OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 25 October 2016

Session 5

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Pàrlamaid na h-Alba

Tuesday 25 October 2016

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HEALTH AND SPORT COMMITTEE
8th 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:

Morris Fraser (Scottish Government)
Geoff Huggins (Scottish Government)
Christine McLaughlin (Scottish Government)
Shona Robison (Cabinet Secretary for Health and Sport)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 25 October 2016

[The Convener opened the meeting at 10:05]

Subordinate Legislation

Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 (Fixed Penalty Notices) Regulations 2016 [Draft]

The Convener (Neil Findlay): Good morning, everyone, and welcome back. Welcome to the eighth meeting in 2016 of the Health and Sport Committee in the Scottish Parliament's fifth session. I ask everyone in the room to ensure that their mobile phones are switched to silent; they can of course be used for social media, but please do not take calls or photographs or film proceedings—assuming that anyone was ever inclined to do so.

The first item on today's agenda is consideration of an affirmative instrument: the draft Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 (Fixed Penalty Notices) Regulations 2016. That is a mouthful. As usual with an affirmative instrument, we will begin by having an evidence-taking session on the instrument with the relevant minister and her officials. Once we have had all our questions answered, we will hold a formal debate on the motion that the regulations be approved.

We welcome to the committee the Cabinet Secretary for Health and Sport, Shona Robison, who is accompanied by Morris Fraser, team leader, health improvement, tobacco control policy, and Johanna Irvine, principal legal officer, Scottish Government.

I invite the cabinet secretary to make a brief opening statement.

The Cabinet Secretary for Health and Sport (Shona Robison): Thanks very much, convener.

Thank you for the invitation to give evidence to the committee on the draft regulations, the approval of which will allow for full implementation of the proposed measure in December. Following that, anyone who is caught smoking in a car that has in it someone under the age of 18 could face prosecution and a fine of up to £1,000. Alternatively, they could pay a fixed penalty of £100 to the local authority.

The Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 was passed unanimously partly because it builds on and mirrors the successful 2006 ban on smoking in enclosed public places. As was the case in 2005, we require secondary legislation to set out two practical details: first, that a fixed-penalty notice must be issued within 21 days, to give the police and councils sufficient time to co-ordinate; and, secondly, that local authorities must keep accounts and use any revenue that is raised through penalties to improve local amenities. Those details have been agreed with the police and councils, which will enforce the law.

The evidence on the harmful effects of second-hand smoke is clear. Children are especially vulnerable. The Scottish Government's commitment to protect children from the impact of smoke led us to announce in 2014 the target of reducing the proportion of young people who are exposed to smoke in the home from 11 to 6 per cent by 2020, which had the potential to protect 50,000 children. Last month's Scottish health survey revealed that we had met that target five years early.

However, the prevalence of smoking remains higher in Scotland than elsewhere in the United Kingdom. The ban on smoking in public places, the display ban and our commitment to a tobacco-free generation all contribute to the cultural and behavioural change that is needed to improve public health, and the ban on smoking in cars with children in them will do likewise.

The Convener: Thank you very much, cabinet secretary. I invite questions from members.

Richard Lyle (Uddingston and Bellshill) (SNP): Good morning, cabinet secretary. When we brought in the ban on smoking in pubs and clubs, everyone thought that it would not work, but it has worked. In the previous session, I supported Jim Hume's member's bill to bring in a ban on smoking in cars with children in them, even though I am a smoker. A number of years ago, because of having grandchildren, I took the decision that I would no longer smoke in my car. My car now smells better and my grandkids enjoy being in it more.

Given that the people who would be against the measure have to know when it is coming in and what we are going to be doing, what steps are we taking to advertise the law? When similar English legislation came in, there was quite heavy advertising on the television. What steps will be taken to inform the public that they should no longer smoke in their cars?

Shona Robison: A public awareness campaign will run ahead of the legislation coming into force, which will involve various media, including TV, radio and social media, as well as website information.

You make an important point. The whole rationale is behavioural change. Given what we have seen with the measures on seat belts and mobile phones, the legislation has been designed to safeguard good behaviour and to change behaviour. The legislation on smoking is very much in the same vein.

It is important that people are informed. As I said, there will be a full public awareness campaign to make sure that everyone knows that the law is changing.

Richard Lyle: Thank you.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, cabinet secretary. What is Police Scotland's view? How does it intend to police the law, particularly in the introductory months? Will there be spot checks? Will cars be pulled over? Will cameras be used?

Shona Robison: Police Scotland has been fully involved in the discussions on implementation and time has been taken to get the enforcement measures in place. I will ask officials to say a little bit more but, as I understand it, the initial intention is to take a softly-softly approach, as we have done with other legislation, so that while the law is changing there will be a soft landing and people will be warned and so on and so forth.

Morris Fraser (Scottish Government): We have had quite intensive negotiations with the police. We have looked at what has happened in England and Wales, where they have had the measure in place for a year, and Police Scotland will take the same approach. As the cabinet secretary said, the police will adopt a light touch at first—the approach will be about education rather than about criminalisation. After all, if no fines were issued, that would mean that people were adhering to the principle and we are looking for that culture change, not criminalisation. Initially, that will mean an education approach.

Clare Haughey (Rutherglen) (SNP): I will pick up on Mr Fraser's point about legislation already being in place in England. Have we had any feedback from our colleagues south of the border about how effective and efficient the legislation has been in reducing smoking in cars and how the public have taken to it?

Morris Fraser: We collect data through health surveys and, even since the ban came in in England, we have noticed that, here in Scotland, there has been a reduction in reports of children saying that they are being exposed to smoke in cars. Although there are no official stats from England on cars, the stats from the health survey suggest that the legislation is definitely having an effect in England and even here.

The Convener: How many people would you expect to be caught by the offence in the first year?

Morris Fraser: When the bill was being progressed, we thought that as many as 100 people would be caught, but that was just a ballpark figure. In England and Wales, there have been only six or seven prosecutions in a year, but the reduction in incidents of people smoking in cars shows that the legislation has worked as a deterrent rather than as something that we would count prosecutions on. If there were no prosecutions, that would be really good. As I said, for the first six months or so, we do not think that the police will be doing anything too draconian unless there are particularly bad offenders.

Clare Haughey: We are talking about the police, but councils obviously have a role in enforcing the legislation, too. Will they be taking a similar softly-softly approach?

Morris Fraser: That will very much be their position. The police and council officials enforce the smoking ban, although the enforcement is almost completely the responsibility of council officers. With the new legislation, both will have the powers, but it will, almost wholly, be the police who enforce it. After all, the police have the power to stop a car while local authorities have only the power to enter a car that has already stopped. Perhaps councils can do roadside campaigns along with the police. They are of the same mind that the issue is about education, not criminalisation.

The Convener: We move on to agenda item 2, which is the formal debate on the affirmative instrument that we have just taken evidence on. I ask the cabinet secretary to move the motion.

Motion moved,

That the Health and Sport Committee recommends that the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 (Fixed Penalty Notice) Regulations 2016 [draft] be approved.—[*Shona Robison*]

The Convener: Do members wish to contribute and raise any debating points?

Richard Lyle: The regulations are worth while and we should all support them, including smokers. They will lead to better health situations for children in cars.

Alison Johnstone (Lothian) (Green): I add my support for the regulations. As the cabinet secretary mentioned in her opening remarks, the prevalence of smoking remains higher in Scotland. If children grow up in an environment where it is not normalised, that will enable us to proceed on a healthier footing in the future.

