, there is one system for patients. If we do not have the balance right and if we change services in an unplanned way, we will go back to having 109,000 delayed discharges and a system that is completely out of balance. That is why there are hard choices to make about how the NHS spends money and what the priorities are.

Clare Haughey (Rutherglen) (SNP): One issue that has been repeatedly raised by health and social care partnerships, including in Glasgow, is about the length of the process associated with the Adults with Incapacity (Scotland) Act 2000. You have identified that it has cost Glasgow city £1 million in delayed discharges. Will you explain why the process takes so long and say what Glasgow is doing to mitigate that or remedy it?

Stephen Fitzpatrick: I am happy to have a go, and then Councillor Kerr can come in.

The issue is complex, because each individual case is different. In Glasgow, we have tried to apply section 13ZA for individuals who lack capacity, where it is in their best interests to move—

Clare Haughey: It might be helpful if you explained what section 13ZA is.

Catriona Renfrew: Basically, it allows a patient to be moved from an acute hospital to a care home, if that is in their best interests. I should say that, objectively, that is the case—our consultants always say that if somebody is ready to leave hospital, it is in their best interests to be in a more homely environment.

Stephen Fitzpatrick: Sometimes, that is not possible because someone already has powers—they might have a power of attorney or be a guardian—or someone is seeking powers. Every individual case is different, which is part of the complexity. There are then issues for the health and care system, in that we are not completely in control of what happens because of the legal process. Increasingly, court time in Glasgow was being set aside for consideration of guardianship applications, but then there was a change and a reduction in court time, because the courts were under pressure, too. That has led to delays in powers being in place and, unless powers are in place, we cannot move someone from the care of a consultant into a social care environment, for example, which is the normal route for people. Court processes are certainly part of the issue.

There are sometimes issues around how assiduous a solicitor is. Very often, a private solicitor acts on behalf of a family member or relative who is seeking guardianship powers. We have heard of cases of people going off long-term sick or going on holiday, which just prolongs the time before guardianship is in place.

Aside from the application of section 13ZA, we are trying to performance manage the process. We now have a policy position under which the partnership will seek to intervene through the courts if we think that a private application is not being pursued as assiduously as it should be, and in such cases, we can seek power to intervene. It is a complex managerial process because the cases are held by countless care managers and social workers across the system. Trying to manage all of that is an undertaking, but doing so is certainly a priority for us.

At a more strategic level, in Glasgow we have initiated the my power of attorney campaign, which aims to educate the public about the issue and the risk that a loved one or they themselves could in effect end up in limbo because of the guardianship process. The campaign points out that it is in people's best interests for someone they trust to hold power of attorney and to be able to make decisions on their behalf if such circumstances arise. That investment started in Glasgow a couple

of years ago and has certainly developed. A number of health boards and HSCPs have been investing in the campaign, which has been very successful in generating applications, to the extent that the Office of the Public Guardian in Scotland sometimes struggles with the demand—there are always unintended consequences. That will have a long-term benefit. We do not expect to see the benefit right away, because many people who are taking power of attorney may not have to use it for many years, but we will get the benefit further down the line.

We are coming at the issue in a number of ways, but it has always been a major one—a major stress—for the acute system.

The other strategic thing that we have done in the past couple of years is to commission beds in particular care homes across the city. People remain NHS patients under the care of a consultant, but they are not in an acute bed. Instead, they are in a place offsite, which relieves some of the pressure on the city's acute system. We are trying to come at and manage the situation in a number of different ways.

Councillor Kerr: Apart from the my power of attorney campaign, there is another part of what you might call the front end of the system. We have a very successful support network in place for carers in the city, and one of the things that the great team who works on that does is to identify carers and get carers assessments done. The possibility of power of attorney is then one of the topics for discussion that can be thrown into the mix—as appropriate, obviously. We try not to miss an opportunity to have such discussions with people as early as possible in the process. The big snag seems to have been that, as we have had that lump going through the system, the system itself has ground to a halt a little bit in some places.

Catriona Renfrew: What has been key is the short-term measure of having these interim beds—which, to confuse everybody, are not the same as intermediate beds—where our consultants are still clinically responsible for the patients but the patients themselves are not on acute sites. We are doing what is in the best interests of the patients, without falling foul of the law. After all, we keep NHS responsibility for those patients, but they are not sitting in an acute hospital, taking up beds or being in the wrong environment for them.

Richard Lyle (Uddingston and Bellshill) (SNP): I have listened to you intently and compliment you on what you have done, but I want to get a handle on this. You say that you have reduced delayed discharge in the city by 70 per cent, which is money saved. When it brought out the bill that became the 2014 act, the Government said that it would save between £100 million and £150 million across Scotland. Are you spending the money that you have saved from people not being in those beds on acute services? A minute ago, Catriona Renfrew talked about drugs and so on. Is the money that we are saving because people are no longer sitting in hospital at a certain cost per bed being spent in other places? Are we actually not going to save any money at all and might you, in fact, have overspent? Is that what we are saying?

Catriona Renfrew: Money around the costs of delayed discharge and acute services will have been and will be saved. However, every year when we reset our budget, there will be another series of funding demands. A saving from delays will come in as a source of funding, but every year another 30 or 40 funding applications will come in that we will be expected to fund. In the 2016-17 budget, for example, half a billion pounds, I think, from the NHS uplift was taken out and given immediately to local authorities. As a result, our board's headline figure included £150 million—I have not got the numbers in front of me, so I am probably exaggerating, but it was a multimillion-pound figure—that we passed straight to the health and social care partnerships. Health service uplifts might show as very large sums of money at headline level, but in 2016-17, a large chunk of that was given—quite rightly—to the health and social care partnerships to finance the development of social care. The concept of there being a spare sum of money just waiting in the health service for someone to spend is not one that I have ever recognised.

