OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 25 April 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 25 April 2017

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HEALTH AND SPORT COMMITTEE
11th Meeting 2017, 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)
*Jenny Gilruth (Mid Fife and Glenrothes) (SNP)
*Alison Johnstone (Lothian) (Green)
*Ivan McKee (Glasgow Provan) (SNP)
*Colin Smyth (South Scotland) (Lab)
*Maree Todd (Highlands and Islands) (SNP)

*attended

THE FOLLOWING ALSO PARTICIPATED:

Claire Cairns (Coalition of Carers in Scotland)
Sonia Cottom (Pain Association Scotland)
Corinne Curtis
Amy Dalrymple (Alzheimer Scotland)
Jo Gibson (North Ayrshire Health and Social Care Partnership)
Michael Kellet (Fife Health and Social Care Partnership)
Linda McGlynn (Diabetes Scotland)
Margaret McKeith (Scottish Care)
Heather Petrie (Voluntary Action South Lanarkshire)
Dr Marion Slater (Royal College of Physicians of Edinburgh)
David Small (East Lothian Health and Social Care Partnership)
Andrew Strong (Health and Social Care Alliance Scotland)
Christina West (Argyll and Bute Health and Social Care Partnership)

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The James Clerk Maxwell Room (CR4)

Scottish Parliament

Health and Sport Committee

Tuesday 25 April 2017

[The Convener opened the meeting at 09:31]

Petitions

Service Delivery for the Elderly or Vulnerable (Consultation) (PE1628)

The Convener (Neil Findlay): Good morning, everyone, and welcome to the 11th meeting in 2017 of the Health and Sport Committee. I ask everyone to ensure that their mobile phones are on silent. It is acceptable to use mobile devices for social media, but please do not take photographs or film proceedings.

The first item on the agenda is to consider approach papers on two public petitions. The first petition is PE1628, which is on consultation on service delivery for the elderly or vulnerable. The committee is asked to consider the petition and the evidence that has been presented to the Public Petitions Committee in connection with the petition as part of its inquiry. Do committee members have any comments on the petition?

Colin Smyth (South Scotland) (Lab): There are a lot of valid points in the petition. Given that we are starting a piece of work today on integration joint boards’ engagement with stakeholders, I suggest that we dismiss the petition but incorporate the issues that it raises into today’s evidence session and cover them during today’s discussion.

Donald Cameron (Highlands and Islands) (Con): I visited the care home in question in Dunoon. I do not mind dismissing the petition as long as we consider the very important local issues that it raises, which I have a particular interest in.

The Convener: Do members agree with Colin Smyth’s suggested course of action?

Members *indicated agreement.*

Whistleblowing in the NHS (PE1605)

The Convener: The second petition is PE1605, which is on whistleblowing in the NHS—a safer way to report mismanagement and bullying. The committee is asked to consider the petition and the evidence on it that has been presented to the Public Petitions Committee. Do members have any comments?

Alison Johnstone (Lothian) (Green): I would like to suggest that we incorporate the issue into our inquiry into national health service governance. That seems highly appropriate. We could perhaps look at having a session on whistleblowing as part of the inquiry.

The Convener: Do members agree to take that very sensible approach?

Members *indicated agreement.*

Integration Authorities' Engagement with Stakeholders

09:34

The Convener: Item 2 is on integration authorities' engagement with stakeholders. We have two evidence sessions today, the first of which is a panel session. I welcome Claire Cairns, who is the co-ordinator of the Coalition of Carers in Scotland and is representing the national carer organisations; Heather Petrie, who is the future and specialist delivery team leader for Voluntary Action South Lanarkshire; Linda McGlynn, who is the regional engagement manager for Diabetes Scotland; and Sonia Cottom, who is the director of the Pain Association Scotland. Thank you all for coming along this morning.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning, panel. Thank you for coming to see us.

Could you start by giving us an overview of the landscape of how integration joint boards communicate and engage with stakeholders in the current climate?

Claire Cairns (Coalition of Carers in Scotland): Our submission was based on the experience of carer representatives on IJBs. Since May last year, we have been running a project to bring together the carer reps from across Scotland. They have had four meetings altogether, to share their experiences and learn from one another, and to look at some of the challenges and the best practice in their representative role. In general, their experience has been mixed across Scotland. At the initial meeting in Edinburgh, there was a degree of frustration, and many reps were unsure of their role or felt quite isolated.

Much of the frustration was about the way in which meetings were conducted. However, as the meetings have progressed, we have seen a lot of improvements and best practice development, so when we came to write the scoping report, which I think committee members have copies of, the experience had changed quite a lot in that period of time. The care reps share a lot of similar challenges across Scotland, including on recruitment and induction, which would often happen later on in the process rather than before they joined the board, but many of them have now received training and have met key people, so they feel that they have been given the support that they need to participate fully.

There are some variations in the support and resources that carers receive in their role. For example, we hope that carers would get all their transport and replacement care costs reimbursed, but that is not always the case. Some carers use their own direct payments when they attend meetings, and that reduces the short breaks that they get for themselves, so that is something that could be looked at.

A key aspect of the role is being representative, so a carer on an IJB needs to go beyond their individual experience, because caring comes in many different shapes and forms. Where it works well, there is a community of other carers that the reps can refer to and go back to and there is good communication. That happens in a lot of areas. Often, people connect to carer forums, their local carers centre and other carer groups, which means that when they go along to the IJB meetings, they have already had conversations with a variety of local carers. However, there are some difficulties, such as the timing of the meetings or the papers coming out late, which mean that those conversations cannot take place before the reps attend the groups.

As I said, there are some frustrations surrounding meetings, to do with things such as the amount of paper involved, getting the papers only 24 hours in advance, the fact that the meetings can be quite high level and the idea that reps cannot contribute to decisions, because they are just being rubber-stamped. There is not as much discussion as people would like. Therefore, there are areas in which there could be improvements in how the meetings are conducted.

The ultimate test would be whether carer reps have made a difference. We did some scoping around that, which we can move on to. Initially, it was difficult for carers to make a difference, but we are seeing more progress in that area. There is some good practice across Scotland, but there are some challenges that need to be addressed.

Linda McGlynn (Diabetes Scotland): Diabetes Scotland has found involvement with the IJBs at a strategic and a locality level to be somewhat challenging. We have a network of about 40 local groups, and many of them were not accessing the information. Several local groups had been involved in local patient involvement forums, so they were aware of the processes, but many of the other groups were not aware of how to engage with the IJBs or the locality plans. Those that did engage found that they could not really see where they had had a significant impact. If they made suggestions, there was no feedback to say, "You said this, but we didn't go for that because of X, Y and Z," so it was fairly challenging.

At national level, we certainly found it challenging. We did significant desktop research to find out where the strategic plans were, what the priorities were and where diabetes sits among the long-term conditions. We found that to be extremely challenging, so we wrote to every IJB and every senior manager to extend an invitation to meet us so that we could find out how we could support the IJBs. I am sad to say that several of the organisations failed even to acknowledge the letter, so we made freedom of information requests. A mixture of information came from those: IJBs said one thing about devolved diabetes services, while health boards said something completely different. We found the communication channels to be a bit abstract and opaque.

We welcome IJBs, which present a good opportunity to improve diabetes services and person-centred care, but we would welcome co-production rather than just a box-ticking exercise.

Heather Petrie (Voluntary Action South Lanarkshire): In South Lanarkshire, my chief executive officer sits on the IJB along with a service user representative and a carer representative. A recent development is that our CEO meets those individuals to discuss the papers, to make sure that information is passed forward. We have also set up third sector forums in each of the four localities in South Lanarkshire. Each forum is chaired by a third sector organisation that sits on the locality boards. There is also a representative from the third sector interface. Therefore, we have information that we can pass back.

In South Lanarkshire, we have about 1,600 community groups and organisations that we know of, so we could not expect them all to sit round the table. We see the third sector interface as being the conduit for passing out information.

Sonia Cottom (Pain Association Scotland): I would echo a lot of what Linda McGlynn said. For us, the process has been quite challenging in operating with the majority of health boards in Scotland. We have also found it quite impractical to become aware of the way in which many integration authorities are developing their services, and it has been challenging to find out who are the key personalities round the table whom we need to liaise with. That is especially the case in relation to the people we have dealt with on health boards in negotiating service level agreements. We have often found out, by default, that the relevant person had moved on and we had no idea who we were supposed to be dealing with. Trying to find out all that information while being involved in commenting on strategic plans that are of a fair size is really quite difficult.

Alex Cole-Hamilton: Thank you very much for that.

I am very interested in the tension that exists between the idea of consultation and the reality of co-production, which Linda McGlynn identified. Many organisations believe that they have somebody at the table who speaks for a sector or a group, they tick that box, forget about it and move on to other things; that has been the case for quite some time. Sometimes, that can lead to a bottleneck. As we know, there are very many stakeholders in the field, some of whom might not know what their interface with the IJB is.

Will the panel, particularly our witnesses from the IJB side of things, reflect on what we are doing to widen the net and to provide a route for getting the opinions of other stakeholders, who might not have a relationship—or might have a toxic relationship—with the representatives on IJBs? That might be through channels such as social media or through other events.

Claire Cairns: As far as the carers movement is concerned, in some ways we have better networks than some other stakeholders. Where a network works well, the carer on the IJB will connect with their local carer forum. We also need to populate the other strategy groups and localities with carers and somehow ensure that all those people communicate so that they work towards the same aims and goals. That is quite challenging. Some areas are much further ahead than others.

09:45

Resources are sometimes put in to support those networks. In Perth, for example, a postholder is attached to the third sector forum, and the carers centre provides support to the carer reps and the service user reps. They have a meeting before they go into the IJB to discuss agenda items and make sure that they have all the information that they need. The postholder ensures that the reps have any training or mentoring that they need and communicates with the carers' voice group in Perth, which extends the number of carers who are involved.

We need another level down as well, which would typically be carers who are interested in policy and legislation and who may have some experience in those areas and want to contribute. That would not necessarily involve carers who are just getting on with caring and have other responsibilities in their lives—they may work or have children, or have lots of other things going on. Realistically, those people will not want to get as involved in the development of policy or strategy locally, but those issues affect their lives. The best way to connect with them is through their natural communities—for example, by people from IJBs attending carer groups that they go to or getting involved in social media. Carers who do not physically attend groups are often online, getting support that way. Engagement is not always about carers going to meetings; it is also about the IJB and the integration authority going to the places where carers congregate or communicate.

Alex Cole-Hamilton: I have a final question, convener. The committee has had a number of sessions with the Scottish health council, which is ostensibly the forum for the voice of patients in the health service. Whether it does that effectively is a discussion for another day. It strikes me that the council is well resourced and could have a large reach. Does the panel think that we should, in these days of integration, expand the remit of the SHC to make it the Scottish health and social care council in order better to facilitate the voice of stakeholders in the design of integration?

Linda McGlynn: I am not sure whether that is the model I would go for, from the diabetes perspective. It is more about ensuring that there are engagement channels up from the local networks. We have, as well as the local groups, individuals who work at local level. It is about knowing who to contact and speak to, and how a message is transmitted up.