Alex Cole-Hamilton: The fact that the 2016 act achieved cross-party, unanimous support in the

Parliament speaks volumes. It would be remiss of me not to pay tribute to my party colleague and the former Liberal Democrat health spokesperson who introduced the bill, Jim Hume.

The Convener: I think that we all agree with that and commend Mr Hume for his initiative. There is widespread support for the move across the Parliament.

Cabinet secretary, would you like to sum up and respond to any of the points that have been raised?

Shona Robison: I agree that, as Alison Johnstone said, ensuring that children are not exposed to smoke is part of de-normalising smoking and normalising not smoking. That is a critical point.

I, too, pay tribute to Jim Hume. This is a good example of cross-party working, where someone comes forward with a good idea and it is seen to be so. The experience of working with Jim Hume to get the legislation to its current point was good and worth while.

Motion agreed to,

That the Health and Sport Committee recommends that the Smoking Prohibition (Children in Motor Vehicles) (Scotland) Act 2016 (Fixed Penalty Notice) Regulations 2016 [draft] be approved.

The Convener: I thank the officials for attending. The cabinet secretary will stay with us for the next item of business. I will suspend the meeting briefly to allow the next set of officials to come in.

10:17

Meeting suspended.

10:18

On resuming—

Health and Social Care Integration Budgets

The Convener: Agenda item 3 is an evidence-taking session on health and social care integration budgets. I welcome to the committee Shona Robison, the Cabinet Secretary for Health and Sport; Geoff Huggins, director for health and social care integration at the Scottish Government; and Christine McLaughlin, director of health finance at the Scottish Government.

I invite the cabinet secretary to make an opening statement.

Shona Robison: Thank you, convener. I welcome the committee's on-going interest in the integration of health and social care and the opportunity to discuss budgets in more detail.

As the committee knows, the number of older people in Scotland is increasing. The number of people aged 75 or over is projected to increase by 360,000 by 2037. That people are living longer is, of course, something to be celebrated, but it presents real challenges for us in how we design and deliver health and social care services. As the population ages, the demand on the health service in particular grows, and the nature, complexity and acuity of that demand grows as well.

Those changes mean that delivering even the current levels of service in the same way as has been done in the past is not sustainable. Radical service redesign, including the integration of health and social care, is required to meet those challenges. This Government's legislation to integrate health and social care is one of the most ambitious programmes of work that we have ever undertaken, and all health and social care partnerships are now fully operational.

Although these are in many ways still early days, the new arrangements are already having an impact on our health and social care services. One of the most significant changes that has occurred as a result of integration concerns the budgets. Integration authorities are now responsible for managing more than £8 billion of resources, which NHS boards and local authorities previously managed separately.

Planning, designing and commissioning services in an integrated way from a single budget allows partnerships to take a more joined-up approach and more easily shift resources to target preventative activity. As with any programme of public service reform, we expect efficiencies to be made that can be reinvested in services. However, integration is about more than budgets—it is about

putting people at the centre of the care that they need.

We are supporting those changes through significant additional funding. We have already provided a further £250 million from the NHS to health and social care partnerships to protect and expand social care services and deliver our shared priorities. That is the first part of fulfilling the commitment from our programme for Government to invest £1.3 billion over the current session of the Parliament from the NHS to integration partnerships to build up social care capacity.

While the new budget arrangements under integration are key to delivering change—and I welcome the opportunity to discuss that with the committee today—it is important to remember that, at its core, integration is about not just budget, but putting people at the centre of the care that they need.

The Convener: Thank you for that. You said when you came into post that you would eradicate delayed discharge. Social care is central to that. Have you succeeded or failed?

Shona Robison: It is work in progress, and I admit that it is tough and very difficult to change something that has essentially been part of the system for a long time. However, I am absolutely optimistic and as committed as I was previously to eradicating delayed discharge. We need to eradicate it.

One of the biggest changes has been the move to the three-day discharge standard. That has done away with the assumption that people will be delayed in the system, which was built into the six-week and four-week targets. The new standard immediately gets people thinking about the discharge of the person rather than about a delay in their care being put together.

Glasgow, in working to the three-day standard, has managed to reduce dramatically the number of delays in its system. Other partnerships have been slower to do that, and Geoff Huggins and his team have been working closely with those partnerships that need to deliver the same performance. If all partnerships were delivering the performance of the top 25 per cent, we would reduce by half the number of delays straight away. I want all partnerships to work to the standard of the best. There is no reason why they cannot deliver the same performance, but we need to work with them to overcome any hurdles and to deliver best practice and do the things that we know work. If we get all that right, we will eradicate delay from the system.

That said, there are complexities around code 9s, and we are working through the adults with incapacity issue, which is difficult to resolve. There are court proceedings that mean that people are stuck in hospital through no fault of the health system or the social care system—those cases account for about a third of all delays. There are those complexities, but I am determined to work through all that to get us to a position in which delay is no longer an acceptable part of our system.

The Convener: Is the social care system as it stands fit for purpose?

Shona Robison: The system needs to be reformed. The Convention of Scottish Local Authorities and local authorities are up for reforming it, and that has to be done in partnership.

We need to look at different ways of delivering social care. I am keen on some models that we have seen that are, if we boil them down, about empowering front-line staff. We have talked before about the Buurtzorg model from the Netherlands, which can be applied to social care or nursing. At its core is the empowerment of front-line staff who work with patients, clients, service users or whatever terminology is used to manage better the people under their care without the need to constantly report back to structures and bureaucracy. We are testing that in Scotland.

Such ideas are the way forward not just for social care but potentially for nursing and community health services. The Buurtzorg model shows that staff get a lot more pleasure and fulfilment in their jobs and, more important, that those who receive the services get better services. The service is often more efficient, too.

The Convener: We will come on to such issues as we go into our discussion.

Alex Cole-Hamilton: One of the key responsibilities of the integration joint boards, particularly given the weight of the money that they control, is the eradication of health inequalities, and one of the biggest issues is alcohol and drugs misuse. We heard from Rob McCulloch-Graham, who is the chair of the IJB in Lothian, that the budget for alcohol and drug partnership funding will be reduced by £1.3 million across the Lothians. That is part of the 20 per cent cut that was delivered to ADP budgets in the previous financial settlement. Do the IJBs have the tools that they need to deliver the reductions in health inequalities? In particular, what will we do about drug and alcohol funding?

Shona Robison: Partnerships are delivering the outcomes that we have asked them to deliver in respect of the number of brief interventions, the delivery of services and more. Some partnerships are going well beyond what they were asked to deliver in targets.

As part of the financial settlement, we asked boards to deliver resources to continue previous levels of funding. I am aware that some boards have done that, but others have not. We are monitoring that, and Christine McLaughlin is in discussions with boards on it.

We have also said that we want to review generally the make-up, delivery and funding of ADPs to ensure that we have the right structures, focus and targets. Resources will be part of that.

I am aware that some localities have expressed concerns, but that has been less the case for others. Christine McLaughlin will say a bit more about the detailed discussions that she has had with partnerships.

Christine McLaughlin (Scottish Government): We have been keen to look at service delivery rather than focus just on the financial position, and to ask partnerships to look at how they could provide in more innovative and efficient ways the services that are needed. I think that we are seeing that happening. The approach falls down if somebody looks at it as involving a cut to the money that they have and providing the same services without changing.

