OFFICIAL REPORT
AITHISG OIFIGEIL

Health and Sport Committee

Tuesday 30 May 2017

Session 5

The Scottish Parliament
Pàrlamaid na h-Alba

Tuesday 30 May 2017

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HEALTH AND SPORT COMMITTEE
15th 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:

Donald Harley (British Medical Association)
Vicky Irons (Angus Health and Social Care Partnership)
Katy Lewis (Dumfries and Galloway Health and Social Care Partnership)
Kenryck Lloyd-Jones (Allied Health Professions Federation Scotland)
Matt McLaughlin (Unison)
Claire Pullar (Managers in Partnership)
Keith Redpath (West Dunbartonshire Health and Social Care Partnership)
Ros Shaw (Royal College of Nursing Scotland)
Karl Williamson (Shetland Health and Social Care Partnership (via video conference))

CLERK TO THE COMMITTEE

David Cullum

LOCATION

The Robert Burns Room (CR1)

Scottish Parliament

Health and Sport Committee

Tuesday 30 May 2017

[The Convener opened the meeting at 09:31]

Draft Budget 2017-18

The Convener (Neil Findlay): Good morning and welcome to the 15th meeting in 2017 of the Health and Sport Committee. I ask everyone in the room to ensure that their mobile phones are on silent; you can use them for social media, but please do not take photographs or film proceedings.

Agenda item 1 is an oral evidence-taking session on the draft budget 2017-18. I welcome to the committee Keith Redpath, chief officer, West Dunbartonshire health and social care partnership; Vicky Irons, chief officer, Angus health and social care partnership; Katy Lewis, chief finance officer, Dumfries and Galloway health and social care partnership; and, via videolink, Karl Williamson, chief officer, Shetland health and social care partnership. Can you see and hear us okay, Karl?

Karl Williamson (Shetland Health and Social Care Partnership (via video conference)): Yes, I can hear you. I should say that I am the chief financial officer, not the chief officer.

The Convener: I am sorry—I should have said chief finance officer.

Karl Williamson: Thank you.

The Convener: Thank you for joining us, Karl. When we want to bring you in, we will try to ask you questions directly so that you know when to answer. This is not an easy format for me, you or the rest of the committee to work with, but we will try to be as helpful as possible. If there are any problems at your end, please wave your hands frantically to let us know.

We will move to the first question.

Alison Johnstone (Lothian) (Green): Good morning. Meeting papers from West Dunbartonshire note:

> "it will only be possible to release resources from the acute services to sustain funding for community services if the number of inpatient beds is reduced".

In its inquiry on preventative spend, the committee heard evidence that creating a split between acute and community services creates a false dichotomy; it will neither decrease demand on the acute sector nor necessarily reduce costs, because staffing and overhead costs will not be reduced. Can you expand on that? Will you give us your views on whether the 2017-18 budget plans indicate a shift in the balance of care, whether such a shift is achievable and whether demand in the acute sector can be reduced to allow resources to be shifted to the community sector?

Keith Redpath (West Dunbartonshire Health and Social Care Partnership): There is a lot in that question. We have made it fairly clear in our report that, having been at the integration process for some time now, we are not uncomfortable with our system of care. However, given the pressures on every part of the system, any fundamental shift needs to include resource shift, too, and the reality is that a shift in that balance will mean fewer hospital-based acute beds.

We are not trying to separate the elements and say that there are two systems; we are part of a single system, and all parts of that system need to work efficiently in order to deliver, but that shift will mean reducing the costs of and the resource consumed by acute and moving that resource to community. Notwithstanding the costs around staff in that respect, we all feel that the staff who come out of acute could provide some of the new services in the community. Because the resource would follow the service and the people, we would not be dependent on new resource; instead, we would be shifting that resource. Our community assets and resources are working very hard, so the capacity needs to come from somewhere and, given the policy intent, the acute sector is the obvious place for it to come from.

Alison Johnstone: Would anyone else like to comment?

Vicky Irons (Angus Health and Social Care Partnership): I am happy to give an Angus perspective. So far, we have seen some small signs of shifts in resources. For example, because of the community services that we have put in place, there is less of a reliance on some of our in-patient facilities in Angus, and the decrease in the use of care homes is commensurate with a number of developments providing more care at home.

The important point about our local partnerships, which look at the use of the acute sector and the cost of that care, is that we take a round-table partnership approach to planning for the future. It is clear to us that although the money might not be easy to shift, where we can work effectively together is on changing practice. We are seeing, through a multidisciplinary team approach, more of those who provide specialist care in the acute sector coming out to work hand in hand with primary care professionals in Angus, and that seems to have been effective in changing

the balance of care as opposed to shifting the financial resource through the budget settlements.