The suggestion would work for some people, but not for everyone. We cannot say that there should be just one mechanism and one organisation; we need a menu of communications, from social media—which we use a lot with our young people—to local groups. We have found that the third sector interface does not always operate in the same way across Scotland, so it is difficult to know who can get into the third sector interfaces. We need to recognise that some people will easily and happily go to local meetings but some people, because of the demands of their conditions, are not able to do that. We need to give those people the mechanisms to communicate up and the mechanisms to feed back. A feedback mechanism that lets people know that they have had an impact is sadly lacking at the moment.

The Convener: What should happen?

Heather Petrie: The current model in South Lanarkshire recently got a new leader for health and social care. She puts out a regular blog, which we make sure goes out to all social media channels, newsletters and everything else. She always asks for feedback; anybody in the community can come back and ask a question, and she is more than willing to sit down and go through the matter.

More open channels are needed. As part of our third sector forums remit, all the locality managers come to the third sector forum meetings and sit down with the third sector, opening those channels.

The Convener: What else should happen? Do panellists agree with that approach, or should a different approach be taken in other areas? If so, what should it be?

Claire Cairns: As I said, there is some really good practice out there, so it is a question of making sure that it is more consistent across Scotland. Most of the support in that regard should be local, rather than national, wherever possible. There is a small role for national support. For example, our carers collaborative enables the carer reps to meet four times a year. That has been beneficial for reps, because they previously felt isolated and were not too sure of their role. I imagine that the group will not last forever because the reps should be able to develop support locally, which will be better in the long term. The national group has been good in the initial stages, as things have developed. When people have good support and good links locally, things work well.

Through the carers collaborative, we produced a set of recommendations for improving the experience of carers on IJBs. A lot of that is about building lines of communication, making sure that there is support, and that people are supported to be representative. Some of it is about sending resources in that direction.

Populating the many groups is increasingly challenging. For example, as the localities develop, people are looking for carers to populate groups. If only one or two carers in an area are taking on all the roles, that can put quite a bit of strain on people. Resources need to be put into identifying, recruiting, training and supporting additional carers who can take on the roles.

Some areas are already doing that. As I said, the system works well when there is a hub, such as a carers centre, where there is someone whose role it is to take information back and forward. When things happen on a more ad hoc basis, the lines of communication do not work as well.

I will not go through our list of recommendations; they are in the report that we produced. I have copies with me, if members would like them.

The Convener: Do the other panel members have suggestions about how we can improve the situation?

Linda McGlynn: I concur with Claire Cairns. We have to look at what is happening locally and what the demands are, and we must put resources in.

We need to realise that, for a lot of the people who we are talking about—certainly people with diabetes—their condition is quite relentless. People cannot always commit to regular inputs and meetings, and meetings can be quite stressful.

We need resources at the local level. Diabetes Scotland supports our local volunteers to get involved. We provide them with training and out-of-pocket expenses. Third sector organisations can support local volunteers to get two-way communication with the integration authority.

The Convener: Do the boards have people with responsibility for engagement, and are they identified as such? Is there an engagement officer or someone whose duty is to engage with you and others like you?

Linda McGlynn: NHS Greater Glasgow and Clyde has an involvement team, which does public involvement across the piece for the boards—that is a model that works. There are also community development officers in local authorities, so it is about how they do engagement. Community development is a good model. It is about putting resources in from the IJB locally and working in partnership with third sector organisations.

Alison Johnstone: I thank all the panel members for being here and for your written submissions.

The Pain Association's submission was very frank. You said that engaging with some of the process is "a mystery", and that

> "attempting to find out within each Integration Authority where responsibility now rests for the commissioning of services"

has proved extremely difficult. You have talked about the creation of

> "a new layer of bureaucracy",

which is making it difficult for you to deliver services, and you have described the challenge that results from three-year service-level agreements being reduced to one-year agreements.

Have things improved at all? Have you managed to find out who you need to speak to if you are to develop important relationships?

Sonia Cottom: We have not seen any improvements yet. The one step forward that we have made happened simply because we requested a meeting with a representative from Health and Social Care Alliance Scotland. Who the people were that we could contact was a mystery to us, so we asked for a meeting with the alliance and guidance about who we were supposed to approach in each authority and who was responsible. As well as writing to the health boards, I approached clinicians on the ground and asked them whether they knew who was responsible in their board, because we wanted to approach them and show them the value of the service. We wanted to show them how we deliver and ask them whether the service could continue in order to provide continuity of service for patients. That was our challenge.

Alison Johnstone: Are you not yet convinced that there is an adequate solution?

Sonia Cottom: No. That view is based on an experience with a particular board, which invited us to a meeting to negotiate our service level agreement. However, at the meeting, we were just told who the new people were who were dealing with the issue and were asked to tell them about our service, but they said that they did not see the value of self-management or people presenting every month to maintain self-management skills. They said that it should be about a one-stop shop to get them in and get them out the door. So, we are back to square 1 in trying to put forward our case and convince them about it. I do not regard that as an improvement or a step forward.

Claire Cairns: At the moment, there is still quite a lot of fluctuation and change in staff on integration joint boards and in integration authorities as a whole, so it is difficult for people to pin down the best person to speak to. When they do, they often find that that person has moved on or that something else has happened. For example, the care representative of one integration authority told us that even the development of localities had come to a standstill because the change of staff in the IJB meant that the key chief officers had left. We were told that they were recruiting new ones and that there will be changes after the local council elections. The situation is in flux at the moment.

At our most recent meeting, we asked our carer reps whether they knew the carer leads in their local area and found that a lot of them did not know that there were carer leads. The carer leads are the primary people who our carer reps would want to connect with in the local area because they would probably be responsible for the local carers strategy under the Carers (Scotland) Act 2016. There is therefore a bit of confusion about the carer leads.

The feedback that we are getting about the meetings is that because things are still being established, an awful lot of time is taken up in talking about staff issues, administration and the organisation as a whole. Particular topics, such as delayed discharge, come up again and again. One carer told us that that topic took up the majority of several meetings.

Among all that, it is difficult to get matters discussed that are more relevant to service users and carers; while things are still being established, other issues are given priority. However, the discussions that are relevant for us are happening more often now and progress has been made in that regard. We suggested that, after the first meeting of the IJB, the carers reps should try to get the 2016 act on the IJB's agenda. We did that because we thought that we should be discussing the legislation and planning for implementation at that level. We also wanted to see how easy it would be for the carers reps to table an agenda item and whether it would be taken up and followed through.

A number of areas have been followed through—I can think of at least five where that has happened—but not all the carer reps across Scotland tried to table the 2016 act for their IJB's agenda. However, there have been fruitful discussions in some IJBs that have been a lot more relevant for the carer reps, which has been helpful. However, such discussion is still unusual and time is taken up in meetings by business that the carer reps do not always find relevant.

The Convener: Claire Cairns said earlier that things were just rubber-stamped in the decision-making process. Is there any debate and discussion? For example, are you allowed to propose changes or amendments? Are you allowed to bring forward alternatives or is that just not within the scope of those who are at the meetings?

Heather Petrie: I do not think that we are there yet. In Soth Lanarkshire, we had an opportunity to get involved with strategic commissioning; the third sector was very much involved in that. We rated the items that were coming up—five of the 10 thematic areas came from what we had proposed, and they were very much about the preventative agenda. However, I really do not think that we are at the point at which we can make that big change, because people seem to be dealing with too much of the higher-level stuff.

10:00

Claire Cairns: At the last carers collaborative meeting, we discussed how things can be put on the agenda for something that is so fundamental in a local area. Some areas had an agenda committee through which people were able to put an item on the agenda; some had carers representatives on the committee, although I have to say that that was very unusual; and others were able to put things under any other items at the end of the agenda. For others, however, even though they asked, there was no mechanism for them to get anything on to the agenda, which meant that they were just not equal partners. Apart from anything else, what needs to be sorted out in some cases is the process to ensure that carers feel that they are equal partners at the table.

Colin Smyth: Following up on that, should third sector organisations and carers representatives have voting rights on IJBs, or is it more about influencing policy before it gets to the stage of the IJB taking a decision on a paper?

Linda McGlynn: I would say the latter. In those cases where our representatives have been able to look at the strategic plans, they appear to have been rubber stamped already without our seeing them and being asked to comment on them. There needs to be a mechanism a wee bit earlier in the process to allow us to influence and steer the decisions that are made.

Claire Cairns: We certainly wanted carers to have voting rights and lobbied for that as the legislation was going through Parliament. We discussed the matter with carer reps, and although most of them would prefer to have voting rights, a few said that not having them freed them up more in discussions. To be honest, though, I think that that was a minority view.

I agree with Linda McGlynn. Not many things go to a vote, but by the time it gets to that stage, most of the decisions have probably been made. However, I know of a case in which an issue went to a vote in an IJB and, had the stakeholders been able to vote, the decision would have gone the other way. That is a tangible example of where the carers would have made a difference.

The issue is very much about what happens before a decision goes to an IJB and about ensuring that things are co-produced instead of carers simply being involved in consultations. When one integration authority reviewed mental health services, it came up with three options for solutions, but it consulted on only one; in other words, it decided what the best option was and then consulted on that. There was a lot of anger from carers, particularly the carer reps on the IJB, because they felt that they had not been part of that decision. It could not have been a full consultation when they were being asked about only one option when they knew that two others had been on the table.

When you come in at the end of a process, you do not own it. Moreover, the solution that is chosen might not necessarily be the best one.

Heather Petrie: I would certainly go for having the power to influence decisions. I am sure that you will all know about the national standards for community engagement, but I do not know whether all local authorities necessarily follow them.

Colin Smyth: Do you think that, because you have no voting rights, you are treated differently in IJB meetings, or does the fact that most things do not actually go to a vote mean that everyone gets their say?

Heather Petrie: I would say that our presence on the board is slightly more than a token gesture, but there is some way to go in that respect. Having more of a say might make a difference if there were true co-production. If money for the third sector came to the sector directly, we might have more influence over how it is put back into the sector.

If that was the case, we would have more control and the boards might recognise us as a true partner. Recommendations about the third sector interface's involvement under health and social care came to me but, because it was guidance, it was not necessarily followed. Our organisation had no investment under the third sector interface regarding what we do in health and social care. I think that the money should go direct to the third sector. Those organisations would then put that money back into the pot, but they would be able to influence the decision about how the money was spent.

Sonia Cottom: It is important for the third sector to be part of the discussions, before it gets to the voting. That would follow up the wish expressed by the First Minister at her inaugural speech on her vision for health and social care integration in October 2015—a wish to see the third sector as equal partners.

The Convener: Is the system more democratic and can you influence it more or less than what was there previously?

Claire Cairns: It is interesting that, in the community health and care partnerships that we had previously, carers had voting rights; there has been a step back on that. It is hard to give an answer on the ability to influence the system. The make-up of planning groups has changed. A lot of the carers are probably the same—some of them have come on from the CHCPs and are experienced and articulate people—but a lot of the personalities have changed. I would say that the situation depends on the area. I do not know whether there is a significant difference from what happened before, but there is more opportunity now and things are progressing. I think that that will be an improvement in the future, but we are not there yet.