The time that is needed to allow partnerships to look at different models with reductions in funding is part of the challenge. Some boards have looked to maintain levels of funding and given a timeframe in which they expect changes to service delivery to happen. That is where the approach is working well.

We will look at that closely as part of the budget-setting process for next year to understand what models partnerships have looked at putting in place. The underlying position that we have set out to boards is that funding should be maintained in this financial year, although we expect efficiencies to be developed through the year.

10:30

Geoff Huggins (Scottish Government): When Rob McCulloch-Graham gave evidence, he also talked about his ability to use resource flexibly across the piece to secure the outcomes. One of the founding principles of integration was that, instead of handing out the money in small bundles and expecting it to be used in a way that was directed nationally, the expectation nationally was that we would achieve the outcomes and be able to evidence that through the indicators over time. In that context, Rob McCulloch-Graham and his colleagues—the chief officers across the country—are expected to think about not just how the money supports drug and alcohol outcomes but how the service across the piece supports drug and alcohol outcomes.

We are therefore in a slightly different space. If we continue simply to follow each pound on the basis of how it was spent historically and if we expect it to be spent in the same way, we will probably not get the benefit from integration that we are looking for.

Alex Cole-Hamilton: The point about outcomes was well made. I am sure that everybody agrees that that is the priority and that it does not matter what resource we put in as long as the outcomes are delivered. However, we will not see the pay-off or the reaction to the reduction in funding of £1.3 million for ADP services in Lothian until further down the track, as we see outcomes drop off as a result.

I have an anxiety about the terminology of efficiencies. Everybody accepts that we need to make efficiencies but, to my mind, efficiencies mean a cut of maybe 2, 3 or 4 per cent, as we have seen year on year. When we are talking about 20 per cent of funding, that is a cut and not an efficiency saving—it is an absolute slash to the budget. From having spoken to people in the ADP workforce, I know that they are up in arms about that. There is anxiety that they will not be able to deliver the outcomes, regardless of how well intentioned the proposal is. I am not sure that we will ever be able to achieve the outcomes without sufficient funding.

Shona Robison: That is why we need to interrogate the position more closely and consider whether outcomes can be achieved. Some partnerships are saying that they can do that and some have maintained the level of funding, so the picture is mixed. We need to spend more time with the partnerships that say that they cannot achieve the outcomes to understand why that is and why others can do so.

As I said, some partnerships are delivering more than they have been asked to deliver, which is not a bad thing. We need to get the targets right. Of course, there is a more general review of targets—of what we measure and why—and that applies as much to alcohol and drugs services as to any other area.

As Geoff Huggins said, if we stick rigidly to thinking that the funding is for this, this and this, nothing will change, which is why we have removed some of the restrictions on what can be spent on what. The aim is to allow partnerships to be more flexible about where they spend their money to get the outcomes. I hope that, if we focus on achieving the outcomes, we can work through some of those issues. We will keep a close eye on the partnerships that tell us that they have problems—Alex Cole-Hamilton has cited one in particular.

Clare Haughey: I have a wider question, which is on budget-setting timelines. Throughout the committee's interrogation of the issue, IJBs have raised consistently in oral and written evidence the misalignment of timelines for budget setting, which has an impact on IJBs setting their budgets. Councils set their budgets at a different time of year from the NHS, which has a knock-on effect. Is there any scope to look at the timings for setting budgets? If so, what work is the Scottish Government doing on that?

Shona Robison: You raise an important issue, and there is a challenge. Local authorities have a statutory obligation to set their budgets before 1 April, whereas some health boards set their budgets in the first quarter of the new year. The challenge of the spending review constraints played into what was quite a difficult situation. We are working with health boards, local authority directors of finance and integration authority chief finance officers to pull together guidance on good practice for budget setting so that the processes will be better aligned for 2017-18.

It is important to bear it in mind that the statutory guidance stipulates that the budget-setting process for year 2 onwards should be based on negotiation about the level of funding, performance and associated risks, rather than a roll-forward of individual service budgets that were used for initial allocations.

I come back to a point that Geoff Huggins made. If all that happens is that the same resources are spent on the same things but in an integrated fashion, nothing will change. That is the point about year 2 onwards—the expectation is of a different process that is based on negotiation and looking at change.

It was not unexpected that year 1 was going to be challenging in that respect, but we expect to see more such change in year 2 onwards.

Christine McLaughlin: We should expect a lot of improvement in this area next year. We have been working closely with the relevant people on that. We knew that the first year would be one of transition. To recognise the need to work with IJBs, we decided to allow the NHS an extended period for the financial plans, which took them into June this year.

Normally, local authorities set their budgets by mid-March, and we would normally require NHS boards to have their delivery plans and financial plans signed off by 31 March as well. We allowed the extended period, but it meant that IJBs started the year without firm plans in place.

It is probably fair to say that strategic financial plans were in place to a certain level, but they did not have the bottom-up detail that people would like to see in budgets. A lot of work is going on now. Some boards are working towards having indicative budgets for IJBs in place in December. In December and January, I would expect to see much greater clarity about budgets for next year. We are also definitely seeing much greater involvement on the ground of chief officers and chief finance officers in the planning process.

There are good examples of local government, the NHS and IJBs working collectively as part of the process and influencing the level of budgets for IJBs. Whereas the approach in year 1 was very much about handing over the budget to the IJB, there is now much greater engagement all the way through. That being said, we need to recognise that, when boards start the year without a balanced position—we have three boards in that situation this year—the IJBs will be part of the solution in looking at how to recover a balanced position.

I want to manage your expectations, because some decisions will still be taken after the financial year-end and into next year. However, that is part of the shift to the IJB influencing the position rather than waiting to see what its budget will be.

Clare Haughey: Thank you for the reassurance that work is being done behind the scenes to try to have more aligned budgets. Are there specific plans for having budgets at the same time, as the budgets seem to have been out of kilter?

Christine McLaughlin: Local authorities work to set their budgets by mid-March and the NHS works to 31 March. I do not envisage a three-month extension happening again next year. All things being equal, we would expect the budgets to be set at the same time.

I spoke to a couple of NHS directors of finance this week to check the situation, and they expect to give high-level budgetary figures that are negotiated with the IJBs in around December or January. That is a much-improved position, which will probably bring the process forward by about three or four months. In summary, you should see alignment of the two aspects.

Miles Briggs (Lothian) (Con): A lot of the evidence that the committee has looked at has shown the difficulties in getting resources out of the acute setting and into the community. As the policy goes forward, what will a successful outcome look like for the budget share between community care and institutional care?

You touched on overspends. How will overspends impact on taking forward the policy in health boards?

Shona Robison: It has always been difficult to release resources from the acute setting. That is no different in the world of integration, with regard to hospitals' set-aside budgets. One example of an

integration authority's plan in that regard is the decision to close Liberton hospital in Edinburgh and arrange for the reprovision of services in the community.

Through the development of alternative services, there are opportunities to strike the balance in a better way. Of course, it is a chicken-and-egg situation, because the services have to be developed to reduce pressure so that the acute service can release the resource. Getting all that in the right order is not easy—I do not think that anyone ever said that it would be.

The integrated care fund, which is worth £300 million over three years, was put in place to help in the transition period, so that services could be built up in a way that could reduce pressure and mean that resources could be released from the acute sector. There are lots of good examples of that money being used to good effect. We expect to see more of that happening and to see resources being used in that way.