Katy Lewis (Dumfries and Galloway Health and Social Care Partnership): The Dumfries and Galloway model is different from the model in a number of other partnerships in that we have not created that divide. Acute and primary care services are all delegated under the directorship of one chief officer, and that has allowed our partnership around the integration table to see the diversity of issues and the pressures on community and acute services.

We are keen to see investment in community services before there is a shift from acute services. Something that we have done quite effectively in Dumfries is to shift our mental health service provision; we have reduced the number of beds and increased the community services closer to home both in dementia care and in the overall care of individuals. With our acute services, we are starting on the pathway set out in that model with some of the investments that we have made, particularly the one-team approach that we are trying in the Dumfries and Nithsdale area. That is very much a multidisciplinary approach, and we are getting it much more established in communities.

Karl Williamson: Up in Shetland, we have seen good progress in shifting the balance of care through the use of an intermediate care team. However, we are finding it more difficult to shift the costs, because we have a small hospital with high fixed costs and there is not a lot of scope for closing further sections of it.

The Convener: Picking up on what Alison Johnstone said, I think that a view is emerging that there is going to be no shift in finance or that any such shift is going to be negligible. Is that the case?

Vicky Irons: Our progress so far shows that there has been a shift. It is reasonably small—

The Convener: Can you quantify it?

Vicky Irons: We were previously looking at resources around 39 per cent, and I think that over the past three years—I will double-check this—that figure has shifted to 41 per cent. It is a small shift, but it is very clear from all parties concerned that we need to see further shifts through the powers that we have in the commissioning plans. It comes back to my point about investing the resources in people. If we can change practice, the resources will follow through the new pathways of care that we are developing with acute sector colleagues.

Alison Johnstone: Obviously, one group of people who we need to invest in are social care staff. When integration authorities responded to the committee's survey last year, the information that we got back suggested that the cost of implementing the living wage for all adult social care workers exceeded the Scottish Government's estimate of £37 million. The Scottish Government stated:

> "The £10 million included for sleepovers will be reviewed in-year to consider its adequacy with a commitment to discuss and agree how any shortfall should be addressed."

Has the funding provided by the Scottish Government for implementation of the living wage been sufficient, and has the £10 million for covering the costs associated with sleepovers been sufficient, too?

Keith Redpath: Because of the make-up of our market in West Dunbartonshire, we are still a direct provider of quite a significant number of services. That is certainly the case for older people, although less so for other adult services. The amount that we were provided with to implement the living wage was certainly sufficient; indeed, we did not require all of the allocation to meet it.

As for sleepovers, we have had a second tranche of funding for 2017-18. All of us would probably prefer it if money were invested in providing direct care rather than in people who are sleeping—even though they are available when service users need them—but that has given us the impetus to review the models of care that we have with various providers and ensure that we are making the best use of that funding. From a West Dunbartonshire perspective, because of the balance in our provision and because our directly employed staff are already paid above the minimum wage level, the cost implications for us have been less significant than they have been in other parts of Scotland.

Vicky Irons: I recognise the risk that was highlighted last year, and we had similar concerns raised with us. Not unlike West Dunbartonshire Council, though, we worked through all the implications and resolved the issues within the resources available.

Katy Lewis: Ours was one of the first partnerships to implement the living wage, and we did that through a tender process, with a cap of £16.50 an hour. The benchmarking from that means that we are sure that most of our big providers are now able to pay that living wage to staff, and we have seen some quite significant improvements in our ability to recruit and retain care staff. We had to invest a significant amount of our social care fund in 2015-16 in that specific issue because of issues around rurality and travel time, particularly in a locality such as Dumfries and Galloway, but we thought that that investment was worth while.

As for sleepovers, we have invested around £400,000 in increasing the rates and in moving to an hourly rather than a fixed overnight rate, and we think that we now have an agreement that meets our legal obligations.

Karl Williamson: We are the direct provider of the majority of services in Shetland, and we have already been paying the living wage. As a result, the Scottish Government funding has been adequate for Shetland.

The Convener: Katy Lewis talked about a cap of £16.50 an hour. How does that operate?

Katy Lewis: We had a process in which all the providers were able to tender on the basis of the hourly rate that they required, and most of them came within a few pence of the £16.50.

The Convener: Did you agree with them that £16.50 would be the hourly rate?

Katy Lewis: That was the rate that we as a team agreed locally would be used as an adequate benchmark for the tender process.