Linda McGlynn: I agree. We still have a long way to go on integration in the IJBs. There is an opportunity for us all to work together more positively and more appropriately. From Diabetes Scotland's point of view, although our experience to date has been less than positive, we are making inroads, certainly at local level. A lot of our local groups are making more inroads as they get the information and communication.

With all such processes, communication is the key and we need to get better at it. If we get better at communication, we will probably get better at engagement, and people will feel as though they have a seat at the table, whether it is a physical one or just an influential one.

Claire Cairns: One thing that would improve carers' feeling that they are equal partners is resourcing things properly—that has come up in our report and at many of our meetings. If a carer turns up to a meeting and that means that they are in effect out of pocket or that they have to reduce the short breaks that they have, that is not acceptable.

Quite a lot of our carers attend a lot of meetings in relation to IJBs and some of the other groups that feed into them. At our last meeting, in January, one of our carer reps said that they already had 14 meetings in their diary in relation to the integration authorities. That is a big time commitment. A lot of those people have other caring responsibilities and some of them work. Some are retired, but particularly the ones who are employed—some are self-employed and one is on a zero-hours contract—and who are juggling their work as well are out of pocket whenever they attend meetings. That should be addressed.

Around the table at an IJB meeting there are a lot of very well-paid people. The carers are putting in a significant number of hours and we should look at recompensing that. I know of one example, from the Highlands, where a carer has been employed to support engagement and, in addition to the work that he does on the IJB, for some things on a consultancy basis. That can be done, and other areas should look at that to make carers feel that they are equal partners. If carers are not resourced in the way that other people in the room are, that is not equality.

Clare Haughey (Rutherglen) (SNP): I have to declare an interest as I am the MSP for Rutherglen. I am particularly pleased to hear that South Lanarkshire is doing so well in engaging with VASLan. Will you describe some of the good practice that has been spoken about? Has it been captured? How are we proposing to roll it out across the country?

Heather Petrie: A number of events are coming up in South Lanarkshire. Through community events, we are trying to reach health and social care staff who might not have worked with the third sector before. That is a way to upskill them; many of them do not realise what the third sector does.

We pass on all the information through our newsletters and social media. We have a blog, and we constantly tweet about what is happening. The communication levels have greatly improved.

Clare Haughey: I would like to know whether any of that good practice has been captured and rolled out across other IJBs or carer organisations.

I am keen to hear from the other members of the panel whether that is the case.

Linda McGlynn: Sadly, I have not seen best practice other than what is going on in South Lanarkshire and North Lanarkshire, although I have seen good practice in how some of the managed clinical networks engage with service users.

In the Borders, for instance, people are busy working on how they can improve services. They will be hosting a series of roadshows up and down their catchment area to engage with users of diabetes services and to explain to them what the situation is, what challenges they are facing and what their proposals are, as well as to get users' feedback. That is very much coming from the health board and the MCNs, which have leadership on that.

We have not really been engaged with or had an awful lot of involvement in best practice in relation to IJBs.

Claire Cairns: There are examples of best practice across Scotland. My theory has always been that, if we collected all the best practice and applied it to every area, we would have our solution. There is best practice in recruitment, training, engaging carers and resourcing. It is a matter of ensuring that that practice makes a difference while enabling carers to feed into strategies that make a difference to their lives.

There are many examples in our report. One area that comes up quite often is North Ayrshire. The carer rep there was on the shadow board before the IJB was established, which meant that they felt part of the process from the beginning. In addition, carer awareness training was provided to IJB members and local councillors to ensure that they had a good idea about the issues affecting carers. The carer reps led on that training. They have also been proactive in co-producing the carers strategy and involving other carers in that.

That is not an isolated example—there are great examples across Scotland. There are still challenges and frustrations but, from the beginning of our project last year to now, we have definitely been seeing an improvement.

Clare Haughey: Is there some mechanism to capture that best practice? The committee has heard over numerous evidence sessions that there are excellent practices in lots of areas of health and social care across the country, but it is a matter of capturing that and rolling it out so that everyone benefits from it. Is there some mechanism, or is someone taking a lead on finding out where the best practice is and determining how it can be rolled out to areas that are not as up to speed?

Claire Cairns: As part of our project—this is just for carers, so I cannot speak for the other stakeholders—we did a scoping exercise, and we collated the best practice from what the carer reps told us. That is in our report. We then produced recommendations, which pulled together how we could take the best practice and implement it across Scotland.

The next stage is to work through the integration authorities. We are working closely with the integration team at the Scottish Government. The carer reps are trying to table the report for discussion. A few have done so already in order to discuss how the recommendations could be implemented locally.

More could be done to put across the recommendations. The coalition is a very small organisation with only one paid member of staff—me—and we have a small grant to run the carers collaborative. What you suggest is therefore beyond our capabilities, and there needs to be a much wider effort. That would go a long way towards creating improvements for carers, certainly on IJBs, although the challenges are probably similar across the board for all stakeholders.

10:15

Clare Haughey: How receptive have you found the IJBs to be to your presentation of what works well in another area or forum?

Claire Cairns: We are at quite an early stage. The report was published about a month ago, and we will have a meeting of the carer reps today—I will have to fly out of here to go to that. Today, they will look at how they will table the report at meetings. As I have said, some have done that already, and we will hear how that went—I will be able to tell you about it afterwards. We hope that the IJBs will be open to such a presentation, but we are not sure yet.

We are continuing with the scoping work and will have another report in January to see how things have moved on, what improvements have been made and whether any recommendations have been implemented in that timescale.

Sonia Cottom: The only forum that we sit on is in Perth and Kinross, and that came about purely by default. From attending those meetings, which feed into the IJBs, I understand that the representation from the alliance is there to provide support, gather information and feed back. That could be one way of feeding back and ensuring best practice.

Linda McGlynn: I think that there is a role for the Scottish health council in that work, as it has produced standards for engagement and involvement. It conducts the assessments of health boards and it has a lot of evidence on best practice, so I think that there is a role for it in the development of best practice formulae.

The Convener: In your experience, are the discussions dominated by issues of service improvement or budget?

Sonia Cottom: Budget.

Heather Petrie: I would say budget.

Linda McGlynn: Resources—fiscal resource, personal resource and information resource—are a big issue. There must be investment in order to have improvement.

The Convener: The feedback that I get from my constituents—I get the impression that this is happening across the country—is that the discussions are dominated by concerns about the financial situation that the new organisations are starting life in, rather than by how we can improve the health and social care of the community. Is that a fair reflection of your experience?

Sonia Cottom: Yes. In my experience, there is an issue in getting the IJBs to see the bigger picture. Yes, there are financial issues, but IJBs have to see the bigger picture and how the third sector can contribute to, influence and scope developments. It is about investing the pennies to save the pounds instead of focusing on how many pennies we are spending. We have to get the IJBs to look at person-centred services instead of focusing just on the budgets.

The Convener: Who needs to see the bigger picture? Is it the IJBs or is it people higher up the chain of government?

Heather Petrie: I am glad that we have moved from being called the voluntary sector to being called the third sector, because every time people heard the phrase “voluntary sector”, they thought that the service was free. I have constantly said that we still need resources for those services.

All the partners need to see the bigger picture—not just the IJBs, but the local authorities. We need to involve all the communities and stakeholders.

Claire Cairns: We could do with more transparency as well, to be honest. As part of the scoping work, we looked through the strategic plans and through the minutes to see how many times carers were referenced. There were only 17 references to carers in the minutes of IJBs across Scotland. That is not to say that they were not discussed more, but their contributions were not always minuted.

Carers would probably like to see a robust local carers strategy that is reflected in the strategic plan. That would allow us to follow the resources across, which we can never do. A lot of the strategic plans are at a very high level. They almost all mention carers as a priority, but they do not say exactly what they will do or what resources go along with that priority.

There may be a lot of discussions about finance, but they tend not to be discussions that stakeholders can contribute to. They cannot say, “This is what we would like to happen to resources in our area, this is how they can be better used, and this is how you might want to do things differently.” That needs to be part of the discussions. Budgeting money needs to be discussed, but can that be done in a more open way?

Miles Briggs (Lothian) (Con): As a Lothian MSP, I have been concerned for a while by what some charities have told me about services that IJBs pay for but do not refer patients to. In future, that could be looked at. Do you have any examples of that that we should be aware of? It is clear that, if that starts to happen, IJBs will be destabilising one another.

Claire Cairns: Can you explain that again?

Miles Briggs: I have met a number of charity representatives who have expressed concern that their patients are not currently referred to services that are funded by their IJB. They think that that might be looked at and that, in future, that funding might not be allocated. There are a number of cases of that across Scotland, and there is growing concern that, if that starts to be a deciding factor for finance, IJBs could destabilise one another. Do you have any examples of similar cases?

Linda McGlynn: Diabetes Scotland does not provide services as a third sector organisation, in that we do not have individual service level agreements, but we provide services and support to local authorities and local communities. We have found that there are issues in the budget allocation in health boards. Some diabetes services have not had a budget uplift in several years, although the number of people with diabetes is increasing. The issue needs to be considered more from a statutory perspective.

We have also found that there seems to be a lack of transparency as to who is responsible for the operational management of diabetes services. Is it the IJB or the health board? There is confusion. Our experience is that the issue is to do with the statutory sector, rather than with the third sector being funded for support services. Having said that, I know that some organisations provide emotional support and help to people with diabetes, and some of those services are having their budgets cut and do not know whether they will be operating next year.

Sonia Cottom: One example of the issues that we have faced is that, despite chronic pain being a Scottish Government priority, if it does not form part of a health board's local delivery plan, there is no jurisdiction for the board to fund it, so there is an imbalance. When we attended a primary care conference back in January, one of the reservations that GPs raised was that, if they referred a patient on to a third sector service, they did not know whether that service would still be there in a few months' time, given all the funding issues.

Claire Cairns: Most of our members are local carer support organisations, so they tend to be involved in more local negotiations, which means that the issue that Miles Briggs raises might not apply. However, some of their funding is shaky. Funding has been cut in some areas, and some areas are looking at putting carer services out to tender, although there are well-established services that have been there for many years and are respected by local carers.

The funding environment is different, which is always difficult for people, and there is some insecurity in the third sector because of that. The Carers (Scotland) Act 2016 will come into force in 2018, so this is a period when we should be providing more resources for carer support and building up services in advance of the new duties. However, in some cases, funding is being reduced, which is not really the direction that we want to be heading in.

Heather Petrie: In our area, the local authority cut funding for quite a lot of third sector organisations, but we have 19 projects that are funded through the IJB. As part of our remit as the third sector interface, we monitor those projects quarterly, and from that we can see the great work that is being done. I have one group that received a contribution of £88,000 over two years to develop a meeting place. It has 252 users per week and I know that, between November 2016 and February 2017, it had 43 referrals from health and social care of isolated individuals who need such support. Some of those people are elderly and otherwise would not see anybody all week, so a lot of good work is going on, and we have the evidence to back that up.

The Convener: Do you report on that?