Geoff Huggins: An interesting example that we are starting to see is the different approach that the Ayrshire authorities are taking this winter. Those IJBs are going into year 2 of integration, as they launched on 1 April 2015. In previous years, part of the planning process for winter would have involved making provision for additional wards and additional beds in hospitals that could be opened as demand went up. Our experience has been that those beds are difficult to close, and we experience the challenge of still having winter wards open in June, July and August, which represents a significant financial burden and means that people are in hospital who would otherwise be elsewhere.

The Ayrshire authorities have brought forward plans based on their experience last winter that are largely built around the addition of extra community capacity to absorb the further demand as they go into winter. They are being careful about the approach, so they are also building in a contingency to ensure that, should they require additional hospital capacity, it is available to them. However, their first line of planning is to build the community service. That does not entail the closure of a hospital or a ward; it involves saying that, instead of doing what we used to do, we will find a different solution. We are beginning to see that approach appearing across the country, particularly as partnerships mature to the point at which they can use the integrated space differently. That is really quite exciting.

Christine McLaughlin: I would like to add something on overspends. NHS Fife is one of the boards that are working through a recovery plan. The chief officer of Fife's IJB is working as part of the senior team that is considering the options there because, in the best situation, the financial recovery plan will support the operational plan. When I discuss with the NHS board its plan and when plans are worked up, the chief officer feels like part of the team. That means that plans are not just given to the IJB as something that must be delivered, because the IJB has looked at the plans and at what it can contribute. That is a positive step that we would like to be replicated across the country.

Richard Lyle: I had the honour of being on the Health and Sport Committee in the previous session. When it considered the Public Bodies (Joint Working) (Scotland) Bill, we understood that one of the reasons for it was to get rid of delayed discharge. We also heard about £140 million of savings, but I do not see those savings coming through now. I have a concern that some joint boards are taking on more than we envisaged; the thing is growing arms and legs. One council that I will not name is now nine months down the road of not setting a budget, and we are going into 2017. Do you have concerns about what some boards are taking on? I have another question on that. Do you have any concerns about whether they will make the savings that we intended would be re-invested in better care?

10:45

Shona Robison: We want integration authorities to be ambitious, but we also want them to be clear about how they will achieve what they set out to achieve and for that to be realistic and then to be delivered.

Efficiency savings are to be reinvested. Regardless of whether that is done through the health boards or the integration authorities, it is to ensure that the priorities, and the resources that are aligned to those priorities, deliver changes. Geoff Huggins has just outlined a very good example in Ayrshire, where resources have been aligned and are beginning to make a difference and to shift the balance of care.

I am probably a bit more optimistic than Richard Lyle—we are seeing some really good examples of integration working as was intended. However, some authorities have further to travel. As is ever the case in this world, there are those who fire on ahead and reap the benefits quickly, and there are those who need more support. Sometimes that is about local leadership and sometimes other challenges get in the way. Geoff Huggins and his team and Christine McLaughlin spend a lot of time, as is right and proper, working with individual partnerships that have more such challenges.

Christine McLaughlin: I was involved in producing the figures that were in the financial memorandum at the time of the bill. The principle was that we should expect a reduction in

occupied-bed days, irrespective of whether that was achieved through reductions in variation, as was mentioned earlier in relation to delayed discharges. This year—the first full year—the efficiency savings that IJBs are required to make in order to balance their overall bottom lines are in the region of £225 million. That will come from a combination of efficiencies.

Richard Lyle mentioned earlier that efficiencies can come in different forms. That is partly about the focus on delayed discharge, but it is more is about the extent to which partnerships can achieve a reduction in variation that improves clinical outcomes and is more efficient. That is where we are headed.

The analysis in the bill's financial memorandum was about indicative costs per bed day, so we know that to make an actual saving we need to take out costs by reducing nursing agency and bank costs, or by taking out the equivalent of an unnecessary ward of winter beds, or something along those lines.

Partnerships are very focused on what translates into cash-releasing savings as much as on what translates into productivity savings. The target of £225 million for this financial year is already above the indicative figure in the financial memorandum, and the amount is required in cash rather than productivity. It will be important for us to look at what is meant by a reduction in occupied bed days through services being provided in the community rather than in acute settings. I cannot give an absolute figure because we need to get through this first year so that we can see what the situation looks like. If the partnerships achieve something in the region of 3 per cent, which is what we are targeting, that will give us a good basis for delivering the efficiencies within IJBs.

Richard Lyle: I agree with Geoff Huggins. Ayrshire IJB impressed me because it showed where the savings were coming from—although maybe that was just the bean counters; I do not know.

I will move on, because other members want to ask questions. I am concerned about integration joint boards taking on too much. When I contacted a social work department this week about a house extension for a physically challenged young constituent, I was surprised to learn that that work now falls under the integration joint board. It might be the case that work such as extending a person's house at a cost of around £25,000 is being allocated to the care in the community part of the IJB, but I was still astounded. The fact that I was referred to the IJB manager totally foxed me. Do you believe that such activity should fall under the integration joint boards?

Shona Robison: I can see the logic of that, given that a failure to carry out a housing adaptation is often the barrier to a person's remaining at home or the reason for their being delayed in hospital. There was a long discussion about the housing element of integration; it was recognised that aids and adaptations are often fundamental to ensuring that people can remain in their own homes or can return home.

Geoff Huggins: I would like to say something about a number of the housing examples. The Highland lead agency is doing work using the housing options approach, in particular to address some of the challenges of offering residential care in more rural and remote settings. It sees housing as a key component of its work.

Similarly, about five or six weeks ago, Moray began the process of creating 13 tenancies to replace a previous residential setting. Higher-quality accommodation will be available for the people concerned, who have challenges with capacity and dementia. In effect, what is on offer for that group will be closer to independent living.

In Fife, extensive work has been done to bring together all the work to do with equipment and aids and adaptations. A number of different stores that sat between the social work department and the health department have been brought together to provide better value and faster access.

In East Ayrshire, the Lily Hill development in Kilmarnock was developed as part of a broader social housing development. In other words, it was not a health and care development; it was a health and care component of a housing redevelopment in the town centre. Award-winning accommodation has been built, particularly for people with learning disabilities, which enables them to be more included in the community than would have been the case when they were in individual tenancies or in residential care.

Housing might have been a bit further behind two or three years ago, but now many of the options that are being developed are being developed in that space.

Richard Lyle: So, everything to do with keeping people in their homes and care in the community will come under an integration joint board. The IJB will have to receive funding from the health board and the council for that.

Geoff Huggins: There is a mandatory list of things that must be brought under integration. Beyond that, consideration can be given to what it makes sense to add to the list in the context of local circumstances.

Housing is developing quite quickly. More areas are bringing in children's social work services and most children's health services are already

integrated. We are seeing that becoming part of the story, as people think across the life course. In a number of areas, we are also seeing the incorporation of criminal justice social work, which has links to mental health services and addiction services. People are trying to find ways of bundling services together and are thinking about things from the point of view of the needs of the individual rather than the needs of individual services, which is very progressive.

Richard Lyle: Thank you.

Alison Johnstone: I am heartened to hear that housing is being viewed in that way. The longest delayed-discharge case that I have dealt with involved a person who had had a stroke and could not return to his tenement flat. We had quite a long wait. It is heartening to hear that such good work is being done—in parts of the country, at least.