Richard Lyle: One of my concerns is that some of the integration joint boards are now saying that they did not get enough money and that they do not have enough money. I, too, was a councillor many years ago, and I know that you in the health board get your budget, you in the council get your budget and there are the headline figures. Have we ensured that we have put in all the money that we should have put in for setting up the joint boards or—and I say this with the greatest respect—have some of the boards been short-changed?

Catriona Renfrew: One of the problems with the construction of the HSCPs is that the health board allocates the money. As a result, we allocate across the acute sector and the HSCPs, and when there is pressure on the board's overall budget, we have to distribute that between the acute sector and the partnerships. In our case, we started with the ambition to fully fund the HSCPs and to try to limit the level of savings that they had to achieve compared with the level in the acute division. However, there is now a savings target for HSCPs and we have not yet identified across the services how those savings will be delivered;

and, as I said, we are overspending on acute care. There is a financial problem across the system.

I know from my experience—as will Matt Kerr, being an NHS board member, although he is concealing that from me at present—that in Glasgow the budgeting process was very difficult, and we are still not in balance, with difficult choices about what we cannot afford to do. That is the reality: the opportunity cost of certain things means that we cannot afford to do them. That presents a challenging debate every year, and this year has certainly been the most difficult financial year that we have faced as a health board.

Councillor Kerr: We have that in common at least. This year was the most difficult financial year that I have known as a councillor, and I do not think that I am alone in Scotland in that experience.

On the point about being short-changed, I think—although, as a board member, I have to be quite careful—that the board has put in what it should, and so has the council. In Glasgow, as I said, a third of the council's budget goes into social care, and we took the decision—for sound service reasons apart from anything else—to put just about everything into the partnership. In my view, there is no question but that there is a financial commitment from the council in that respect.

I am trying not to be too party political here, but there is a point about how local authorities are funded in the long term. I have been a councillor for nine years, and the local authority budget has been cut in every one of those years. A third of our spending goes on social care, so one cannot take the amount of money that has been taken out of local government and expect there to be no effect on social care, because it will have an effect. We do our best and work with everyone we can to try to mitigate the effects, but at the end of the day pressure will increase and bring situations such as delayed discharge to a head.

Through our hard work on integration, we have managed to get ourselves to where we are now, and I am really proud of all the staff who have worked so hard to achieve that. However, there is a wider issue about funding for the entire system that needs to be looked at.

As Catriona Renfrew mentioned—and this will definitely not be news to the committee—the NHS is always running at a standstill in terms of funding; 'twas always thus, going right back to Bevan. If you set a budget, it will be spent—do not worry. It is the same in social care, especially in a city such as Glasgow where need is huge. As I said, we are not the only people in the country who are in that boat.

The situation is not really being addressed. At some point, the political class—I mean that in the widest possible sense, across all the parties—needs to level with the public about that. I am proud of the system right now, and I am here talking about how we have done well in Glasgow on delayed discharges. However, I worry that such progress is not permanent or sustainable unless we have a genuine discussion with the public about how our care services are funded in the long term.

Richard Lyle: With the greatest respect, you have reduced delayed discharge in your area by 70 per cent, so where has that money gone?

Catriona Renfrew: Part of the budget-planning process at the end of each year will have been to look in total at the new pressures that we face and at how we are going to finance things. There is definitely new investment in community-based services and in the HSCPs in comparison with where we were three or four years ago. There is a greater range of community services and greater spending on them, but that has not closed the whole financial gap.

It is an extremely worrying position to be in that we still have savings targets to meet this year. Inevitably, short-term savings are not necessarily the most sensible things to do. The core issue will concern what size of acute sector is deliverable and affordable, and what size the acute workforce should be, because there is a series of workforce challenges around acute care. It is hard, for example, to recruit consultant geriatricians. Some of those difficult issues need to be out in the open for debate. The acute sector will consume as much money as taxpayers want to give it, but people would not then get community services; social care and home care when they want it; or palliative care that will enable them to die at home. Doing all of that is not possible.

Stephen Fitzpatrick: Sorry—I would like a final quick word. The important point to stress is that this is not a steady state. We are dealing with new demand—a tidal wave of demand. Every time that we make an efficiency, there is demand coming through to consume it. That is what we are experiencing in Glasgow.

The Convener: Thank you all for your evidence this morning; we will be watching the progress that you make with real interest.

11:00

Meeting suspended.

11:03

On resuming—

The Convener: The members of our second panel on delayed discharges are from South Ayrshire. As we are not expecting any opening statements, we will move straight to questions. We have with us Tim Eltringham, who is the director of South Ayrshire health and social care partnership; Councillor Rita Miller, who is the chair of South Ayrshire integration joint board; and Liz Moore, who is the director of acute services at NHS Ayrshire and Arran. Again, it would be helpful if people were brief with questions and answers.

I invite Alison Johnstone to begin.

Alison Johnstone: I believe that you were all listening to the previous evidence session during which the witnesses from Glasgow seemed to focus less on a lack of funding and of care home places and more on various cultural barriers that they had to overcome. However, you have made it quite clear in your very detailed submission, for which I am very grateful, that

"there has been insufficient funding to enable the placement of people requiring care home support to leave hospital."

Are there enough places, if there was sufficient funding?