Heather Petrie: The report goes to the IJB so that it has all the information.

The Convener: Do you also use that information to lobby those who provide grants to your organisations and those at a higher level?

Heather Petrie: Of the applications for moneys that were made, quite a lot were knocked back, but the 75 per cent that were accepted had match funding from elsewhere to support their applications.

The Convener: We are out of time, so I thank the witnesses for their attendance.

10:27

Meeting suspended.

10:30

On resuming—

The Convener: We now move to a round-table session on integration authorities' engagement with stakeholders. We will go round the table to introduce ourselves. My name is Neil Findlay; I am an MSP for Lothian and the convener of the committee.

Clare Haughey: I am the MSP for Rutherglen and the deputy convener of the committee.

Michael Kellet (Fife Health and Social Care Partnership): Good morning, colleagues. I am the director of the health and social care partnership in Fife.

Margaret McKeith (Scottish Care): I am from Scottish Care.

Miles Briggs: I am a Conservative MSP for Lothian region.

Amy Dalrymple (Alzheimer Scotland): I am head of policy at Alzheimer Scotland.

Donald Cameron: I am an MSP for the Highlands and Islands.

Dr Marion Slater (Royal College of Physicians of Edinburgh): I am a geriatrician and I represent the Royal College of Physicians of Edinburgh.

Alex Cole-Hamilton: I am the MSP for Edinburgh Western and the Liberal Democrat health spokesperson.

Christina West (Argyll and Bute Health and Social Care Partnership): I am chief officer for Argyll and Bute health and social care partnership.

Corinne Curtis: I am the service user representative on the strategic planning group of the Orkney health and social care integration authority.

Alison Johnstone: I am an MSP for Lothian.

Jo Gibson (North Ayrshire Health and Social Care Partnership): I am the principal manager at North Ayrshire health and social care partnership.

Maree Todd (Highlands and Islands) (SNP): I am an MSP for the Highlands and Islands.

Andrew Strong (Health and Social Care Alliance Scotland): I am the assistant director at the Health and Social Care Alliance Scotland.

Colin Smyth: I am an MSP for South Scotland.

David Small (East Lothian Health and Social Care Partnership): I am the director of health and social care for East Lothian.

Ivan McKee (Glasgow Provan) (SNP): I am the MSP for Glasgow Provan.

Tom Arthur (Renfrewshire South) (SNP): I am the MSP for Renfrewshire South.

The Convener: We will start by getting your views on how the engagement process is going. Is it all smiley, happy and tickety-boo, or is it not?

Margaret McKeith: I will kick off. The level of engagement varies considerably across the country. In some health and social care partnerships, the independent sector has a positive level of engagement, whereas in other areas it is tokenistic and we are there just because we need to be. The main difference is the personnel who are in post in the health and social care partnerships. The level of engagement can depend on how they view the independent sector as a whole.

The Convener: The key point is that it is down to personal relationships.

Margaret McKeith: Yes—it is personal relationships.

Andrew Strong: From our research and that of our third sector health and social care support team, the picture is that involvement is limited. In our written response, we have detailed people who are not necessarily involved in the mechanics of the IJBs—people who are not there as the reps for the third sector, carers or people who use supporting services. They have often told us that they find it difficult to source information about what is going on locally. The wider public may have limited understanding and find it difficult to engage. To support that, our third sector team has produced a range of resources, such as basic information about what is going on in the boards and their commissioning intentions and plans, but that only goes so far. There are also issues for national third sector providers, which I am sure that Amy Dalrymple will talk about.

At the IJB governance level, the relationship between the statutory sector and the third sector, the independent sector and people who use supporting services is inherently unequal, because of the nature of voting rights and the number of people on the boards. In some areas, there are eight councillor representatives and eight health board representatives but one person representing the whole of the third sector, one person representing people who use supporting services and one person representing carers. That is what has been developed, inherently and knowingly from the start of the process—it is an unequal relationship.

David Small: To be fair, it is early days, as most IJBs have been in existence for only a year or so. Hopefully, that experience is reflected across Scotland.

In East Lothian, we took the approach of having a broader membership than the minimum that is required. The independent sector, the third sector, carers and the public all have seats on the East Lothian integration joint board, in addition to the statutory members. Those four seats allow that other voice to be heard.

We are reviewing how the third sector has input to the IJB. Until now, the third sector member has been the third sector interface chief executive. They have come forward with a proposal for an election process in the third sector in East Lothian. We are positive about that—we would welcome such a process. We are having a dialogue about the feedback mechanisms and how that person would be representative. We are positive about the proposal, which we expect to consider shortly.

We are developing a new engagement strategy, because we recognise that the engagement that we did early on was for a particular purpose—it was on the strategic plan, which had to be in place by March 2016. We carried out a particular kind of engagement on that, but we now need a more forward-looking engagement strategy that takes us beyond that. We are consulting on our engagement strategy for the future.

We hold development sessions as well as formal IJB meetings. Our IJB has formal meetings every two months; in between each meeting, we have a development session. The next one will be about carers issues—that proposal was made by the carers' member on the IJB. That will enable all members to consider carers issues and how they link into the strategic plan for the future.

We recognise that we could do more. Last year, our joint inspection report on older people's services made recommendations about improving our links with the third sector, so we have some work to do. The substructure beneath our strategic planning process, which is where we would get into the detail of individual strategies and client group issues, is perhaps not as robust as it should be.

In summary, it is probably work in progress, but I think that we are making positive progress.

The Convener: For the record, is it the case that the four additional members do not have voting rights?

David Small: That is right—that is in the regulations.

The Convener: I cannot recall what the legislation says on the matter. Is it the case that you cannot give those members voting rights?

David Small: That is correct.

The Convener: You do not have the leeway to do that.

David Small: The legislation makes it clear that the members with voting rights are the health board members and the elected council members.

Corinne Curtis: In our area, the engagement has gone from being quite tokenistic to still being quite tokenistic but with slightly better support. In the past few days, I have received emails that finally recognise the difficulties that public representatives face and that indicate ways in which that might be addressed. As a service user representative, I find my job absolutely impossible. I am not representative—I cannot represent, because I do not have a network to feed back to or to get information from. Even the process for elected representatives, which looked really good on paper, did not work. In the first round of seeking representatives, nobody applied. In the second round, nobody applied, but I was asked whether I would apply by a friend who works in the third sector interface. I was the only person who applied. Because I ticked the criteria for someone who might be a representative, I got on. Therefore, I am in no way a representative.

Now that I have attended a few meetings, I have come to the realisation that my job is to act not as a representative but as someone who monitors public participation. I think that that is a key thing. It is not possible to be representative at that level, but if I can insist that participation happens at a much lower level, from the bottom up—which is what ought to happen, rather than someone asking questions from the top down—I might be able to get somewhere.

Some of the other difficulties have already been mentioned. One is not being able to put items on the agenda and another is the fact that the strategic planning group does not really do strategic planning; it goes through a tick-box exercise on things that have been presented, which offers little opportunity for discussion. All those things make life a lot more difficult. The whole focus seems to be too top down. All the information that we get to make decisions on consists of broad statistics rather than what is seen by people who work at the coalface, which is where all the information should come from. The public involvement should start by talking to health professionals and carers. That information can then filter up to be used as valid information for planning. I do not see any of that happening.

Michael Kellet: I echo what colleagues have said—I agree with David Small and others that engagement is a work in progress. We in Fife are in a similar position to the one that David described in East Lothian. We have four seats that are allotted to an independent sector representative, a service user, a third sector representative and a carer representative, and those colleagues are active and vocal round the IJB table. However, we are the sort of very large IJB that Andrew Strong described, so we have eight elected voting members and eight members from the health boards. That means that the table is very large—it is significantly larger even than this committee table—which is an issue for us. I know that those four colleagues sometimes feel that it is a challenge for them to be heard effectively.

In Fife, we have done some very good work. There was extensive involvement in the strategic plan, which was pulled together before I took up my post, and colleagues were supportive of the level of engagement in that respect. As has happened in other parts of the country, the strategic planning group thereafter felt unsure about its on-going role, and we have been working with the group to resolve that issue.

We are now in a position to look forward and think about how we get into genuine co-production mode with our partners. There are a couple of areas in which we are beginning to do that. For example, we are looking at how we in Fife implement Sir Lewis Ritchie’s review of urgent care, and we have had stakeholders involved in that process from the beginning. We are currently recruiting a mix of service users, staff and carers to help us to conduct an options appraisal of the options for change around urgent care in Fife. For me, it feels like we are entering the co-production phase.

At the end of March, we held a redesigning care together event with the independent sector. Donald Macaskill, the chief executive officer of Scottish Care, chaired the event, which was attended by 70 people from across the sector. The conclusions from that event will shape how we invest in new models of care in Fife as we move forward.

Those are a few examples of how we are moving into that phase. As others have said, engagement is a work in progress; I think that that is the case for all IJBs across the country.

Amy Dalrymple: One big issue that has come up for us is the variability that exists. With that in mind, I will recount a wee anecdote. I was at a meeting of an umbrella group of organisations—one of the several groups that we are involved with—and one of the chief officers of a health and social care partnership was there. We were talking about the very difficult decisions around shifting resources from acute care to preventative and community approaches. I made the point that we—as a group of mainly national, but also local, third sector organisations—could help with the conversations around that and in ensuring that we bring the community with us in the decision-making process. The response that I got was that it would be very welcome if we were to help to communicate why certain decisions had been made.

That is a good illustration of someone completely missing the point that I was making. Witnesses on the earlier panel and some of the people round the table now have made the point that engagement is about bringing people with you and doing things with them, rather than just communicating decisions that have already been made. That is a real misinterpretation of the term “engagement”, which the committee has used in its inquiry.

The committee also talks about stakeholders. The stakeholders are all very different and we come with our own points of view; indeed, Alzheimer Scotland comes with several points of view. We are a national third sector organisation, but we also have several local services and local groups around the country for people who have dementia and their carers, so we have a role in ensuring that individuals are involved.

Andrew Strong referred to people who are not representatives. As an organisation, we can be a partner in helping to improve care and support for people with dementia, but we are not being used to our full extent in any of those roles around the country. There are pockets of good practice, but nowhere is doing everything right—everywhere has something to learn. Even the places that are doing really well on some aspects need to come up to speed on other aspects.

10:45

Finally, involvement below board level is needed. We have talked a lot about the IJBs but, at locality level, it is really important that the involvement of the dementia leads, the dementia strategy groups, older people’s mental health groups or wherever dementia is dealt with is not just at board level. That is tokenism—it ticks a box. The involvement needs to run right through the health and social care partnerships’ work.

Christina West: I share the views of my colleagues David Small and Michael Kellet. There is certainly work in progress in Argyll and Bute. As a result of consulting on our strategic plan, we have made some changes to the configuration of our locality planning groups. We went from six to eight specifically in response to community feedback about local communities and where people wanted to see a planning influence and infrastructure created. Things such as community transport, which was not previously on our list of priorities, have taken a higher priority in our strategic plan.