The Convener: Did the providers know that when they tendered?

Katy Lewis: Yes, they knew that.

The Convener: So everybody knew that the rate was £16.50.

Katy Lewis: We have done a lot of work on engaging with our providers locally on the costs of their provision, particularly on how that links with more rural packages, where we were getting signs that travel time was a really big issue for some providers.

Colin Smyth (South Scotland) (Lab): I refer members to my entry in the register of members' interests. As a local councillor in Dumfries and Galloway until 4 May, I was involved in the council's budget-setting process.

I would like to ask the panel members whether the budgets for each of their IJB areas have been set for the forthcoming year.

09:45

Vicky Irons: Ours has been set and agreed.

Keith Redpath: In West Dunbartonshire, we have an agreement on the council's contribution. We are still in discussions with the health board about its contribution but, at the previous meeting on the variation in the national health service budget, we set the budget on the basis that we would continue to have discussions and that we would cover from reserves as necessary any pressure on that, which amounts to £0.25 million.

Katy Lewis: We have an agreed budget in Dumfries and Galloway.

The Convener: Karl, is your budget agreed?

Karl Williamson: Yes. We agreed the budget, but there is a deficit on the NHS side.

Colin Smyth: So the budget has been agreed in some but not all areas. Have you identified all the savings that you require to make in the forthcoming year, or are there any gaps in the budgets?

Keith Redpath: With regard to West Dunbartonshire, there were no savings to be made on the council side. By that I mean that each council was allowed to reduce its allocations under the rules set out in Parliament; that meant that we had money left that we had not used recurrently from the 2016-17 allocations, and that went to the bottom line. We have not actually had to make any cuts. On the NHS side, we are looking at a 2 per cent turnover target to meet the requirements of the flat cash and, as I have said, we are still in discussion with the health board about £0.25 million.

Vicky Irons: Angus Council had a full set of efficiency plans considered by the IJB in April, and those plans were approved. We have a small £49,000 shortfall in efficiency savings to be identified through the NHS Tayside budget agreement. We also have a similar shortfall in the Angus Council settlement, but the efficiencies that we need to identify are more in the region of £200,000.

More significant to Angus and the Tayside partnerships across NHS Tayside is the estimated shortfall in the devolved budget for prescribing in Tayside. In that respect, Angus currently has a shortfall of more than £1 million.

Katy Lewis: In Dumfries and Galloway, we have a £5 million gap in identified savings, and to bridge that gap, we have agreed with our integration joint board a business transformation programme in which we are setting up various service redesign programmes that we will work through.

As chief finance officer, I have held over the past six to nine months a range of workshops with our integration joint board members to set out the scale of the expected challenge. Of course, there is also the whole of the acute service in Dumfries to bear in mind, and some of the pressures that sat primarily with NHS boards now sit within the totality of the integration joint board in Dumfries and Galloway. We recognise that we still have to make progress in closing that gap and that the partnership will have to make a range of difficult and challenging decisions as we move forward.

Karl Williamson: In Shetland, we have a balanced budget on the local authority side but a £2.5 million funding gap on the NHS side. That is

about 6 per cent of the total IJB budget. We have identified savings amounting to £1.2 million, but £1.3 million remains unidentified, which is a challenging position.

Colin Smyth: The witnesses seem to be talking about the council side and the health board side, but is the budget not supposed to be integrated? My perception of the process is that, instead of the IJBs setting the budget and determining how much money they require, councils are setting aside how much they are allocating and health boards are setting aside how much they are allocating. In fact, it sounds as if it goes further than that, with the health boards effectively deciding what savings they are making and the councils appearing to be making judgments on what could be saved from their own allocations. I thought that the budget was supposed to be integrated, so why are you talking about the council allocation, the health board allocation and the different gaps?

Keith Redpath: The reality is that that is how the funding for the integration authorities is set up. We have two sources of funding: the local authority and the health board. I know that, in previous evidence sessions, people have suggested that there be a single process, with the funding perhaps coming directly from Parliament, but that is not the reality.

When the partnerships were first set up, the due diligence work considered the amount of council funding and health board funding that had previously been used for the same purposes, so that people could satisfy themselves that the money that was allocated was fit for purpose. Once the funding comes to us, we are duty bound to ensure that, in a sense, it loses its identity; it gets pooled, and we are then able to use it more flexibly. However, the original allocations still come from councils and health boards.