Tim Eltringham (South Ayrshire Health and Social Care Partnership): If you review the figures that we sent you, you will see that earlier last year we were struggling with placement identification—that was the most significant issue for us. Just in the past few weeks, we have been able to release some resource to make placements. There have been a number of people for whom it has been difficult to make placements in care homes. The evidence that we submitted demonstrates that 14 or 15 months ago we had a significant rise in the number of people who required a care home place, and that puts pressure on the overall numbers. Some care homes are more popular than others, and although there might be vacancies in some homes, families and older people themselves often express preferences for the most popular homes, which can sometimes make it appear that there are not sufficient places overall.

Alison Johnstone: What unmet demand do you have?

Tim Eltringham: We have not tested that to destruction yet. At this stage, we are confident that the number of people whom we are talking about whose discharge has been delayed is still between 20 and 30. We have placed or arranged funding for around 30 people over the past four or five weeks. Whether we will be able to accommodate all those people in the home of their choice remains to be seen.

Placement in care homes and the arrangements and funding for that involve a balance between new people turning up and attrition—in other words, people dying and places becoming available. Over the past two or three years, we have felt that there is something in our local system that is propelling people into care homes a little earlier than we would hope, with the result that the length of stay is a little longer than we would hope, which is using up that capacity more than we think would be sensible. If the committee feels that it would be helpful for us to do so, we could say a little about how we are trying to reduce the overall number of people who are assessed as requiring to go into a care home.

Alison Johnstone: Yours was one of the few submissions that we had that isolated the expenditure that related specifically to delayed discharges, which is obviously helpful when it comes to measuring progress.

Another way of making progress on the issue seems to relate to culture. In your submission, you talk about hospital staff having a lack of confidence in the ability of community services to support people. Is it a case of educating and raising the awareness of acute staff and others of what is available? Is that happening?

Tim Eltringham: I think that our response would be very similar to the one from our colleagues in Glasgow. The situation is often on a knife edge. Within a multidisciplinary team, some people will be more risk averse and some will be more risk enabling, if you like. Once someone is in hospital, there needs to be confidence among the team that is responsible for their discharge that it will be a safe and appropriate discharge. As someone who has worked their whole career in the community, I absolutely understand that. I think that your point is that we need to do everything that we reasonably can to support that decision making among our acute colleagues.

Perhaps Liz Moore would like to respond to that.

Liz Moore (NHS Ayrshire and Arran): I can corroborate what Tim Eltringham said. Our acute teams need to have great confidence in the services to which they discharge their patients. We are doing a range of work to build that confidence in community teams. We now bring community teams into our acute hospitals to work with our consultants and our ward staff to demonstrate the range of services that are available for older people. There is general risk aversion as regards older people going home when they do not have full family support and so on. We will continue to do work to build confidence in services as services change.

As we heard from Catriona Renfrew, a range of services for families, communities and older people are now available in the community. Often, acute services do not know about that range of services. They are not familiar with everything that can happen in communities and, unless someone can explain to them in great detail that a patient will be safe and someone will visit them at a certain time, they worry about sending patients home. That is why they look for that information. Again, education is necessary to advise acute services of those community services and we need to build confidence through those services integrating with acute hospitals. That is what we are doing now.

Rita Miller (South Ayrshire Integration Joint Board): The family also has an influence. We have already developed our model and are trying to change it. Families need to understand that, in most cases, it is better for people to be discharged to the community. However, they also have to feel that their relatives are not at any real risk and that the risks have been taken into account. We need to describe that different world to families so that they will be confident and not end up contacting MSPs and other politicians to say, "Wait a minute. A wrong assessment has been made. I think it should be different." There is a lack of confidence in some families, whereas others will say, "Best thing that ever happened. We did not want that anyway."

It is necessary to build up local confidence, not just among professionals but in the community.

Tim Eltringham: If a patient has a cognitive impairment as a consequence of dementia or another long-term limiting condition, or has what is often described as delirium—I am not a medical person—perhaps as a consequence of a urinary tract infection, which might be short lived, colleagues across the health and social care system are collectively more anxious because the person's ability to look after themselves is less robust. One of the developments that we are keen to progress is a much closer relationship between our colleagues at the front end of a hospital or in the medical receiving wards and psychiatric services for older adults. We are looking to strengthen those arrangements to give clinicians whose area of expertise is not in cognitive impairment a degree of confidence that a discharge can be made safely.

Richard Lyle: You will have heard my earlier question about my concern that many of the integration joint boards are now suggesting that they do not have enough money. Your submission is excellent. I will double-check your total budget for the HSCP for 2015-16. The health board put in £94.6 million and the local authority put in £66.6 million. What is the set-aside budget of £21.6 million?

Tim Eltringham: The Public Bodies (Joint Working) (Scotland) Act 2014 recognises that, without the integration joint board being able to influence the spend on unscheduled care, it is unlikely that we will make progress on many of the issues that you explored with colleagues from Glasgow. What happens in somebody's own home is as important for trying to manage the shift and for considering unscheduled care in the round as what happens in a general practice, in accident and emergency, in the receiving ward and in downstream wards. We need to consider all that resource in the round and the set-aside budget is an attempt—at this stage, it is a little crude, if I am honest—to enable the integration joint board to understand how much resource in Liz Moore's facilities, particularly the acute hospital in Ayr, is consumed by the people of South Ayrshire. The integration joint board is charged with overseeing how that resource will be managed in due course. It is responsible for a number of delegated services and the provision of those services through me. Unscheduled care will continue to be managed directly by the director of acute services in the health board, but the integration joint board has a say in how the set-aside budget should be spent.

Richard Lyle: Where does that money come from?

Tim Eltringham: In essence, it is health board money.

Richard Lyle: Okay. I want to go back to the question that I asked the witnesses from Glasgow. In your submission, you say:

"There were 3,196 lost bed days due to Code 9 delays in 2015/16. At a cost per night estimated to be £170, the annual cost was £665,000."