Over the past year, we have tried to support our locality planning groups to develop. The eight across Argyll and Bute all have carer, clinical and third sector representation on them. We have developed health and care profiles that set out the health and social care needs in those natural communities, and we have begun to provide information about how budgets are spent there. Communities can become far better informed about decision making on how resources are spent in meeting our strategic plan objectives.

Each of our locality planning groups has now developed a locality plan that focuses on how the strategic plan translates into local care delivery, but they need information in order to provide that. Although we are beginning that journey, we can still provide an awful lot more detail and a level of sophistication and analysis to help people to understand the data that we provide them with to inform their decision making. That is the level below the IJB. We are taking the letter of the legislation, which is that localities are the engine room of integration, and are trying hard to support bottom-up growth.

Dr Slater: It is clear that approaches to engagement, collaboration, board structure and governance arrangements are highly variable, and they are made harder by the scale and pace of change that is expected.

Some of our fellows have had no engagement at all. Others are aware of the process, but have found that it is overly difficult to get involved, with barriers to participation. Those who are involved have found that their roles on groups are unclear, that there is little in the way of clinical input, and that there is no real sense that a clinical voice is recognised or acknowledged; rather, there is a sense of frustration that some IJBs appear not to value clinical opinion. Opportunities to use the knowledge, skills and expertise of front-line staff are being missed.

The failure to use data to inform service change really concerns me. Many proposals lack robust evidence, and more could be done to improve that.

Jo Gibson: I echo a lot of what has been said. We in North Ayrshire are a year older than most of the other partnerships—I am sure that that does not show—and we did a lot of work at the beginning to try to create an inclusive ethos. Earlier this morning, we heard from colleagues from the Coalition of Carers in Scotland that carers have been involved as well as the third sector interface, service users and the independent sector. From our shadow state to where we are today, we have focused initially on very senior structures and involvement in the IJB and the strategic planning group, which many have described. We have done that not only through the mechanism of the meetings but with a lot of development and support behind the scenes. There were a lot of development days in which we shared information and got a shared understanding of what each colleague brought to the table. Since then, we have seen only the tip of the iceberg in terms of the potential.

The development of the locality planning structures gives us architecture in each community and the chance to access the voice of communities. It has also opened our eyes to how we can involve people in designing our services in a way that benefits citizens not only through the design of more efficient and effective services but through their being involved. We have seen lots of positive outcomes for individuals and groups because of that.

We are beginning to see people mix up the hats that they wear. Initially, our third sector interface colleague or our independent sector colleague represented just that one view. Now, we are using those skills differently and individuals are taking different roles in the partnership. One of our locality forums is chaired by our carers rep from the IJB and one is chaired by our third sector rep. When we have commissioning decisions to make, we set up small groups, which are populated by a range of individuals who make the decisions and bring back recommendations to the IJB. We are blurring the boundaries between organisations and creating greater understanding because of that.

The Convener: Marion Slater suggested that people's views are not being listened to and that their input is not sufficient. From the previous panel, we heard how issues around finance have been dominating proceedings. Are there enough people involved in rolling out the engagement with stakeholders to capture their views? Is it financial pressure or the culture of the new organisations that is preventing that?

Corinne Curtis: I think that it is the culture of the organisations. I have been quite shocked at the difference between the national health service of New Zealand and the national health service in the United Kingdom in terms of patients being respected as people who have information and knowledge about their conditions and being able to talk to the professionals who are involved in their care. It all starts from that.

More widely, at policy level, I have been looking at a number of different documents, including the New Zealand Ministry of Health's "Better, Sooner, More Convenient Health Care in the Community", which is about the integration of primary and secondary care rather than the integration of health and social care, although it is fairly similar. When I look at "Changing models of health and social care", which is the Scottish document, the thing that really strikes me is that all the examples of best practice in it seem to be based on other people's best practice documents. For example, it refers to a model from Alaska that is being tried here and to other models from other places. By contrast, the New Zealand document starts by describing what had been happening in primary care and what has been done about it. It is a really big change for the UK generally and for Scotland.

Amy Dalrymple: I hear the IJB chief officers and representatives round the table all saying that it is early days, that integration is a work in progress and that they will help us to progress, but I agree that the focus so far has been on resource issues. It has been on structural issues as well—it has been a big structural issue—and we have seen the clash of cultures in that context.

Frankly, the NHS is one of the most hierarchical organisations that I have ever come across. When I first read the submission from the Royal College of Physicians of Edinburgh, I was intrigued. Our take on it is that the health sector is very dominant in the health and social care partnerships and that those partnerships are very much driven by health decisions, so I wondered how the members of the RCPE could feel that they were not being listened to. Then I realised that it is because of the hierarchical nature of the NHS.

The NHS's culture is very different from the one that I come from in the third sector and community development. There is a big cultural issue for those of us from the third sector who are involved in the partnerships in that there are all those levels and they do not speak to each other in a back-and-forth way—they issue instructions to each other, or information is requested. That makes it harder for us to get involved, especially when the focus is not on collaboration, co-production and improvement in services because people are busy trying to make sure that the information technology systems speak to each other.

The Convener: Please do not get us started on IT.

Amy Dalrymple: Yes, you represent Lothian—I know.

Dr Slater: I agree that the issue is more cultural than financial. Certainly, my experience of the IJB where I work is that its approach has been overly top down. As has been alluded to in lots of the submissions, it seems that priorities have already been decided and there is little scope for discussion or change. We have been asked to develop a hospital-at-home service, although there is very little evidence in favour of that approach. The large Cochrane review at the end of 2016 suggested that, when compared to in-hospital care, hospital-at-home services probably make little or no difference to the likelihood of admission or to patient health outcomes. Evidence of their effect on length of stay or cost to the health service is also lacking. However, that approach is being pushed, and there is plenty of resource to develop it. That has caused a lot of friction and tension in my service, because some people support the proposal and others feel that we need robust evidence to support it.

However, finance is not available to us to develop other services. That comes back to the point that Amy Dalrymple made, that, although health is a large part of the IJBs, the experiences of front-line clinicians are not being allowed to influence the approach. Our acute services are overstretched as they are, and that is without expecting the same service to take on more developments.

Another issue that is often overlooked is the pressure on staff. We have huge numbers of vacancies, particularly in community nursing. That is not taken into account sufficiently in many of the proposals that have been set out.

David Small: Clinical engagement is important. I guess that it depends partly on the services that are provided under the authority of each IJB. For example, in East Lothian we have perhaps one consultant who is a member of the Royal College of Physicians of Edinburgh but we have maybe 100 people who are members of the Royal College of General Practitioners. We have a GP on our IJB in addition to having the statutory minimum of a clinical director, who is also a GP. We also have a consultant physician—a cardiologist from the Royal infirmary of Edinburgh—and we have the chief nurse and the chief social work officer. The professional input to the IJB is varied. We must not miss the multidisciplinary nature of what we are trying to do. We have therefore deliberately gone for the broadest possible professional input to the IJB. As has been said, those are non-voting roles, because of the statutory basis of integration joint boards, but it is important to have that diversity of input. We also have consultant psychiatrists inputting to our strategic planning group.

Hospital at home is an interesting issue. I take Dr Slater’s point on that, but most of us are trying to develop some version of hospital at home to avoid unnecessary hospital admissions among older people or people with dementia or delirium when that might be the worst thing for them. I appreciate that there is evidence both ways, but I think that hospital at home is one of the key tools that we will have in the future to meet the aspiration to reduce unscheduled care bed days under the health and social care delivery plan.

The Convener: Is that view based on evidence that you have?

David Small: It is based on practice across Scotland. I think that South Lanarkshire and Fife introduced hospital at home services early on—before the IJBs, even—and they have produced evidence of outcomes such as reduced admissions and shorter stays.

Michael Kellet: I can confirm what David Small just said. Hospital at home has been in place in Fife for some time and is a key part of our armoury in shifting the balance of care and keeping people at home whenever possible. However, Marion Slater makes a fair point, because there is a genuine difference in clinical views.

Like David Small, I think that ensuring effective clinical involvement is really important. We have a similar arrangement to the one that David described in that we have clinical voices round the IJB table. In the senior team that works with me in the health and social care partnership, I have an associate medical director and an associate nurse director as well as a qualified social worker. That is an important mix. Again, it is a work in progress, but it ensures that the clinical voice and the professional voice more broadly, including the voices of housing and social work professionals, are heard round the table.

There was an interesting discussion in the previous panel about how much time IJBs spend on budgetary, procedural and structural issues instead of dealing with substance. That has been a challenge, and it is potentially a factor of the relative infancy of IJBs. In Fife, we have spent a lot of time thinking about our budget and budgetary challenges but, in the past few IJB meetings, we have discussed home care, new models of community care and mental health issues, and in the next couple of months we will discuss the prospect of urgent care at community hubs and implementation of the Carers (Scotland) Act 2016. Moving forward, we need to strike a balance between having the necessary discussion of difficult issues such as budgets and thinking about the substance.

11:00

Andrew Strong: On the point about culture change, words such as “co-production”—which Michael Kellet referred to earlier—were used in the development of the 2014 act and I am heartened to hear that, in Fife, there have been developments around co-production and transformational change. The committee’s inquiry is timely in relation to that, but we really need to look beyond consultation. We cannot just talk about consultation; we need to look at some examples of what people round the table have done and how those can be rolled out elsewhere. We whole-heartedly support the idea of co-production underlying the guidance, and we want to see more of it in the coming years.

I take the point that we are in the early days of the development of some of the health and social care partnerships, but we want to see more co-production taking place. With the IJBs, we are probably more likely to see such things happening at the strategic planning and locality level, and being fed into the top governance level, than at the top level. That links to some of the points that have been made. Perhaps the committee could think about asking IJBs questions about what co-production is happening at the different levels.

Margaret McKeith: The independent sector is the biggest provider of social care in Scotland, so it is disappointing that we have a seat on only seven IJBs across the country. In the areas where we have a seat on the IJB, such as Fife, North Ayrshire, and Argyll and Bute, there is some really good partnership working. Michael Kellet has referred to some of the innovative work that is taking place in Fife. We are seeing some innovative approaches to service delivery, which is undoubtedly benefiting the people who live in those areas. Scottish Care is keen to have a seat on all the IJBs in those parts of the country where we have a presence.

The Convener: I am keen to bring in colleagues who have any additional questions.

Colin Smyth: A recurring theme is that there is a lot of good practice out there. What mechanism needs to be put in place, either at Government level or other level, to make sure that best practice is shared across Scotland and implemented where it is relevant?

Corinne Curtis: Best practice is more about the how than the what. It is more about where the ideas for innovative projects come from and how people at the bottom level are engaged in order to get those ideas across. It is also more about liaison between the services and the people who use them.

There are a lot of differences between the engagement practices in the various areas of the country. In Orkney, we do not have a public engagement officer in the health board, and public engagement has been devolved to the managerial level in each area. However, nobody is monitoring that to see whether it really happens.

It would be good to look at how engagement happens at all levels, particularly from the lowest levels upwards rather than from the top down, and to show people how to develop innovative projects rather than replicate ones that already exist.