You mentioned the Highland model. When we heard from Nick Kenton of NHS Highland a couple of weeks ago, he said:

"what makes the lead agency model powerful is that operational budgets, management and governance are entirely integrated into one body."—[*Official Report*, *Health and Sport Committee*, 4 October 2016; c 2.]

Audit Scotland has noted potentially confusing lines of accountability around IJBs and a lack of clarity about who is ultimately responsible for quality of care, so I am interested in hearing your views on whether the lead agency model offers advantages. Is there perhaps a feeling that the governance arrangements of IJBs are making autonomy difficult, particularly with regard to budget setting?

Shona Robison: The Highland example will provide a good way of interrogating the situation because it uses both the lead agency model and the IJB model in the area that it covers. In that one area there will be a lead agency for part of the system and an IJB for the other part, which will provide an interesting contrast.

I am not convinced that this is about structure and whether the lead agency offers better governance and accountability solutions than IJBs. Rather, I think that leadership is the most important thing. We have seen most progress where there has been strong local leadership, where ideas have been flowing and where people have been ambitious for change. Some really good results have come out of that.

Geoff—do you wish to add anything?

Geoff Huggins: The Highland example is interesting if we read forward from our discussion on housing. Of course, housing is not part of the lead agency's responsibility. However, over the past two or three years, there has been greater engagement with the council on the functions that still sit with it; after all, such change involves the delegation of a function, so the council still retains responsibility for functions that are discharged by the health board.

The challenge is that part of the intention behind integration is to tie together a wider range of organisations and individuals in order to secure better outcomes for people, but finding simpler ways of doing that in order to reduce complexity and the degree to which people are involved probably does not take us there. I therefore agree entirely with the cabinet secretary that the areas that are moving fastest and doing best are those where greatest leadership is being shown. It is ultimately about leadership as well as the interdependence that integration is intended to build.

Christine McLaughlin: In the first 18 months or so of the lead agency model, there were a number of budgetary issues. Although the model was simpler in some ways, there was a lack of understanding about the budget that was transferring from the local authority to the health board, in particular, and it probably took people about 18 months before they fully understood the scope of the services that were being covered. There was a different set of transitional issues; however, those are very much in the past, and things are now working much better.

Perhaps we need to accept that in the first year of something so different, there will be a degree of turbulence in the system. I am not sure that one process has been necessarily shown to be smoother in the first year than the other.

Alison Johnstone: Thank you.

Obviously, we are faced with increasing demand on our services with a growing ageing population and rising costs. Although there are clear challenges, they are not all financial; some are about making a cultural change if we are really going to make the shift from acute services to real community care. In earlier evidence sessions, we have heard about risk aversion and about people in certain services not being aware of the community offering. Geoff Huggins has just mentioned the need to tie together a range of services, but what is going on behind the scenes to ensure that professionals in all areas are aware of one another's work and of the opportunities in transferring, at the appropriate time, people back to a home setting or a different care setting?

Shona Robison: One of Glasgow's strengths lies very much in its operational managers being empowered to take certain operational decisions and to get on with change. That has resulted in the ability to do things differently and to change things if something is not working. I have spoken to managers and staff in Glasgow, who pinpointed

that as the key to success in addressing delayed discharge.

11:00

You mentioned risk aversion, which is an issue. Change is difficult, and doing things differently is always a risk. However, the evidence that is emerging on what works well should help to minimise that. There are great examples of change that has led to better services—and sometimes to more efficient better services. In the context of increasing demands, our having an ageing population and there always being resource constraints, it is important that things are done differently. However, that sometimes means change, and the public have views on some changes. We need to ensure that when change happens or is proposed, the benefits of the new services are made clear. We have had debates in Parliament about some of the changes.

We politicians must all interrogate proposals for change, but we also have to accept that we need change: if we carry on spending money on the same things, we will get the same results. We have to change because the population is changing and needs are changing, so our services need to evolve if we are to meet not just the needs of today, but needs 10 or 15 years down the line, which will not be easy. We need to support local leaders in driving forward those changes.

Geoff Huggins gave the example of our approach to winter beds. Not opening masses of acute beds in the winter is doing things differently and carries a degree of risk. As always, there is a contingency plan if it does not work, because the risk needs to be managed. However, if it leads to sustainable avoidance of people who do not need to be in hospital going there, surely that is better than opening winter beds just because that is what has always been done.

Geoff Huggins: A few things are beginning to come on to the table on cultural and behavioural change. A conversation about acute commissioning has, in the past three or four months, emerged in the chief officer group. The question is whether, given the structure of the unscheduled care service that is currently provided by hospitals, that is the service that they would want to buy. That has come partly from experience. As they have addressed delayed discharge, they have found that the hospital has still been a challenging environment. In some cases, the space that has been created by additional discharges has simply been taken up by additional admissions. The chief officers are therefore now having a conversation about how they engage with the hospital environment.

Around half the chief officers come from local authority backgrounds and half come from health backgrounds. Those with health backgrounds tend to have been involved in planning or community work. That group is engaging with what goes on in hospital in a new way: they are beginning to ask questions about whether, if they were setting out the specification for the service, they would specify it differently so that it would work better as part of an integrated system.

We are also seeing a cultural bias towards greater use of data—people are tracking activity and financial data in a way that they have not done before and are using our analysis—which shows that 2 per cent of people use about 50 per cent of the resources—in order to understand better where to use the resource and what choices they might make differently.

The chief officers are an interesting group. They meet monthly and we meet them monthly. They are engaged in conversations with one another about what they find is working and how they are working in the broader environment. I am expecting the change process to accelerate as people see more opportunity and gain confidence. It is quite a quickly transforming space.

Alison Johnstone: Thank you.

The Convener: What percentage increase did health and social care receive across the piece this year?

Christine McLaughlin: The uplift for this year was 5.5 per cent on average for territorial boards. Does that answer your question?

The Convener: You said 5.5 per cent.

Christine McLaughlin: That was the uplift.

The Convener: That is not what boards tell us.

Christine McLaughlin: I can give you the breakdown—

The Convener: If that is the case, why is NHS Lothian, for example, cutting £90 million?

Shona Robison: Although the allocations are as Christine McLaughlin said—

The Convener: Cabinet secretary, may I ask Ms McLaughlin to answer first, before we come to you?

Shona Robison: Of course.

Christine McLaughlin: Let me be factual. The value of the uplift to boards was £474 million. The breakdown of that includes a real-terms uplift of 1.7 per cent last year, funding of £250 million for social care, and a combination of other things including additional NHS Scotland resource allocation committee funding for boards that were

below parity, and funding for delayed discharges. That is what made up the total uplift—

The Convener: NHS Lothian tells me that it got 1 per cent.

Christine McLaughlin: The real-terms uplift was 1.7 per cent, and NHS Lothian—

The Convener: The board also tells me that health inflation is 6 per cent.

Christine McLaughlin: Let me take you through that. The minimum real-terms uplift for all territorial boards was 1.7 per cent, and NHS Lothian received additional funding for being below parity in its funding. Like all boards, it obviously has to be able to balance the inflationary pressures that it has. That is why, on average, boards will make just under 5 per cent efficiency savings this year, which are to be recycled within the system—

The Convener: Can we stop there? You are getting into accountancy speak that I do not understand and do not want to understand. You said that boards got 1.7 per cent.

Christine McLaughlin: That is correct.

The Convener: Does that take account of the 6 per cent health inflation?