However, you also say:

"The estimated cost in 2016/17 and in 2017/18"

will be

"£489,000 each year",

so you will save about £176,000.

Your detail is fantastic, and I wish that we could have got the same from our previous witnesses. However, the nub of my question is: are you going to tell us that you will save money, that you will overspend or that you have been short-changed?

11:15

Tim Eltringham: My answer is perhaps similar to that of my Glasgow colleagues. We can apply a notional cost to code 9s, and the committee will be aware that, like Glasgow, we have worked hard on

code 9s and are keen to identify early on people for whom issues under adults with incapacity legislation emerge. It is, as I have said, a notional cost. The ward that those people inhabit, whether it be a two, three, four or 10-person ward, is still staffed to the required capacity.

Again, Catriona Renfrew from Glasgow and Liz Moore would make broadly the same comment—indeed, I am sure that Liz will do so in a moment—that the demand on the acute service is beyond what I think anyone has modelled in terms of the numbers of people emerging at accident and emergency and the numbers of people who have required hospital treatment. The system needs a huge number of beds at the moment, and trying to identify small pockets of money that are savings is actually very difficult.

As for whether we have been short-changed, I have to be careful what I say about this, but I think that the NHS and the local authority have both played by the rules of engagement. The arrangements—which this year have been more complicated than in previous years—have been reviewed and stand up to scrutiny.

On the question whether we have enough money, my answer is the same as that from our colleagues from Glasgow: I could spend the money two or three times over. There are particular pressures this financial year on health and social care partnerships, particularly in relation to the payment of the national living wage—in other words, the UK Government's living wage—and the arrangements that we have had to put in place to fund sleepovers for people who need 24-hour care. Under European legislation, we need to pay almost twice as much for a night's care, which means that in South Ayrshire I have to pay £1.2 million extra. No extra care is being provided, but people are quite appropriately receiving the payment that is due to them under the law. As far as pressure on the service and the budget is concerned, that has probably been the single most significant issue.

I do not know whether Liz Moore wants to say anything about acute services and demand.

Liz Moore: Perhaps I can put the numbers in context. Over the past three years, we have seen an increase in demand for services with regard to patients presenting to our emergency departments. That demand has become more significant since the winter of this year and has continued over the summer, which is a quite different pattern from what we have seen in previous years.

I will look specifically at the over-65 population, given their higher tendency to be admitted. The fact is that 60 per cent of people over 65 who come to an emergency department with an unscheduled care presentation will be admitted, while the percentage for the general population is much smaller—it can be in the mid-20s. Three years ago, we admitted on average 16 over 65-year-old patients into Ayr hospital—that is the hospital that we are talking about today. Now, the figure is 20. If we consider that, on top of that, the length of stay for every other age group is increasing, we are talking about a significant number of beds. Indeed, it appears that we might require 20 beds to deal with the increase in the number of patients who have come into the system in the past two to three years. Obviously, you will not want us to say that we need more beds and that we will build them, but that shows the sheer demand on the system. You spoke to our Glasgow colleagues about the matter, and like them we are looking at a number of ways of reducing that impact on acute services. It does not help older people to be in an acute hospital longer than they need to be to receive a very specialist acute period of care.

I am therefore working on the matter with our partnership directors in particular. We have three partnerships in Ayrshire, and we work together across the area. Patients move across Ayrshire; South Ayrshire patients do not always remain in their own hospital but can go to other hospitals across Ayrshire.

The aim of our strategy on services for older people is to reduce admissions, where that is possible. That goes right up to the front door. We are looking at having teams in emergency departments to prevent older people from being admitted when they do not need to be if care and support can be put in. In the acute hospital, we are looking at our processes for assessment, treatment and diagnosis to ensure that patients do not stay any longer than they need to, as well as at trying to reduce any delays in discharge. Those are the processes that we are putting in place.

However, there is a demand issue in the NHS, as we heard from the witnesses from Glasgow. Demand is increasing, and we work tirelessly, day in and day out, to develop the services that we need to develop for the future in order to be able to meet the demands that we will face in NHS and social care services over time.

The Convener: There seems to be a bit of doubt about what the daily cost is for a hospital bed. You say that it is £170. When Alex Neil was the Cabinet Secretary for Health and Wellbeing, he regularly used the figure of £3,000 to £4,000 a week. ISD Scotland says that the figure is £214 a day. Why are we all over the place on the issue?

Tim Eltringham: We probably both know the answer to that.

Liz Moore: It depends on how you cost the bed. Different boards will base that on the bed that the patient is in—for example, there is a figure for an intensive care bed. In Ayrshire, we use a different system for interim placements—we use a community hospital rather than a care home, and £160 is the cost for that. Ordinarily, we do not keep patients who are waiting for an assessment or for a care home place in an acute bed. When possible, we transfer such patients to a community hospital. Therefore, the cost that we provide is the cost of a community hospital bed as opposed to the cost of an acute bed, which can be anything from £260 to upwards of £350. It just depends on the level of clinical care that is provided with the bed in question.

Colin Smyth (South Scotland) (Lab): I am interested in some of the barriers to tackling delayed discharge that you mention in your submission—in particular, what you describe as "Workforce Pressures". To what extent is recruitment and retention of staff a problem in tackling delayed discharge in a rural area such as South Ayrshire?

Tim Eltringham: I will start, but I think that Liz Moore is best placed to talk about the hospital service.

I do not want to overstate the problem. We tried to include examples of the sorts of things that are occasionally likely to be problematic. The witnesses from Glasgow talked about their experience in managing care-at-home staff. In South Ayrshire, we face peaks and troughs—sometimes it is more straightforward for us to get staff. Unlike the Glasgow model, which is an arm's-length arrangement for provision of care-at-home services through Cordia (Services) LLP, we have a mixed economy: about 30 per cent of the service is provided in-house and 70 per cent is purchased externally. The in-house service tends to pay slightly more than the externally purchased provision.