Jo Gibson: I agree that, between us, we already have a lot of the solutions. However, the job in the new IJBs is relentless—it has been from the start—so it is difficult to free up time to study what is happening elsewhere and begin a discussion about how we might apply that on our own patch.

Nevertheless, I think that we have opportunities to do that through colleagues in the alliance and through the Scottish health council, whose role was referred to by the previous panel. We already produce narratives about what we have achieved and what has worked well. It would be helpful if one of those national bodies compiled that information and distilled it for all of us to use. We now have a geographical link with the alliance, which is beginning to do that, and we have a geographical link with the Scottish health council. If it was clear that there was a remit to share that information, that would be helpful.

Every partnership will also produce an annual performance report, and we get guidance from the Scottish Government on what should be included in that. It would be helpful if that report also reflected how engagement is working and if extracts were distilled and shared so that we all had something approaching a go-to toolkit.

The Convener: Is the alliance working on that? Do you have a remit and the funding to do that?

Andrew Strong: We are attempting to do that. Our third sector team is funded to provide a clear understanding of the third sector’s role in the integration landscape, enabling the sharing of experience and creating connections in the third sector. Technically, that would not fall within the remit, but in some cases we are looking at what is happening with stakeholders and sharing that with our networks. We have monthly integration forums with the third sector to share what is happening locally, and we are hosting a range of strategic commissioning events that 115 organisations across the country are signed up to. We also share information through regular newsletters and so on.

Michael Kellet: It is an important issue and there is no easy answer. The alliance has an important role to play, as has been described by Andrew Strong and Jo Gibson, but there is also a role for the national statutory bodies.

We have a regular meeting of chief officers. David Small, Christina West and I were at that quarterly meeting last Friday. Healthcare Improvement Scotland came along to talk about the work of the ihub, which is a relatively new development that is aimed at supporting improvement across health and social care. HIS talked about how it captures and spreads best practice through its work with the Scottish health council and the our voice initiative, which the committee will have heard of.

Nevertheless, IJBs and chief officers have a responsibility to exchange information and ensure that we follow best practice. Jo Gibson is right to say that the job is busy and relentless, but it is important to take the time to do that. There is also a role for the Scottish Government, which it recognises. I am involved in the steering group of the NHS event—the big, two-day conference that the Scottish Government organises in the Scottish Exhibition and Conference Centre in Glasgow—and a lot of this year’s content comes from IJBs and is about best practice. That is a practical example of how best practice is spread. Even so, it will remain a constant issue for us.

Amy Dalrymple: If it is worth doing—not just because it is in the legislation but, as I firmly believe, because we can use it to improve services and outcomes for people—it is worth doing properly by putting in the time and prioritising resources and attention.

I slightly disagree with Colin Smyth about there being a lot of good practice. There is some good practice but not a huge amount. Organisations such as mine can support good practice because, as well as our network of local groups, we have the national infrastructure of Alzheimer Scotland behind that. However, one of the issues that we have with engagement with the third sector is that it takes place through the TSIs and there is great variation in the capacity and willingness of the TSIs to work with their members—particularly those of us that are national organisations. There is room for improvement there.

On accountability in the TSIs, I was intrigued to hear what David Small said about talking to his local TSI—it might be Strive—about an election process for representing the third sector on the IJB. That is an important idea. I have talked to people who do my sort of job in other national organisations and there is a problem in engaging with the TSI in some areas. I am not referring to South Lanarkshire—the witness from there who spoke earlier is still in the room.

Greater transparency of information would be helpful. As well as using the national networks, we can do our job better—we can help to share good practice—if the information about whom to share it with is available. In some areas, it is difficult to know who is the most appropriate person to contact. The chief officers who are sitting round this table do not want to be bombarded with inappropriate information and suggestions from organisations such as those that I or others who have spoken represent. However, if it was more obvious who makes particular decisions, we would not bombard them but would ensure that chief officers and others had information that was relevant to their roles.

In many areas, there is a lack of transparency about who is in charge of what and who is accountable for what. It is not always obvious who is in charge of engagement or who is in charge of particular areas of care. One voluntary organisation made a series of freedom of information requests to find that out, because that information is not available anywhere obvious.

We can support the process of spreading good practice, but we cannot do that unless we have the information about where it needs to be spread.

Alison Johnstone: I feel somewhat depressed, having read the submissions and listened to the various contributions in this evidence-taking session. If a service user representative has said that they are not a representative but are monitoring public participation because it is simply impossible to engage more fully, there is an issue. We hear a similar message from the Royal College of Physicians and the third sector. It seems that the issue is cultural and structural.

I hear some positive suggestions that, just because time is moving on, relationships are developing and the situation is getting better but I am concerned about the length of time that that is taking. Is there anything that we can do now to ensure that the idea of greater collaboration and engagement is taken seriously?

Corinne Curtis: I will give an example from my experience in New Zealand, where I was involved in a number of Ministry of Health working parties. They were considering primary health care guidelines but my experience as a consumer representative, as I was called, is relevant.

I was an equal partner on those committees. I had full voting rights and equal speaking rights. That was a little bit of a problem because it meant that I was tacitly in agreement with the decisions that were made at the end, even though I may not have been. However, I was definitely treated as an equal. In fact, I was paid as an equal: because I was not being paid by my workplace, I got a day rate for attending the meetings. That is important as well, particularly for carers and service users who, like me, may have considerable disability that puts them at a disadvantage. I could not work full time but I was spending time on a voluntary position that took away from my ability to do any more paid work. It is about respecting that.

I was on those committees to give my perspective on issues, not to represent the views and opinions of people. It was also about having really robust data. I have been absolutely horrified at the lack of data that has come through the strategic planning group. We have had really broad-level statistical data and no analysis of how it relates to the local level, of some of the projects to which we are expected to say yes or no or of what has gone on before. We have also had no good estimations of how much money a proposal might save or what it might do differently. There has been no real information on which to make a proper decision.

I may not have understood the information on some of the New Zealand committees, but we had a researcher who read through it all, graded evidence, pointed out stuff as we discussed issues and told us what did and did not fit with what or told us that, although something sounded really good, we did not have good-quality evidence to show it. That kind of stuff was accessible to us so we did not need to have a high-level understanding of a matter to be able to discuss it at a high level.

The Convener: Is your experience of the strategic planning group peculiar to your area or is it happening across the piece? If it is happening across the piece, we have a real problem. If major decisions about the use of public funds are being taken with no evidence base, that flies in the face of the approach that is supposed to be applied to public services, which is that we have evidence-based policy.

11:15

David Small: I was just reflecting on what you said. The East Lothian strategic plan, which you can find online if you are interested, has all the data down to the two-locality level. I appreciate that East Lothian's geography is obviously different to Orkney's, and we have gone for two localities, east and west. You will find that the strategic plan analyses down to east and west locality level on such things as use of medicines, disease, disease prevalence and length of life, but we probably have a bit more work to do on developing meaningful local plans, because quite a lot of our services are provided across East Lothian and do not distinguish between the two localities. The question is, what do we build from the bottom up, based on the data that we have, and how can services be responsive to the differences between east and west? They are different. The town of Musselburgh is very different to the town of Dunbar. The needs are different and the problems that service users experience are different, so we still have some work to do. In the context of work in progress and all of us trying to do the right thing to improve engagement and services, I would agree with the point that was made.

On a more general point, across Scotland there will be hundreds of people involved in integration joint boards and strategic planning groups from all sorts of backgrounds, including members of the public, members of local third sector organisations and of national third sector organisations such as Scottish Care, and members of professional representative bodies. We need to consider how we can get the breadth of that experience, to get a general feel for how things are going across Scotland. It is early days, and we will find that there are areas where it is not so good and areas where it is better. Even in one partnership, you will find things that are not going well and other things that are going very well, and there is a challenge in bringing all that together. I liked the suggestion by Jo Gibson that the national annual report from IJBs, which will be coming up soon, could include engagement and the voices of those who are engaged, as well as the voices of people such as Michael Kellet and myself who are writing stuff in performance reports.

The Convener: Do you recognise what Corinne Curtis has said?

David Small: Not in relation to East Lothian.

Dr Slater: I am sure that there are some excellent examples of data collection, but the feeling overall is that it is not being used properly. I was astonished by the Care Inspectorate's response and the examples that were given. There is no evidence associated with them, not even qualitative evidence. It is just a case of a wellbeing officer going in and saying, "We feel that this is a truly innovative use of service." It may be, and I am sure that it is making a difference to people, but that should be measured.

Alison Johnstone asked what we can do now to improve things. I think that we can start collecting data now to evaluate those projects. That is something that we could do today. For each project that is started or taken forward, we need to start collecting the data to show whether it really is making a difference to service.

To return briefly to the hospital-at-home initiative, I am not against hospital at home at all. We have some excellent examples of how that works, but the whole reason for data collection is that we have to bear in mind that expanding services outside the hospital can mean uncovering previously unmet need or providing extra services that people will use on top of those that already exist. We cannot assume that preventing admissions means that all associated costs can be topped up by savings, so we need robust data. It is a public resource and we should be utilising it in a responsible way.

Andrew Strong: My comment is less about data, although the point that has been made about monitoring and evaluation of budgets and key projects is important, because what usually happens in times of austerity is that things such as that fall away. I go back to what Corinne Curtis said at the start of her contribution, about the accessibility of boards and planning mechanisms. She hit the nail on the head. If we truly value public involvement in the boards, we need to pay for it and budget for it, and ensure that people are able to attend and are financed to do so.

That also applies to the third sector interfaces. Third sector organisations do not have the level of financial capacity to be able to complete that role, which is why there is such a patchy picture. RNIB Scotland has recently made some asks of integration joint boards about accessibility for people with visual impairments, and that will go for other organisations as well. If we are taking a human rights-based approach, we need to make sure that respite is available for carers to be able to engage, that disabled people get access to meetings and are supported to and from meetings, and that we budget for expenses, overnight stays and so on. Those are the mechanics behind good and valuable involvement and we need to make sure that that happens. It comes back to the point that was made earlier about the Scottish health council’s participation guidelines, and we need to make sure that those are put in place for some of the boards.

The Convener: Do people who are involved with your organisation get compensated or paid for their involvement?

Andrew Strong: Yes.

Michael Kellet: There is consensus from colleagues around the table that data is really important. We are in a similar position to the one that David Small described. We have seven locality areas in Fife and, relatively recently, we developed detailed descriptions of the health and social care issues in those individual communities. My organisation is not as advanced as Christina West’s in putting the locality groups together, but when they are together—it is an immediate priority—there will be really valuable data about the particular issues in each community.

As our colleague from the RCPE said, we also need to have data about policy developments to assess them and to understand whether they are worth rolling out. In Fife, we are very keen on that. Over the past year, we have put in place a new model of home care reablement called START—which stands for “short-term assessment and review team”—that is designed to support people to get out of hospital quickly by assessing their needs over a short period of time and, where possible and appropriate, by ensuring that they get the right level of support, rather than the level of support that they were initially provided with. That is beginning to show benefits, because we are monitoring, evaluating and recording the data, which will inform the onward development of the model.