Colin Smyth: The Government will argue, however, that you have the authority to determine how much you require to implement your strategic plan. Are you saying that, in practical terms, that is just a piece of theory that is not being used? As an IJB, you do not say that you need £X from the local authority and £X from the health board to deliver your strategic plan, which is therefore your budget. The Government would argue that the powers that it has given you allow you to do that, but you are saying that you just wait and see what the health board and the council give you, and you then decide how to allocate the funding. That is what is really happening in practical terms.

Keith Redpath: When we get our allocations, we can then consider how we best meet the priorities in our strategic plan. However, the initial allocations can come only from those two places. I am certainly not aware of a partnership anywhere else that has taken the approach of initially thinking about what its population needs and then going back to its funders—councils and boards—and saying, "This is what we need; please give us it."

Vicky Irons: From the Angus perspective, I endorse Keith Redpath's comments about what happens once the money is devolved. We are certainly using it with more flexibility locally, and we are investing significantly in social care out of the totality of the resources that are delegated to us.

One dynamic that exists in Angus—I am not sure whether it exists anywhere else—that requires us effectively to retain the description of a health resource and a local authority resource is the risk-sharing agreement regarding any overspends relating to the costs of health and social care that we entered into, through the integration scheme, with the NHS board and the local authority, for the first two years during which the IJB was operational. That requires us to maintain systems for recording and articulating spend against health services and local authority services, should we be required to draw on that risk-sharing agreement. However, there is a recognition that we want to move forward in the spirit of the guidance establishing IJBs, and to have a more integrated approach to negotiating budgets.

The question of who sets or negotiates the budget is interesting. From experience of the past couple of years, I say that the due diligence process has been very helpful in identifying an adequate and fair budget and in the negotiations for reaching a budget settlement.

There is no denying that, although we are an integration authority, we are partners with the local authority and the NHS board. Therefore, we are not immune to the efficiency programmes that they must put in place to provide sustainable care, and we have to be part and parcel of those. That has all been playing out during the negotiations for the initial year and for 2017-18.

Colin Smyth: In your written evidence, you seem to imply that you would prefer a system of direct funding from Government. You talk about the frustrations of having separate partners and you imply that something almost like a direct funding model might be better.

Vicky Irons: Some of the information that we have put forward has supported the approach that has been taken this year, which has been more to do with the national direction regarding the resources that will be directed towards IJBs. That has really helped local discussions, as the approach has been fairly unequivocal. Our preference would be to have more direction to enable us to adopt a fair starting position for those

negotiations and then to move on to direct allocations to IJBs in the future if at all possible.

Colin Smyth: I am sorry to sound like Jeremy Paxman, but I will come back in at this point. How would we ensure democratic local accountability if everything was directly funded by the Scottish Government instead of through local authorities?

Vicky Irons: We would have to consider the make-up of the IJBs, but the current preference would be to continue along the lines of experience from last year with more national direction on the allocation that is to flow through the two bodies to the IJBs. We also said in our evidence that we would like the precedent that was set this year of allocating funds through the NHS boards to continue, but with clear directions.

The Convener: Would all the panellists prefer the money to come directly from the Scottish Government? In answering that question, will you say whether you have a health or local government background?

Keith Redpath: I have a health and local government background. I have managed health and social work services across local government and the health service for the past 30 years. I have experience of exclusively managing social work services in councils. I then moved into the health service and then into a joint position. My IJB has not reached a view on direct funding, so I will give a personal view.

I share Vicky Irons's view that clarity on what the new money that is being invested can and cannot be used for is incredibly helpful, particularly in a time of financial challenge for the whole of the public sector. Although we are bodies corporate in substance, the reality is that the IJB directs councils and health boards on what it wants the money to be spent on. Over time, there is the potential for IJBs to become the direct employers of the staff.

Direct funding is one solution. If people perceive the current method of allocating funding through local government and health boards to be problematic, that would be the most obvious solution. However, the current method can work. We have run an integrated service since 2010, and the budget negotiation process that we have gone through in the past couple of years has not necessarily been any more difficult than it was previously. We have had the time to work through a number of issues. There will always be a bit of negotiation, but people should come to that with common sense and understanding. I come from an area that has been broadly supportive of integration and what that is trying to achieve, and that has not been a particularly difficult matter for us.

Katy Lewis: It is quite well documented that, over the years, we have asked for greater alignment between council and NHS budgets and processes so that there are no inevitable delays.

I have a health background. I declare an interest as director of finance in NHS Dumfries and Galloway. I therefore have a dual role.

We want to ensure that the timelines are as early as possible in the year. We have seen later timelines for agreeing the budget, and that makes our jobs in agreeing a financial planning piece more difficult.