I can give you a hot-off-the-press example. We recently advertised for about 25 staff internally and we got 11 or 12 applicants, about 10 of whom are suitable to take on. We will advertise again. The low application rate might just be because it was the summer holidays.

The private providers report to us that they are having difficulty with recruitment and retention. The current uncertainty about the rates that local authorities and partnerships can pay providers is creating difficulty for them, both in relation to the national living wage and the living wage that will apply from October—the Scottish living wage, if you like.

In our professional services—I am referring to social workers, district nurses and so on—at times we struggle to attract staff, especially as we go further down the county towards places such as Girvan that are further away from the main conurbations, as Colin Smyth implied in his question.

In general, there is a more significant issue with recruitment and retention of hospital doctors. Liz Moore is probably best placed to answer on that.

Liz Moore: On delayed discharge, I would not say that there are delays in the system specifically around the lack of doctors or nurses within acute-care environments. However, we have challenges around our medical staffing in Ayrshire because we are away from the central belt, and we have a number of vacancies in our medical professions, particularly in medicine. That is not such a significant issue in our surgical specialties. I mentioned having the best processes in place to ensure that we care for older people in the best possible way; we can have delays if we do not have on site the number of medical doctors that we require, or doctors who have the required skills and expertise. That is not impacting on delayed discharge, but it does impact on the day-to-day management of the hospital, given the increasing demands.

In Ayrshire, we have done lots of different things to improve our recruitment and retention, including international recruitment. We have about 30 consultant vacancies in Ayrshire, which is a significant number, given that we have in total about 230 consultants. That impacts on our current services.

Across Scotland, we are starting to see pressure on nursing. You will be aware that there has been increased agency spend on nursing, which was not a feature in the past. That has been due to the expansion of services. As we expand services, be it in communities or in hospitals, we require nurses in a number of different areas, because it tends to be nurses and allied health professionals who provide the majority of the care, along with carers and the staff of voluntary organisations.

We need to be careful around projections for nurses that we will have to train in order to ensure that we have enough staff. We are investing in services rapidly to meet the demands in the health service, and a requirement to invest in clinical staff comes with that. We are running a wee bit behind in producing the numbers of staff that we need to deliver high-quality services in health and social care.

A new phenomenon is that we are starting to see that in care homes, as well. Patients in care homes are now more complex than they might have been five years ago. At that time, care homes had fewer registered staff on a shift than

they require now. We know that they are now struggling to recruit the number of registered nursing staff that they need to deliver nursing care. We are all competing: if there is a job in an acute hospital and a job in a care home, the chances are that a nurse who does not have a job will apply for the acute hospital post. We need to keep up with demand for services by having the number of staff that we require.

Delayed discharge is not having a direct impact, but it has an impact on services in health and social care.

Rita Miller: The Convention of Scottish Local Authorities is doing an exercise for some local authorities to get costings for care because the national care home contract is being renegotiated. Care homes are saying that availability of highly qualified nursing staff and what care homes will have to pay them represents one of their additional costs, and they are expressing general concern that they will not be able to recruit the high-quality staff that they require.

As Liz Moore rightly said, we are ensuring that people stay in their own homes for as long as possible, so the group of people who go to care homes are frailer and need more intensive care. We need a different balance of staff, because care homes will need more and better-qualified staff to fulfil their duties to their patients. We are in a complex situation—make no mistake about that.

I said to the convener as we came in that we are really appreciative that we have been able to come here to tell you about the situation, because it is so important that we get it right and that you do not think that we are always saying, "We need more money." We are trying to use Scotland's resource better because we know that the challenges are coming up. No one is going to put a pot of money away in their pocket for this, but it is an interesting exercise.

11:30

Liz Moore: Workforce projections are important. In Ayrshire, we are projecting better into the future what we will require to deliver services in communities as much as in acute environments, which is where the delays occur if something cannot be delivered across the system. We are doing that as one.

Ivan McKee: I want to go back to the delayed discharge picture. Correct me if I have this wrong, but the graph on page 10 of your submission shows that you had a reducing trend over a period and then an increasing trend over the past few months. If I am reading the colours correctly, the vast majority of that is because of a lack of funding to access care home places, which you talked about earlier. The code 9s are actually a very small number. If you did not have the issue with care home places, the graph would probably still be on a downward trend.

We have talked about financial issues. I kind of get that, because the cost of people going into a care home is variable and you pay per day, whereas in acute care, unless you restructure in order to take out costs, there is a big fixed cost. It is probably harder for you than it is for somewhere such as Glasgow because, being a smaller board, you have less scope to restructure. If it costs you, say, £100 a night for a care home versus £200 or £300 a night in hospital and you did not have that other demand coming in, would you have scope to restructure in order to realise savings?

My second question is on the broader pipeline. You talked about A and E driving utilisation of acute beds and you mentioned a wee bit about what you are doing on that. That was one of the things that we talked about at our weekend meeting with GPs, who had a graph that showed that A and E figures are going up because funding for GPs is going down in real terms. Will you comment on that? Is there an issue with the gatekeeper that means that you are getting extra demand in A and E that is spilling over into acute care and causing a problem further down the line?

Tim Eltringham: There were a number of points in there. The first was about restructuring and looking at our bed models. I guess that that relates to the interim report on the modernisation process that we are undertaking across Ayrshire and Arran. That is in appendix 1 of our submission—it is now in the public domain but it was not published before that. There are discussions about whether we have the bed model right in a number of areas, particularly in community hospitals. Obviously, there are sensitivities associated with that, but we recognise that there are probably better ways of managing the resource.