Alison Johnstone said that she feels quite depressed by the evidence that she has heard. That is a fair challenge. We need to get engagement right at the IJB level and to take into account all the points that people have made today, but the real opportunity is at locality level—for example, the seven locality areas in Fife, those in David Small’s area and the eight in Christina West’s area. As Christina West said, that level is designed to be where the engine rooms of integration are and where the opportunity lies for service users, carers, patients, families and those who are providing and managing services to get together to shape and inform the delivery of services. It is where the opportunity for co-production lies, so that is the light at the end of the tunnel that we need to keep our eye on.

Jo Gibson: I do not recognise what Corinne Curtis has described of her experience at the strategic planning group and I very much hope that all my colleagues on our strategic planning group would agree with me.

Our first strategic plan was based on a very detailed needs assessment that was available to everybody. It was brought together by a range of professionals and we based our decisions on what we understood to be the issues in the population at the time.

Since then, the strategic planning group has received a quarterly performance report and the group considers in detail what progress has been made against the strategic plan. We share locality profiles, which others have described, with the strategic planning group. They are documents that we have built up that detail everything that we know about each locality. We try to enable the strategic planning group to be as informed as us so that, when we make decisions about commissioning, everyone has the same amount of information.

We have recently introduced a medium-term financial plan, which helped us a lot in the latest budgeting round because it laid out the scale of the challenge that is before us over the next three years. A few weeks ago, we spent some considerable time with the strategic planning group going through the detail of that financial plan to ensure that we have a shared understanding of where we are going.

I totally agree with what has been said about data and evaluation. I am sure that you have rehearsed many times the complications around information and information governance. Early on, we decided to invest some of our integration care fund money in a group of people who we called the change team. We ensured that in that group we had people with skills in information analysis and evaluation, project management and occupational development support. We have taken the time to study both quantitative and qualitative data before embarking on change in order that we can see the effects as we move forward.

One of the things that has enriched us greatly is using peer researchers to help us understand the impact of a service on service users and their families. We have trained and supported peer researchers to do that and have reimbursed them where possible. That approach has worked well in a number of projects, so we are working to train a larger cohort of peer researchers over the next year to build on that.

Christina West: I want to pick up Alison Johnstone's question about what we can do to enhance collaboration and engagement. My IJB has raised concerns about that. Over our first year we embarked on a series of ambitious changes. Some of them went less well than others in terms of our communication and engagement. The IJB has considered the lessons that were learned from that carefully, as a result of which we will invest more dedicated resource in communication and engagement, specifically to target and support our locality planning groups. Getting the case for change out there and ensuring that communities understand it well is a real challenge for us.

We have had fair accusations levelled at us about our use of jargon and how we use our data and make it explainable. The IJB has learned lessons over the past year and I hope that the investment that we are making this year will help us focus on having a more meaningful engagement process. We have the locality infrastructure, but the feedback that we are getting suggests that the case for change is still not well understood.

People understand that the fiscal challenge needs to be addressed, but in Argyll and Bute we face other challenges relating to the diminishing population and the fact that there will be an increase of more than 74 per cent in the number of over-75s by 2035. We know that our workforce will decrease by 14 per cent and we are already beginning to see recruitment challenges. The health and social care partnership faces the totality of that challenge; it is not just about the budget. It is important that we communicate and engage with communities in a way that lets them understand the challenges that we face, so that together we can decide what the future looks like. That is what our investment will focus on.

Donald Cameron: I want to pick up on that final point. We talk about stakeholders; the general public is one of the key stakeholders. Marion Slater and David Small talked about the role that clinicians play internally. Their role can be taken one step further, because clinicians have a public-facing role to play when change is necessary. Often people trust a doctor or a nurse making the case for change more than they would trust someone in NHS management or even an elected politician, because they can provide a powerful clinical or medical reason for change.

Petition PE1628, which is before the committee, was initiated principally because of proposals regarding Struan lodge, which is a care home in Dunoon that Christina West will know about. It encapsulates many of the issues that we have talked about this morning; the real problem is the lack of engagement in communities, which is particularly apparent in, but not confined to, rural areas. I pay tribute to Max Barr, the petitioner. The petition reveals that, to put it bluntly, the local community does not feel involved. They feel that the engagement that has happened is superficial and that decisions are predetermined, and the community health forum does not feel informed. It often takes the formation of an action group, a local media campaign or the involvement of local politicians to really ratchet up the pressure.

11:30

My main point, on which I would be grateful for people's views, is that there is a gap. All the good work internally around strategic planning, locality planning and co-production is important, but there is a gap between that and how changes are achieved with the support of the general public—the petition about Struan lodge focuses on that. I am keen to hear what solutions there are. Members of the general public will hear only that their local care home is closing; that is the message that comes across. How do we advocate and get support for controversial change in such areas?

The Convener: The points that you raised about service redesign and change came up when we had evidence sessions with the Scottish health council. Who wants to begin on that question?

Amy Dalrymple: When the first thing that the public hear is that their local care home is closing, there is a problem. If the first thing that the public hear is that there are difficult decisions to be made because of a decreasing population and pressure on resources, and that we need to work together to figure out a solution, they might not feel uninformed. A real culture change is required in order to work like that, however.

I referred to the NHS being hierarchical, which is the nature of government, but that is also true of local authorities, and health and social care partnerships and IJBs are creatures of the NHS and local government. They have come together to create the IJBs, but they are not used to stripping back what they do to let the public see the mechanisms of how they work. That means that we get a fait accompli in decisions having already been made; for example, we get the public hearing the announcement that the care home is closing, and there is no sense of public involvement in that.

Co-production is about public involvement, rather than just consultation. I saw in a report by a health and social care partnership something like “We co-produced this by consulting people”, but co-production and consultation are entirely different things. Co-production starts not only before a decision is made but before we even know that a decision needs to be made or what it should be. It involves saying “Here is our locality and our community. What are the issues here that we need to address?” It is not even about saying “These are the issues.” The data helps, but it is about what the members of the community feel the issues are. The data might present some aspects as a problem, but the people in the community might feel that together they could manage that quite well if they are allowed to get on with it and do things in the way that they want.

I see that my fellow panellist from the isles, Corinne Curtis, is nodding in agreement with that point, which is about something that I have seen in island and rural communities in particular.

Co-production is about involving people right at the beginning, but doing that is going to take courage and a culture change. From—I am not going to say “our side of the table”, because representatives from the different sectors are interspersed around the table—our sector’s side of things, we are well aware of the massive change that co-production is going to be. We are here, though, to support that happening. The national, local and third sector organisations, community groups and individual activists who are here can make a contribution to that culture change and support the big organisations to make it. It is about admitting that culture change needs to happen and having the courage to strip back and expose the bits that might be a bit mucky and in need of a bit of oil to stop them creaking.

Christina West: I will respond to the generality of Mr Cameron’s question. As I said, we have a particular challenge in getting people to understand the case for change. Specifically, when we look at localities, the difficulty is that we need people to understand the whole system. While we are trying to shift the balance of care, we see individual buildings and beds becoming the focus of the discussions in local communities. That will be because people have genuine confidence in the service and good experiences of it, and they see any change to it as a reduction or diminution of the service.

As Amy Dalrymple said, it is important to have a conversation and to lay bare the fact that we are facing, which is that we cannot continue to deliver services in the way that we are delivering them—not just for financial reasons, but because we do not have the workforce to provide the service and we cannot meet the increasing demand using our current models. That requires a very different kind of conversation. It is important to get people to understand the enormousness of the challenge that we face.

The currency of buildings and beds is a really important issue for us, because we are charged with shifting the balance of care, so we need to develop confidence in our community services. An Acumen service user said to me recently, “Christina, we need communities to have sufficient confidence in their community services—the type of confidence they have when they see a building with a front door.” I do not think that we are there yet in building communities’ confidence that services that people can receive in their homes can be as safe, as effective and of as high a quality as services that they receive in buildings. The fact that people will fight tooth and nail to save services in buildings is a particular challenge that we face.

On care home capacity, we have a very mixed economy across Argyll and Bute, and we have huge variations in the costs of care that is provided in our care home sector, whether in our local authority provision or the independent sector. When we talk about shifting the balance of care, people often think about the shift from acute to community services, but I am also thinking about bed-based care in residential care homes and whether we should be supporting more people to be cared for in their own homes. We need to see shifts not just from hospitals into the community but from residential care into homecare services.

On our engagement on Struan lodge, the timing was undoubtedly an issue. I and the IJB have apologised and said to the community that we did not get it right. There was an absolute error in judgment in the making of decisions that were very focused on budget. Due diligence had identified a £1.58 million deficit in May. We had already agreed our budget and our savings plan, and then we had to identify £1.58 million of savings—in social care, really. Changes were accelerated in a way that I do not believe the IJB will ever do again.

I suppose that that is the learning that we have had this year. We accelerated decision making and we did not take the time to go out and communicate with our communities and our stakeholders. We did not take the time to explain the case for change and why it needed to happen. We have without a doubt learned some very valuable, if painful, lessons.

We have responded to the feedback that we got from communities. In November, we agreed as an IJB to take a six-month pause in the changes that were being put on the table for Struan lodge. We undertook 19 community engagement events, at which 190 people turned up, and we had 45 questionnaire responses. The Struan lodge development group has now come up with an action plan of different proposals for how Struan lodge might be used in the future.

We now need to consider the totality of that feedback, because there is no consensus. As we would anticipate with any community, a diverse range of views have been expressed that see us either disinvesting from the 12 residential care home beds and using the resource as a community hub, which is what was proposed—a hub for support for carers, reablement services, signposting people and using the available local infrastructure through the independent sector to provide residential care—or maintaining that local authority provision in Dunoon. That discussion is still to take place at the IJB.

We will absolutely take account of all the feedback that we have had, but with engagement comes a diversity of views, and the IJB will need to consider that in the round at its meeting in May.

Donald Cameron: I am grateful to Christina West for that explanation. I hope that when the IJB considers the issue in May, it will take on board the very strong feelings that are apparent. What Amy Dalrymple said is right: often, the public feel that a decision is taken and everything that follows is tokenistic, which is the phrase that has been used. The challenge is to reverse that process: to start with a genuinely open book and to bring people with you. I would be grateful to hear what others around the table have to say on that.

Corinne Curtis: I have quite strong views on consultation, having been involved on both sides of it. I have been used as a consultant to get consumer views, as well. I hear a lot of different things. One is about “consultation fatigue”—that we do not bother asking people because there is too much consultation fatigue out there. To my mind, such fatigue happens when the public are asked too many stupid questions, such as, “Please comment on this 64-page strategic plan.” No—they should perhaps be asked to give their views on one aspect of it, but they should not be asked that. Real questions get real answers.

Another example was what was deemed to be quite a successful social media consultation, in which 125 people were apparently involved. Perhaps the person who was counting forgot about spiders and bots on Facebook that boost the numbers in such matters. There were not really 125 people involved; there were about four who actually said anything real. That was in response to a general question from the person leading the discussion, on what respondents would like to say about the strategic plan. Again I say sorry, but that is too big a question. When respondents did say something, the reply was, “That is really interesting. We will note that.” Where did that go? I do not know.