Christine McLaughlin: I do not recognise the figure of 6 per cent health inflation—

The Convener: That is what NHS Lothian told me.

Christine McLaughlin: The inflation that boards talk about will be a combination of pay inflation, drugs inflation—

The Convener: Yes—it is inflation across the board.

Christine McLaughlin: Pay inflation has been running at about 1 per cent, and prescribing inflation is probably in the region of 10 to 12 per cent for NHS Lothian—

The Convener: NHS Lothian told me that the across-the-board rate of health inflation is 6 per cent.

Christine McLaughlin: Probably the simplest way to put it, if I can do so, would be to consider the total level of efficiency savings that boards require to generate in order to break even, because that should, by and large, be the figure that you are talking about—albeit that it will include things like developments to services as well, and NHS Lothian would have had some developments in its plans—

The Convener: In effect, NHS Lothian has to make a 5 per cent cut.

Christine McLaughlin: That is not a cut; it is the level to which the board needs to make efficiencies in the system, in order to—

The Convener: That brings me to my next question. During all my time in local government and Parliament I have heard people use the word "efficiencies"—we have probably heard it 20 times this morning. That leads us to ask why we have been paying very senior managers lots of money to run such inefficient services. If someone from Mars were to drop in, who had not listened to the background to all this, they would say, "Hold on a minute. These people have been running services for so long. If the services are so inefficient, why do we continue to employ them?" I do not believe for a second that they are so inefficient, but it is the inference that we can draw from what you are saying.

Christine McLaughlin: It is certainly not the inference that I draw. Generating efficiencies involves a combination of things. All boards look at the extent to which the services that they provide could be provided more efficiently, and at the extent to which they could do things differently. I do not for a second think that that implies that boards are being inherently inefficient in how they do things. However, boards must strive continually to live within their means.

NHS Lothian's efficiency savings target is about 6 per cent, as you said, but that is not all about cost inflation in pay and drugs, for example; it is also about developments that NHS Lothian is putting in place. I disagree with any implication that boards are being inefficient in what they are doing—I agree with your analysis on that point.

The Convener: Are cuts being made?

Christine McLaughlin: Boards are looking at a number of things this year within the overall savings of just under 5 per cent. Some of the things that they are doing will be savings that they will make this year—

The Convener: Are any cuts being made to services?

Christine McLaughlin: The savings that boards will make this year will sometimes be savings that they will not be able to make on a recurring basis. I can put it that way.

The Convener: Is that a "Yes"?

Christine McLaughlin: It depends on what you mean by a cut in services—

The Convener: Are services being cut, in your opinion?

Christine McLaughlin: In my opinion, boards are looking to provide the best outcomes that they can with the funding that they have, and there are a whole range of services within—

The Convener: That is not the question. Are cuts being made to services?

Shona Robison: Boards—

The Convener: I am asking Ms McLaughlin what the answer is from her experience, because she is the finance person.

Christine McLaughlin: If I can answer the question from my experience, I will say that boards are taking an approach that involves identifying savings to their baseline that do not impact on clinical outcomes. What the convener says is not language that I would typically use with boards nor is it language that directors of finance would use—

The Convener: I know that it is not the language that they would use and it might not be the language that you would use, but it is the language that the public and the people whom we represent would use. Many of them will understand what you are saying, but to cut through that, they understand it in terms of there being cuts to services or there not being cuts to services. It appears that you cannot answer that question.

Shona Robison: Maybe I can try to answer the question, convener. I think that the public understand that record levels of funding have gone into the NHS. I think that the public also understand, though, that demands have increased and will continue to increase. We all live within resource constraints. Even you, convener, would, I am sure, accept that.

The NHS has had the lion's share of Scottish Government resources for a number of years, including this past financial year. Within that, however, I have never argued that things are not challenging. Boards are required to manage the resources with all of the demands that are made on them through inflation, pay, or services that continue to grow. That is why we have just spent the last hour talking about why things need to change and why services need to change and evolve.

If we keep doing the same things and not changing services, your constituents, convener, will not get the best deal for the public money that goes into those services. I think that, collectively, we all have a stake in making sure that the money is spent as efficiently as possible.

There are 25 per cent fewer managers in the NHS under this Government because we believe that it is right not to have a top-heavy management structure in the NHS. Those managers have a very challenging job to do. Christine McLaughlin and her colleagues work very closely with them to ensure that every public pound that we put into the NHS gets to the front line to provide the most efficient and best service for the people of Lothian or other board area. Of course that is challenging—that is why we are spending time talking about integration and why we are talking about examples of providing services better and that is why we are here this morning having this evidence session.

The Convener: I am still not sure whether you are saying that there are not cuts to services.

Shona Robison: There will be changes to services, convener. I am sure that you would not expect everything to stay the same. If we had taken the approach that there were not going to be any changes, we would not be sitting here talking about the world of integration and changing services. We want services to be better.

Ivan McKee (Glasgow Provan) (SNP): I will follow up on that, but will shift the focus slightly to talk about outcomes and performance measures. To reflect on that discussion, to my mind, if "efficiency" is not an absolute term, it is very much a relative term. You should always be able to get more efficient, no matter how efficient you are. To reflect on the cuts versus efficiency debate—again, to my mind—I say that efficiency is about getting more from less, whereas cuts are about getting less from less.

Efficiencies are absolutely the direction in which we should go, but as part of that, defining "more" is clearly important to outcomes. I would like to hear the cabinet secretary's reflections on the performance measures, the outcomes and the indicators that we have in place. Are they up to the job? I know that there is a review coming up.

In respect of our discussions with health boards in previous meetings, is there an understanding of the importance of being able to link budgets to outcomes and how that process works? We got the feeling that there might be a gap in perceptions and understanding in that regard.

11:15

I want to stress the importance of something that has come up a couple of times. In the letter that we wrote to you following our survey on delayed discharge, we made the point that it seems that there are different interpretations of the metric, in that some health boards include interim care in their delayed discharge statistics and some do not. I am not saying that NHS Greater Glasgow and Clyde is not doing a good job, but what it is doing certainly appears a lot better because it does not include in its metric interim care step-down beds.

The main thrust of my question is about how performance measures are linked to budgets, and how the approach is developing.

Shona Robison: What we measure and why are important. The review that Harry Burns is taking forward is geared to ensuring that we measure the right things, and that is about outcomes for patients. We can talk about putting money into that service instead of this service and about whether services will change, but at the end of the day, outcomes for people are the most important thing.

The work that Harry Burns is doing across the health and care systems is about whether we can get a set of measurements that better reflect the outcomes. At the moment we have a set of targets—we have reduced them dramatically over the years—a lot of which are quite input focused; they measure what goes in rather than what comes out and the outcomes for people. Did a person end up staying in their home with a good quality of life for longer because of an intervention? We are getting better at measuring that, but Harry Burns's work will help to ensure that we get the measurements right, across our whole system.

Investment in the priorities of the health and care systems will then inevitably shift towards outcomes. If the Government sets targets for what we expect boards to deliver, resources will follow the targets. If the targets change and become more outcomes based, we expect integration authorities to prioritise their resources in the context of those outcomes. I hope that that will help to shift the balance of care and to shift resources into more preventive spend and keeping people out of hospital.

The work that Harry Burns has undertaken is important. He is the best person for the job—he understands the system very well and he will be able to get us to a place where we have a system that will stand the test of time. We will balance the views of the professions who have an input with those of the public and patients, because it is important to hear the public's views on what is important to them. Harry Burns will do all that as part of his work.