In relation to GPs, our colleagues from Glasgow in the previous panel reflected the pressure on general practice, particularly in rural areas. There are opportunities for us to work much more collaboratively with GP practices and we are having a pretty good go at that in Ayrshire and Arran.

One of the initiatives that I referred to in our submission is anticipatory care planning. In some respects, there is nothing new under the sun; 25 years ago, there would regularly have been circumstances in which district nurses, social workers and others met in the GP practice to talk about patients who were at particular risk and how to maximise care for that person, what would happen if things go wrong and so on. Today—I think—14 GPs practices in South Ayrshire are, following a pilot or a test of change that our clinical

director pursued within his own general practice, meeting with a view to rolling out that methodology. It is a very simple proposition.

The key to a lot of this, both at the front end of the hospital and in general practice, is multidisciplinary work and decision making. Those are the things that are likely to have the greatest impact in terms of maintaining people in their own homes rather than propelling them through a system in which admission to a care home becomes the default position at the end of the process.

I think that the other part of your question was about acute services. Have I answered it? I am not sure.

Ivan McKee: You touched on it. If you had a scenario whereby you could move people to care homes at a lower cost per day, and assuming that you did not have a wave of stuff coming through, would you be able to restructure to take that money out? That is where the whole discussion started.

Tim Eltringham: There are elements where we could use money more productively. It remains to be seen whether that will provide the whole solution, at the end of the day. One of the things that we feel is significant is risk management, which goes back to a question that has been asked of our Glasgow colleagues on the previous panel and of us. When a person is admitted to hospital, we are in some difficulty in terms of discharge for a variety of reasons. That is particularly so for older people who have complex needs. Our system is not slick enough to manage the expectation of the older person and their family that there will be a quick discharge back home after the health issue is fixed. Our arrangements in Ayrshire at the moment are not sufficiently robust in that regard, and we are just beginning to try to improve that. If we do not get that right, we will continue to see the pattern of very high demand. What we are trying to do—and will do successively—is manage early discharge and rehabilitation at home. That has to be the way forward.

Liz Moore: We have been bed modelling in Ayrshire for some time, particularly in South Ayrshire. You will be aware that we have just built a new emergency department and that we are now in the second phase of building a combined assessment unit. The unit was modelled on the basis of prevention of admission where admission is not the right thing to do. The unit is being built alongside the emergency department and will open next spring. Any patient who is referred by their GP will go directly to the unit and not to the emergency department, but any patient who comes in a 999 ambulance, is brought in by a carer or is a self-presenter will go to the emergency department and will then be streamed into the combined assessment unit, which will allow the multidisciplinary team to carry out an assessment. We do not have the facility in Ayrshire to do that just now; we are still working with the traditional model of hospital care because of the facilities that we have. The unit will allow us to build multidisciplinary teams, and that was built into our model of care.

This is an opportune time—having moved forward with our health and social care partnerships—to build teams both in the community and at the front door of acute services in order to avoid admissions when we can. We will be able to pick up patients and help them back into the community, help families to understand about care requirements, and do the best that we can beforehand to ensure that a patient is not admitted to an acute hospital bed when that is not required.

As I said, all that will come on stream in the spring and will give us another avenue for caring better for patients.

Rita Miller: A combined assessment unit has a much calmer atmosphere than A and E. Our A and E consultants say that A and E is not the right place to take a person who is in any way agitated, because it is very difficult for them. The older and frailer people get, the worse the experience is for them. If people have robust packages of care at home, we can regard a need for extra medical care as a blip in that, rather than as a “full Monty” situation. Keeping such people within their package of care avoids all the bother of reassessing and rejigging, which puts a lot of stress into the system. Taking people into hospital for a few days means that they are then involved in delayed discharge and reassessment, which is another route.

It is far better for the individual and their family if we can hold people in a safe and secure way within their own home and take them out of that only when it is absolutely essential because they really need heavy-duty care. It is not that we are going to give anyone a second-rate service, because we would want to do things in the way that I have described. We do not want to put people into care homes, either. We want to keep them out of care homes for as long as possible so that those who have to go into care homes spend as little time as possible there, and are then put in the right situation in which to die in comfort and with their family. We do not want the old pattern; we want to keep the care-home bit to a minimum.

Miles Briggs (Lothian) (Con): A lesson that I have taken from the people from Glasgow who gave evidence earlier is that NHS Greater Glasgow and Clyde has really looked at how it does early commissioning for hospital patients and

at how it transitions patients from hospital. From what people on this panel have said, and from the detail on the number of beds, it is clear that NHS Ayrshire and Arran has one of the lowest numbers of NHS and local sector care home places available. A response to a parliamentary question that I asked in July said that you have 94 beds available. NHS Tayside is a similar-sized board but has 328. To what extent are you reforming transitional services so that people can be moved out of acute care and either go home or go to a care home place in the voluntary or the private sector?

Tim Eltringham: I am not sure that I understand which beds you are talking about.

Miles Briggs: I was asking about local authority and NHS sector beds; there are 94 available beds in registered care homes in that sector. Other health boards have much larger numbers of beds available for transitioning patients to a bed in the voluntary sector or the private sector. Is your lack of capacity in that regard having any impact?

Tim Eltringham: Okay. I hope that this will be helpful; I am not sure that I understand fully what the issue is here. In relation to care home beds for long-term care, we are resourcing the better part of 900—we have talked about whether there are vacancies and so on. In relation to interim beds, which I think is the issue that you were asking about, we are not funding such beds in the way that Glasgow has chosen to do. Glasgow does not have community hospitals in the way that Ayrshire and Arran has.