People need to understand what real communication is and what real learning from the people with whom they consult is. We are missing a huge opportunity. Every now and again, I look on the patient opinion website for my local area, to see what people are saying. Actually, they do not say much, because they have learned that if they give their opinion on such a site about a service, they will get back a stock response saying, “I am sorry that you had this experience. If you contact me directly, we will see what we can do to make it better.” That does not do anything. The people who respond on such sites should be learning to say, “Okay. This person has a problem with the service here. Does anyone else have that problem? Is it a systemic one? What can we do about it generally?”, instead of just seeing it as a case of, “One individual has had a bad experience. We are sorry about that.” Those are the ideal opportunities for finding where changes could happen.

I could give the committee dozens of examples of wasted services in Orkney, particularly when people have had to travel from the isles to either mainland Orkney or Aberdeen. The number of wasted trips to Aberdeen is shocking. All such trips from my island also involve an overnight stay somewhere, because people cannot get down to Aberdeen and back in a day. We should learn from users’ experiences of that, but I do not know where to point people so that those can be recorded, let alone acknowledged and acted upon. There are huge numbers of such experiences that we could learn from in order to make plans about what is and is not working and where we might want to shift resources.

The other point that I want to make is about the service user role, which I think is not to help people to make decisions but to give the information that will help the professionals to make decisions. I have come to that opinion because of an experience that I had in New Zealand, at the time of the beginnings of the mental health service user movement. The professionals were starting to listen to the experiences of people who used mental health services. I was working with a patient organisation that realised that the issue was not about telling the services what we wanted in the way of services, but about just saying what our experiences of using them were, which then gave clues for the people making decisions about where things needed to change. Telling the stories, rather than giving recommendations, made the biggest difference.

11:45

Jo Gibson: I want to build on a couple of points that Christina West and Corinne Curtis raised.

To date, health and social care partnerships have not done a lot to promote our existence to our public. The message has not gone out strongly at national level, either. We could do with some help with informing the public that we exist and that our responsibility is to shift the balance of care. We have a responsibility to do that locally, but a national campaign to support us would help. We are also trying to gain an understanding of the scale of the challenge and share that locally. Again, it would help if that was supported nationally.

I want to share a little story that illustrates how we are beginning to stop thinking, “These are the problems that we need to discuss with the public” and instead try to create the context in which the public identifies the problems and we work together to address them. One of our locality forum members shared this story. She had been in her kitchen while her daughter was sitting at the kitchen table with seven friends. One of the friends identified that she had recently started to take antidepressants, and slowly, over the course of the next half hour, I think that seven of the eight young people admitted that they were on antidepressants.

Our locality forum member was understandably shocked about that, and she brought the issue to the locality planning forum, where the local GP said, “I’m not surprised. We meet person after person who describes anxiety and stress, and we feel that we have little option but to prescribe antidepressants.” After that conversation, we took the issue to our locality forum network, on which all six locality forums were represented and which had six GPs and six IJB members. We discussed the issue and looked at the data, and what was described was confirmed in prescribing data and in recent research about levels of stress and anxiety among young people in North Ayrshire.

We were then able to make different decisions. We have put community connectors into surgeries, to provide advice on mental health and wellbeing. We worked with the Scottish Government and set up a participatory budgeting event on mental health in the area, and we allocated £50,000 to community groups and individuals who had ideas about that. We commissioned the third sector to develop a specification for us on what a low-level, effective mental health service would look like in North Ayrshire.

That is an example of shifting the conversation, so that the public and the community identify what matters to them and we respond with them. I hope that it is slightly less depressing than some of what we heard at the start.

David Small: In relation to what Christina West said, in East Lothian we had an experience that started in 2011, which was long before the integration joint board was established—and before my time, too—when we reviewed the future of two community hospitals and there were proposals to close them. The negative reaction that the proposals generated is still with us, in 2017. We are only now getting over the history of that negative reaction and starting conversations again with the communities about what the two facilities could be in the future and how they could be not just health but joint health and social care services and hubs. All that is back on the table, but it has taken six years to win back trust so that we can have those conversations. Even now, it is difficult and there is a lot of suspicion. It takes time.

The lesson for me is to start early, before we even know what the problem is and certainly before we think we know what decision is to be taken.

The Convener: I want to wind up the discussion, but first, will the representatives from IJBs say whether they have set their budgets for this year? We have talked about last year’s budget; at this point in the financial year have you set your final budgets for the year?

David Small: Yes, we have. We have received the council’s budget, and it was accepted by the IJB at the end of March. The health board set its budget on 5 April, so at our IJB meeting at the end of March we discussed an indicative proposal from the health board, which was agreed. We do not anticipate that the final offer will be any different.

Michael Kellet: I am pleased to say that we are in a similar position. Our 2017-18 budget for delegated and managed services was approved by the IJB on 23 March. Fife IJB’s total budget is £475 million. I make it clear that the budget does not quite balance—over the year, we must manage the remaining budget gap of £2.1 million. There are pressures on the budget that we debated and acknowledged during the budget-setting process.

Christina West: We have had notification of both delegations of budget, but the IJB has not accepted the budget as we do not yet have a plan that would allow us to deliver all services within the budget that has been delegated to us. At the moment, we have a quality and finance plan for the next two years, with a £20 million funding gap. Of that gap, £11 million is in year 1 and £9 million is in year 2. We have not yet identified all the service redesign savings and proposals and so on for year 1, and there will be a further discussion with the IJB at the end of May about that.

The Convener: That would be about the IJB identifying what it views as savings, rather than the community identifying what should go into that plan.

Christina West: When we started our budget-setting process, we asked our locality planning groups to come forward with redesign ideas that would fit with the strategic plan. Our quality and finance plan, which we developed over two years, started in October 2016. We asked our communities what priorities and redesigns they want to see in localities. Their ideas did not meet the budget gap, so we have had to work as a management team and with LPGs to identify further redesigns that will allow us to meet the budget gap.

The Convener: Are you saying that you see those service redesigns as being driven by the budgetary process, rather than by service delivery and service improvement?

Christina West: We are very confident that all the savings that we have identified thus far are in complete alignment with our strategic plan, which is why the IJB was happy to agree to them at the previous meeting. The issue is the £2.8 million savings gap for this year and any suggested proposals have not yet been aligned with the strategic plan, which is why the IJB has not yet made its decision.

The Convener: Do you think that you can implement those cuts—I will call them that—with no impact on service?

Christina West: There will be an impact on service, without a doubt.

Jo Gibson: Our IJB agreed its budget on 9 March based on an indicative budget from the NHS and following a council meeting on 1 March. The budget included £5.3 million-worth of savings that had been identified and approved. We still have a £1.2 million gap in the savings on the NHS side. We made proposals on that, but as they were unpalatable to all concerned, we are back to the drawing board.

The only place where we can go for savings on the NHS side is community services, because we cannot reduce funding in primary care or mental health services. Anything that we do to reduce community care services flies in the face of shifting the balance of care and of our strategic planning. We are in a difficult position; negotiations continue. I have no further information.

The Convener: You have probably observed this committee before, so you will be familiar with this line of questioning. If they are savings, why are people objecting?

Jo Gibson: We needed to make a 4 per cent saving on the NHS side. We have achieved much of that, but there is still a gap. Because the NHS services are ring fenced and because of the essential need to develop community and primary care and mental health services, we are in a difficult position—as is the case for other boards.

The Convener: I am assuming that the people who are being affected by those savings do not perceive them as savings.

Jo Gibson: Like Christina West, the savings that we have made have been in the area of redesign. We are going to provide a more effective and—I hope—more appropriate service for people. That is all in line with the strategic plan and has been widely consulted on. We are not clear where the remaining £1.2 million-worth of savings will come from and conversations on that will continue. I foresee that, unless something changes, it will mean service reductions in areas that are crucial to our communities.

The Convener: That does not sound much like savings, but there you go. I thank everyone for their attendance—it is much appreciated. Please keep an eye on further developments in this area of the committee's work.

11:54

Meeting suspended.

11:59

On resuming—

NHS Governance

The Convener: Item 3 is an opportunity for members to discuss the main themes arising from the informal evidence session with NHS senior managers that we held last Tuesday. I invite comments on that session. Are there no comments? Members are not usually so shy and reticent.

12:00

Alison Johnstone: The group that I spoke with was of the view that raising concerns was difficult—people did not want to speak out because it could be perceived negatively and might have a negative impact on any career progression and relationships with other colleagues. It did not feel as though there was an open culture in which issues could be discussed without an element of concern. That was the impression that I had from my group.

Jenny Gilruth (Mid Fife and Glenrothes) (SNP): What was the rationale behind using that union in particular? Was it because it represents people at management level in healthcare?

The Convener: Which union?

Jenny Gilruth: I think that everyone came from Managers in Partnership.

The Convener: There were a few trade unions represented in that discussion.

Jenny Gilruth: Was MIP involved because it represents healthcare managers? I ask because its United Kingdom membership is 6,000, but in Scotland it has only about 500 members—at the last count—which is about 8 per cent of its membership. Given that, I am not sure how representative it is of healthcare managers more broadly.

The Convener: I think that we approached the union because it is an organisation that has a collective voice, whereas we might have struggled to get individuals.

Clare Haughey: One of the things that struck me was that some of the people that I spoke to had a UK-wide remit and they spoke very positively about the NHS in Scotland in comparison with the rest of the UK. They also spoke about the privatisation of the NHS in England in particular and their concerns about the impact of privatisation on staffing there. They contrasted the two systems.

The Convener: The group that I sat with were all Scotland-based staff members. They raised quite significant concerns about the culture that goes from ward level up through the system and the way in which it stifles innovation and prevents people from taking positive risks in developing services. There was an individual who, having raised a series of concerns, had experienced quite significant bullying and harassment in her role as a manager.

The overwhelming thing that the group wanted to contribute was about the pressure that they felt to deliver targets. They felt that the continuing pressure to deliver those targets can take over everything else. Some commonsense things that they would have liked to have brought in in their service area, ward, or area that they managed were put aside because of the overwhelming pressure to deliver the numbers. They saw that as a negative experience.

Miles Briggs: As we work on our report, it will be quite difficult to make those voices heard, particularly when people approach us as individuals or as MSPs to express concern about bullying and harassment—sometimes by senior advisers in the health service who report to ministers. We will have to consider how we can make those voices heard. In some cases, people are using us as their complaint system. I want to ensure that we get it right as a committee so that those voices are heard in our final piece of work.

Maree Todd: To pick up on what you said, convener, some of the people I spoke to talked about the effects of stress. They said that when people are under pressure to make cuts, they revert to managerial styles that are not very effective. Although the people in my group had positive things to say about, for example, the patient safety programme and how excellent it is at empowering people at the coalface and delivering bottom-up change, they said that when people are under pressure they just revert to a top-down approach—“This is what you are going to do”—and bullying.

The Convener: That definitely came across. I took screeds of notes, which I will pass on to the committee clerks. If other members have similar notes, they should send them on to the clerks so that we can capture some of the themes that came out of our discussions.

12:05

Meeting continued in private until 12:34.

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