Geoff Huggins: I can say a wee bit more about where we are with the indicators that sit underneath the outcomes. Currently we have 23 indicators, the first 10 of which are largely evaluative. We get them every two years from the Scottish health survey. We generally get them a number of months after the survey is completed, so they are probably not sufficiently useful to partnerships in reshaping services, although the space that the indicators are in, which is about people's experience of the healthcare system, is a key area about which we need to understand more.

The second group of indicators is more numerical, and our view is that they focus too much on the interface between the hospital and the community. There is certainly not enough about the quality and experience of primary and community services, and there is very little about population health—the only indicator in that space is premature morbidity.

The challenge is that we try to reflect better what we know matters to people. The cabinet secretary is right that Sir Harry Burns will do a good piece of work. We are certainly seeing from developments in other systems an increased focus on, for example, isolation and loneliness—which are seen as being core to people's experience of their health and wellbeing—rather than on the health and the care system. We are also seeing a move from looking particularly at care failures through safety to people's sense of safety, which affects the degree to which they engage with services in the community. That will take us into the space of needing new ways of measuring what is going on.

May I respond also to the question on—

The Convener: Will you be brief? We have only 10 minutes left before we move on to the next agenda item, but by all means finish your point.

Geoff Huggins: I was going to go on to the second half of the question about the delayed discharge metrics. We have offered an answer on that. We probably need to understand why we include community hospital beds but not care home beds in the figures. Even within community hospitals, we will include a person on the delayed discharge figures only if the person is ready to go home. Therefore, not all such people in community settings, including community hospitals, will be considered to be a delayed discharge. The question is whether there is something preventing their being discharged.

People in step-down accommodation in Glasgow will be receiving assessment and reablement. The assessment is that that is the appropriate place for them to be. It is possible that a person may become delayed in that space, but if they do, the system, as it has been built in Glasgow, simply does not work because it relies on continued movement of people through it.

The best evidence of the impact and the focus is that increasingly people are going home rather than to institutional settings. We are saying that that is part of the discharge process—it is not simply a separate place for delay; it is a place where something is happening.

Ivan McKee: Is there an understanding of the relationship between delayed discharge and the budgets? I agree absolutely with everything that you have said. The issue is at the next level. Do chief executives and people who are in that space understand that the issue is about having a

mechanism that will line up what they are spending and what they are delivering from that spend. I suppose that you could turn that the other way round. If you rocked up and said that you had £100 million extra money to spend on a specific outcome, chief executives would be queuing up to tell you exactly how they were going to take the money and deliver an outcome for it. However, if you flip that on its head and ask them how the money that they are getting is delivering outcomes, they suddenly find it very difficult to give clarity.

The Convener: Was that just a point?

Ivan McKee: Yes, unless anybody wants to say anything about it.

Colin Smyth (South Scotland) (Lab): Good morning. I have a couple of questions about the social care fund and—you will not be surprised to hear—the living wage. On Friday, I met Margaret Paterson, who is the Dumfries and Galloway branch representative on the Scottish Care national committee and managing director of Stewartry Care, which is a local care provider. Margaret described the somewhat fraught process that took place running up to 1 October to get agreement between IJBs and social care providers to deliver the living wage. The process has also been described to us by a number of people who have come to the committee. It is clear that IJBs and providers do not want to see a repeat of that process next year, assuming that the Government continues the commitment to pay the living wage beyond this year. What lessons have been learned from the process? What improvements do you see coming next year? How will the living wage be funded beyond this year? Will we get proper costings for the living wage, so that we do not have the disconnect that we had this year between the Government's original estimates and what the reality has turned out to be for social care providers? Will we build on the living wage by guaranteeing that it will be paid to staff who carry out sleepover shifts next year?

Shona Robison: First, it is good that we are on track to deliver the living wage and that staff working in the social care sector who previously did not get the living wage will get it from 1 October. I am sure that, collectively, we all support that.

The process has been difficult. By its nature, a series of local negotiations has had to be delivered, and that was never going to be easy. Geoff Huggins and his team have very much supported those local partnerships in being able to get to the place that we have now got to. Geoff will be able to give you the latest update on where we have got to. Of course, if there has been a delay in reaching agreement with any providers, individuals' pay will be backdated to 1 October, so no one will lose out because of any delay in reaching that agreement.

The issue of sleepovers has been challenging. Because of the views of providers—the very people that you have just been talking about—who said that more time needed to be taken to ensure that services were not withdrawn from vulnerable people, which I am sure nobody around the table would want, and to ensure that the issues that needed to be resolved were resolved—indeed, the unions have supported that position—a process has now been put in place to resolve the position of sleepovers. I have made it clear that I want people who are being paid for sleepovers to be paid at the living wage rate, and that is the ambition. However, I understand the complexities of that, which is why we listened to what providers and the unions said and why more time has been taken to ensure that we get that right in a way that does not undermine or pull the rug from under vulnerable people getting services.

I ask Geoff Huggins to give the committee the latest information on where we are.

Geoff Huggins: I met the provider organisations—Scottish Care and the Coalition of Care Providers in Scotland—the unions and COSLA yesterday, and I have been meeting them about once every two weeks or more frequently. Alongside that, there have been telephone calls and emails over the period since probably the beginning of August. It has been a testing process in which, in effect, we have negotiated with 32 local authorities. Those 32 local authorities have then negotiated with somewhere north of 500 providers. Ultimately, the benefit of that will be felt in changes to around 100,000 employment contracts, which is not insignificant—it is about 2 to 3 per cent of all the employment contracts in the country.

We have tested the current system to destruction and have worked through, over a six-month period, processes that councils would normally have gone through cyclically over three to four years. There are a number of elements of learning from that. We talked yesterday—particularly in the second half of yesterday's meeting—about what the policy means for 2017-18 and what we would do differently on the basis of our experience. We are looking at the particular challenges for providers that provide services across a number of authority areas, especially those that are likely to be delivering either mental health and learning disability services or higher-tariff services, and at how we can think differently about that situation in future years. Part of the challenge this year was that some providers had to reach agreements with 23 or 24 different authorities before they could reach an agreement with their staff.

We are working through some of the procurement challenges as well. In some areas, the amount of resource that councils have to conduct procurement has been limited, so further work is required there. We are also looking at some components of the cost structure of services. We have been surprised that, although in many cases the living wage can be delivered at £15 or £16 an hour, some providers say that they cannot deliver it for £20 an hour. Given that the wage that we are talking about is £8.25 an hour, we are trying to understand why it is more difficult for some providers to pay the living wage even when there are differentials in place.

Scottish Care has raised with us the issue of differentials and on-costs, which we have said that we will look at. However, to be fair, the £250 million resource that has gone in is broadly comparable to what we anticipated that the policy would cost. The figures that we offered last year, through the Scottish Parliament information centre, are not that far away from what we are seeing in practice, although the distribution of those figures has perhaps been different. How the policy has impacted in different local authority areas has been variable, as has been the degree to which partnerships, in looking at what it is costing them, have included some of their staffing costs for in-house services as well as services that are provided through the private and voluntary sectors. That is particularly where the additional resource was offered on the basis that councils were saying that they were already living wage employers coming into 2016-17.

We will meet the other stakeholders again three to four times between now and Christmas, and — [*Interruption*.]

Alison Johnstone: I apologise. That was my phone.