In South Ayrshire, the hospital that predominantly provides what we might call interim care, a combination of complex care for some people—what might previously have been called "continuing care"—end-of-life care and significant rehabilitation support is the Biggart hospital, with 113 beds. There are 20 beds at Girvan hospital, but there is a slightly different model there.

Do we need more such beds? I think that it is unlikely that we do. For reasons that we have explored and that we referenced in our submissions to the committee, delayed discharges were consuming probably two fifths of the 113 beds at Biggart for a period. That was in essence a dead weight, because we were not using those beds productively to rehabilitate people. We have made a little progress in recent weeks in addressing the problem. While those beds are taken up with delayed discharges, we are not using the facility for the kind of interim care that would give us best value by focusing on rehabilitation or, where necessary, end-of-life care.

What we expect from part of the modernisation work that we talked about in our submissions is that the opportunity to tackle significantly the delayed discharge issue in the context of care home places will give us a better handle on what the real demand for interim placements is. However, your question was whether we have enough capacity, and in fairness I should say that we do not know the answer to that.

Miles Briggs: What could you learn from the reforms in NHS Greater Glasgow and Clyde? Could you pick up some of that board's approach?

Tim Eltringham: I have worked in Greater Glasgow and Clyde and in East Renfrewshire—I am pleased that there is a good legacy in East Renfrewshire. Much of the learning about what is likely to work and what might take us in the wrong direction is known to people around the system.

We are in no way complacent, but I think that the figures suggest that had it not simply been for the resourcing issue we would be continuing to use some of the initiatives that Glasgow and other partnerships have adopted.

11:45

The integrated care fund and the resources available through the delayed discharges money have allowed us to look at a range of innovations, particularly the sort of things that are referenced: anticipatory care planning; significant investment in further rehabilitation capacity, which has enabled us to focus on modernising our care at home service, which was needed; and a reablement service, at the front end of the home care service. Rather than people simply being assessed and getting a service for forever and a day, the process at the beginning is very much focused on rehabilitation and using a person's capacity to maximise their ability to undertake daily living activities themselves, rather than us doing it for them.

Those are a number of pieces of the jigsaw, which are very similar to things that have been done in Glasgow and the neighbouring authority of Greater Glasgow and Clyde. There has been a resourcing issue for us in the period, which I hope that we are getting past now.

Liz Moore: Maybe I can explain the impact on Ayrshire, which is different from the impact on Glasgow. For patients in Glasgow who were transferring from acute hospitals to care homes there were very few other options than that route. Glasgow was purchasing care home places and using interim placements to allow assessment to be carried out or because there was a period in which the patient could not move on for other reasons.

In Ayrshire, we always step down from acute hospital to community hospital. That has been our model for many years and we aspire to retain it.

When recently there have been delays—which did not occur in the past, as Tim Eltringham explained—the impact on Ayrshire has been that beds have not been available for patients who would routinely have stepped down to community hospital for rehabilitation. Those beds have not been available in recent months because patients in them have been waiting to move to a care home. Community hospitals, not the acute hospital, have the delays. It backs up so that acute hospital patients cannot move to a rehabilitation bed as quickly as we would like.

In this interim period we are bringing some rehabilitation support into the acute hospital, to try to prevent patients from not benefiting from rehabilitation. It has been a challenge to get staff to do that; we are working on that, while we work through this period of having a particular problem, which we have had since the beginning of the year.

We always step down to a community hospital bed, so that a patient has the opportunity to rehabilitate to the point at which they might be able to go home with a care package, as opposed to having to go to a care home. That is why we have avoided using the care home approach. That has worked well until recent times, when we have had this particular problem.

The Convener: A few people still have questions, so I ask members be as brief as possible.

Clare Haughey: I will ask two quick-fire questions. In your responses to question 7, you said that you had reduced your number of code 9 delayed discharges. I would be interested to hear briefly how you did that and whether other health boards can learn from that.

I will go off on another tangent. We have been driven by money, process and structure, but at the nub of this issue is a patient—a person—who is not getting where they need to get to timeously. What are you doing as an HSCP to support that patient and their family?

Tim Eltringham: On the code 9 issue, the answer is simply that we have been focusing on it and driving the process. Stephen Fitzpatrick from Glasgow described management oversight, and there has been management oversight. Identification as early as possible of patients who may have capacity issues allows us to set in place processes more quickly. Obviously, we are pleased that those numbers have come down.

Implied in your second question is the fact that we recognise that people are not in the most appropriate place to get care. That is a frustration for us as a senior management team, for families and, particularly, for nursing and ward staff at the Biggart hospital that we referred to. We have tried to keep people as informed as possible of the state of play, but we cannot escape from the fact that it creates tension, anxiety and frustration for families and staff at the front line.

Richard Lyle: I will try to be brief. First, I compliment Councillor Rita Miller and her officials on the level of detail that we received from them. I also want to touch on a sensitive subject that Rita touched on a minute ago—death. I noticed that there were 4,643 deaths in Ayrshire and Arran in 2015. It is a very sensitive subject and I apologise if I offend anyone.

In a survey, the National Audit Office found that 40 per cent of people who died in hospital did not have the medical needs that required them to be there. They could have been cared for in a care home or in their own home. Nearly a quarter of them had been in hospital for over a month; 50 per cent of residents admitted to hospital who died could have been cared for in their care home.

A friend of mine wanted to get out of hospital but sadly did not. She wanted the dignity of dying in her own home. Should we do more to give people that dignity?