11:30

Geoff Huggins: We are also putting together an event, which will take place towards the end of November or at the beginning of December, at which we will think about and work through the issues to do with sleepovers. At the moment a number of areas offer enhanced wages for sleepovers, on the basis that people felt that they could make progress this year. We want to think about how best to use sleepovers and the degree to which services can be structured in other ways to give people better outcomes.

The Convener: I apologise for the noise pollution from the Green Party there. [Laughter.]

Colin Smyth: I come back to one of the questions that I asked earlier. How will the living wage be funded next year? I presume that there is a commitment to continue to pay the living wage. I am keen to know that there is such a commitment and how it will be funded.

Mr Huggins, you said that the Government's estimate of the cost and the reality are pretty similar. However, the information that the committee has had from 20 IJBs that completed a survey for us is that the cost of the living wage—for just those 20 IJBs—is about £47.7 million. Your estimate was £37 million, so it is not clear to me that that is close to the actual cost, which seems to be significantly more, given what IJBs told us.

That takes me to the second part of my question. Will the Government calculate and publish its estimates of the costs per IJB of paying the living wage in future years?

Shona Robison: On the first part of your question, the living wage is a key commitment, which we want to ensure continues to be delivered. Ensuring that that can happen will be part of the spending review negotiations. Of course, we need to look at the real-time information, which is still filtering through, about the actual cost of delivering the living wage from partnership to partnership.

There is significant variation. Some partnerships were further along the road to paying the living wage, so their costs are different from the costs for partnerships that were paying service providers an amount that was further away from the living wage. We will look at all that as we take forward negotiations, to ensure that we continue to deliver the living wage in future.

Geoff Huggins: On the difference between the estimate and the actual costs, when we looked at the material that the committee sourced from integration authorities we found a couple of examples that stood out. Dumfries and Galloway's figures suggested that the living wage would cost the partnership about £4 million, but that £4 million includes the resource that is associated with Dumfries and Galloway Council staff as well as the resource that is associated with private and voluntary sector services.

As I said, the commitment that was made on the use of the new and additional money—the £250 million—was focused on resource in the private and voluntary sector and did not include costs relating to council staff. It is entirely legitimate for partnerships to use some of the £250 million to support additional wage costs in the council, and that is what Dumfries and Galloway declared to you, but such costs were not in the data that we provided through the Scottish Parliament information centre.

Beyond that, there is the question of the impact of sleepovers. As we went into the process, no one—not us, not the providers, not COSLA and not the unions—forecast sleepovers to be the

issue that they were. We have had to work through the issue, and we are not in the most satisfactory place in that regard, but we will work to achieve our objectives in that space. Some of the difference is accounted for by the sleepover issue.

Colin Smyth: Do you stand by your estimate of £37 million as the cost of the living wage for IJBs?

Geoff Huggins: We have looked at that again over the past few days in the context of next year, and our assessment of the costs in respect of the services that were covered by the commitment—that is, independent and voluntary sector services, including the services that are provided through the national care home contract—is that they are in that ballpark.

Shona Robison: The point that Geoff Huggins has made is that some of the returns included commitments that councils were funding for their own staff, so they included the uplift for their staff rather than just the commitment to deliver for the independent and voluntary sectors. That was not in the figures that we provided to SPICe, which were estimates for the delivery of the living wage for the private and voluntary sectors.

Having said that, we will—obviously—use the real-time information once all the deals have been completed and the financial information is available. We will have that real-time information to inform us in relation to where we go next year, and we are already beginning to have those discussions with local government.

The Convener: No one here would say that the payment of the living wage is not good news. However, when we met 25 social care workers recently to discuss a range of workforce issues—it was probably the most powerful testimony that I have heard for a long time from witnesses who have spoken to committees—they raised numerous points. I have a full page here, but they include down time during the day, travelling time, paying for uniforms, paying for phone calls, lack of continuity of care and lack of feeling valued.

We are familiar with all those issues in the social care sector and we will write to the cabinet secretary soon about that, but one issue that comes across very clearly was reinforced by Mr Huggins's evidence this morning when he said that the Government has been involved in 32 negotiations affecting 500 providers and 100,000 staff. In the evidence that the committee has heard, all those issues have been brought together in both the providers and the trade unions calling for national collective bargaining. It is hugely significant that both sides are saying that we need that.

Is there a commitment from Government to move soon towards national collective bargaining in the sector? Personally, I think that that is the most significant thing that could be done at a governmental level to address all the workforce issues in a systematic manner and make social care what it has to be—a sector that people want to join and not one that people want to leave.

Shona Robison: I have never claimed that addressing pay alone would be a panacea for creating a change in how we view and value the care sector. That is going to require more than just addressing pay. That said, pay is important, and the principle of paying the living wage to those who look after our most vulnerable people is a good signal that we value the care sector and we want to encourage people to come into it and remain working in it.

The issues that you raise in and around the sector beyond pay are absolutely legitimate issues, and career progression is another one. We are looking at how we can create better career opportunities within the care sector, potentially for people to move into the regulated professions if they so wish, and how we can create the opportunity through education and training for people to do that.

We are very aware of all those issues. It cannot be just the responsibility of Government to resolve them, though; it has to be done in partnership with local government and the sector itself. We have the national care home contract, which delivers a national deal for care homes. Home care and care at home are different, and we have had numerous negotiations on them. We are now talking to the sector about how we can move forward to address some of the common issues across the sector and perhaps avoid some of the difficulties that we have had. Geoff Huggins is closer to some of those discussions, so he may wish to comment.

Geoff Huggins: Yes. As I said, we have met the unions face to face five or six times since the summer to discuss where we are on the living wage. They have yet to raise with us that they would like national collective bargaining on behalf of staff. It may be that they are raising that issue elsewhere, but they have not raised it with us and I am not aware that they have—

The Convener: Could you ask them at your next meeting?

Geoff Huggins: I am not aware that the unions have raised it with COSLA either, because of course their negotiation would be with local government and not directly with central Government. What we are having is a conversation about whether there would be value in having a framework for care at home, and for housing support where that relates to care services, like the framework for the provision of residential care through the national care home

contract. That could set target rates for the hourly rate to be paid to providers in different sectors and across different geographies, and there would also be expectations in respect of things such as terms and conditions. That is a conversation that we have been having and I think that there are pluses and minuses to it. However, we have certainly indicated to providers and other partners that we are happy to continue to have that conversation.

I am not sure whether those two things have become intertwined. However, the next time that I see the Scottish Trades Union Congress, I am certainly happy to ask it what its position is in respect of collective bargaining.

The Convener: Thank you. I thank the cabinet secretary and her colleagues for giving evidence this morning, and I suspend the meeting briefly to allow them to leave.

11:41

Meeting suspended.

11:43

On resuming—

Petition

Gender-neutral Human Papillomavirus Vaccination (PE1477)

The Convener: Item 4 is petition PE1477, which was referred to us by the Public Petitions Committee and which we previously discussed on 13 September. I invite members to give their views on the petition.

Ivan McKee: My view is that we should keep the petition open and wait for the results that will come back to us next year.

The Convener: Do you mean the results of the on-going work?

Ivan McKee: Yes.

The Convener: Are there any other views on what we should do with the petition? If not, are we happy to support Ivan McKee's position on it?

Members *indicated agreement.*

The Convener: Thank you. As agreed earlier, we will now go into private session.

11:43

Meeting continued in private until 12:15.

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