Liz Moore: Absolutely. We attempt to ensure that patients can go home to die. That can be a complex situation. Often, families can be scared to take a relative home who may be in the last stages of life. Again, it comes back to being confident about being able to provide the care and support that that family requires, along with aids and adaptations. That can take a significant amount of time if patients do not have a bed downstairs and so on. It can often be quite difficult to approach that.

Other than that, it comes down to community-based services having enough resource to be able to respond if something goes wrong for families and, again, it is about giving families the confidence that support will be there.

On all occasions, we attempt to get a dying patient home. It is the first conversation that we will have and it tends to be around being able to put those support mechanisms in the home as opposed to not allowing a patient to go home from the medical perspective. We have multidisciplinary teams involved on a regular basis.

We are getting better at it and, with our health and social care partnerships, we are also trying to identify possible transfers from the acute environment. A hospice does not have many beds and hospice care has quite a strict criterion—it is not about longer periods of care—so we are looking again at our community hospitals to try to ensure that we have appropriate capacity in each of them. We can then transfer a patient from an acute hospital if families would prefer that and then families can be with a dying relative in the

community hospital. That means that we do not have to work to put in aids and adaptations in the home and all the other things that I mentioned.

Alternatively, the general practitioner might be having that discussion with the family. Often, the GP reaches the point at which they are saying, "We will possibly have to admit your relative if we cannot keep them at home." The family can then work with the GP to have the relative admitted to a care home. As you can imagine, it is complicated but we are attempting to ensure that dying patients can die at home where possible.

Tim Eltringham: The only other thing that I would add is the use of technology-enabled care at home in order to provide that option. We could pursue that another time.

Rita Miller: The hospice is carrying out a pilot in which it is providing a little unit. It tried providing an apartment but that did not work very well. It now has a little bungalow in the grounds that families get to use. That seems to be quite a successful approach.

We also have the midwives unit at the maternity hospital. There is privacy at the unit, and the midwives come in and out. Perhaps we could develop something like that, which would give families a lot of privacy but the hospital stuff would still be around it in an emergency. That might reassure families and be a much better way of dealing with things. We need to look at this—

Liz Moore: We need new approaches.

Rita Miller: Yes. New approaches are required and we need to look further into how we can do that.

Richard Lyle: Thank you.

Alex Cole-Hamilton: Very quickly, I am interested in how you manage when you have a deficiency of beds for patients to go into after discharge. What use do you make of out-of-authority placements? Is that linked to the term "Hosted Services" in the budget line that you provided, which I do not quite understand?

Tim Eltringham: I will deal with the last issue—hosted services—first. The three partnerships in NHS Ayrshire and Arran recognised that it made sense to manage some services on a pan-Ayrshire basis across the three partnerships. Mental health services—particularly the hospital in-patient services—are managed by North Ayrshire because they happen to be located in North Ayrshire but they are available to all of us; in South Ayrshire we manage and oversee the allied health professionals; and East Ayrshire has responsibility for the hosted service in relation to primary care. It is simply a managerial or governance construct.

On the other part of your question, I do not think that we would have difficulty with out-of-area bedding, but most people wish to be cared for in their own locality. Are you referring to NHS beds?

Liz Moore: If we have delays in our community hospitals and, as I said, those delays back up into the acute hospital, we create additional capacity in acute services—that is the impact, and we have done that in a hospital over recent months. To enable good patient flow through the hospital, we have had to create extra capacity.

Donald Cameron: You talk about the community hospitals being the provider of the interim beds. Are those patients out of the delayed discharge figures? Do they count as discharges, or do they still come within the delayed discharge figures?

Tim Eltringham: They are still part of the delayed discharge figures. There are 113 beds in Biggart hospital, and at any one time we have had 45 delayed discharges in there, which are reported as part of the figures that are in the papers.

Donald Cameron: So, until a patient is discharged from the community hospital, they remain a delayed discharge.

Liz Moore: Yes.

Tim Eltringham: Yes. We are resourcing the provision differently from Glasgow and, in another area, they might appear as delayed discharges.

Donald Cameron: That answers my next question, which was about whether there is a shifting from one hospital to another—they are still within the system.

Liz Moore: It is just a different model.

Donald Cameron: Okay. Thank you.

The Convener: I have a final question on care home placements. Your written submission says:

> "The downward curve in the graph from October 2015 reflects a decision by the IJB to reduce care home placements to contain costs within the budget available."

That suggests that decisions are being made not in the interests of the patient but in the interests of the bean counter and the accountant, who are saying, "You need to cut this." You then have to decide that, although Mrs Smith should go to a care home, she cannot.

Rita Miller: It was a decision that the board took, and everybody on the board knew the decision that we were taking. We took it very reluctantly, of course, but we have to live within our means. We asked a lot of questions about how the situation would be dealt with in reality so that no one would be put at risk, because we were looking for the least-worst option. However, we did

not have anybody bailing us out by giving us more money.

On Friday, I asked my colleagues at COSLA how they dealt with the situation. They were in a similar situation but, in some cases, they have been able to paint over the cracks to a certain extent because they have received a subsidy from both their parent bodies, as it were, which has allowed them to go ahead. That is fine—that has dug them out of a hole this time—but we feel that we need to change the whole system, not just speed up the process of putting more people into care homes. That is not solving the problem and is not sustainable in the long term. We have to change the model and get more provision in the community.

You are right—it is Hobson's choice. It is not a good choice, and we discussed it because we were concerned about exactly what you have mentioned. We were reassured that no person would be put at any risk, but it is still not the best situation to be in. If people were put into community hospitals, their rehabilitation would not be as active as we might want—that is true—and we would not want to do that.

The Convener: Thanks very much. We really appreciate your evidence this morning. It has been very helpful to us all.

11:59

Meeting continued in private until 12:18.

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