I also make a plea for longer-term financial direction, even if it is only indicative. The ambition is that we will not plan on annual cycles. Some of the service changes and resource shifts will inevitably take a longer time, but greater certainty about resources over, for example, a three-to-five-year timeline that links with the timeline for the strategic plan would be welcomed.

Karl Williamson: I, too, have a dual role: I am head of finance at NHS Shetland and chief financial officer of the IJB.

From the IJB side, direct funding would be welcome because it would safeguard the IJB budget and drive the shift in the balance of care but, from the NHS side, it would probably not be as helpful. As I said, we have fixed costs in the acute hospital. If we have to protect the IJB budgets, that will put the savings disproportionately on to the acute services, which are already almost at a minimum. Direct funding would be helpful from the IJB side, but perhaps not so helpful from the NHS side.

10:00

Tom Arthur (Renfrewshire South) (SNP): From what has been said, it seems that the creation of IJBs is a process rather than an event. What are the limits of the current funding model in achieving the autonomy and independence that we all recognise IJBs require if they are truly to deliver on their aims?

The Convener: Who wants to go first?

Karl Williamson: I guess that it is a question of having good partnership working and being mindful that each organisation has its own efficiency targets to meet. I do not think that I can say more than that at this point.

Tom Arthur: Is it a limitation that partnership working will always come down to the individual partners involved, which means that there is likely to be variance?

Katy Lewis: I know from the experience that we have had in Dumfries and Galloway that the success of our partnership to date has been based

on effective relationships between our local authority and NHS partners. That is not going to go away as a result of what happens with the arrangements in the IJB.

We need to look at where the integration joint board sits in the current climate. In health, there has been a great shift towards looking at regional planning and how that is going to work. We need to be clear about where the decision making is done. Colin Smyth asked how we ensure that decision making is done in a locally democratic way. In Dumfries and Galloway, we have tried to delegate as much of our budgets as possible to our localities. We have reinforced our locality structure to get locality management. An important aim is communities having ownership of some of the service changes that we are making. For me, that is an extremely important strand of what we are trying to achieve.

Keith Redpath: I share Tom Arthur's view that the creation of IJBs is a process rather than an event. As I said earlier, we have been working on integration for a long time, albeit that the governance around that, along with other bits and pieces, changed in 2015, when the new legislation came in. We have been working on integration formally since 2010, although we have had integrated community care management arrangements since 2008, so we have been addressing the issue for a long time, and we have been able to work through many aspects of it.

I was the community health partnership director in West Dunbartonshire from 2005, and I now have a smaller management team to manage the totality of the IJB's business, which includes all of what was community health and all of what was social work. We have been making £0.5 million of savings in management costs alone for the past seven years, and there will be opportunities for others in that area. We have been through a process of establishing the trust and the relationships that are vital to making the system work. We would certainly advocate that, as Tom Arthur suggests, the model will evolve and develop as we go forward.

Tom Arthur: On the idea of moving to a direct funding model, the issue of democratic accountability has already been raised. What other challenges do you envisage would be faced in moving to such a model?

Katy Lewis: There are quite well-established resource allocation formulas for how health boards and local authorities receive their funding, so it would be necessary almost to start again with that, and the issue of equity and fairness would have to be addressed, which would be incredibly challenging.

Vicky Irons: I want to build on a comment that I think that Keith Redpath made and the comments about integration authorities becoming more independent bodies. There are a range of other things that we would need to consider, including the employment status of the people who work in the health and social care partnership.

At the risk of being slightly contradictory, I want to build on the comments of Katy Lewis about Dumfries and Galloway and say that, to date, our effort has absolutely been invested in building good, strong local partnerships through the localities, building relationships with the people who actually provide care and integrating that at the point of delivery.

I guess that there has been less focus on trying to create total independence of the new integration authority. That is the result of a range of issues, not the least of which is that we are part of the local authority and the local NHS board and have a series of interdependencies as a result. Many of the corporate services that we use are provided by the parent bodies.

Regionalisation was mentioned. Our experience over the first year of operation and into this year has shown that we have interdependencies to create beyond our own boundaries. There is now a greater requirement for IJBs to work regionally on the pressure points that we have. Our focus is therefore on building on our local partnerships and then creating the wider regional partnerships that we need to sustain ourselves.

Tom Arthur: Is it fair to say that the potential for integration is limited by the capacity for partnership between local authorities and health boards?

Vicky Irons: Certainly from my perspective, the effectiveness or capability of the approach is underpinned by good local partnership. I guess that the flipside is that the potential for integration is about the quality of local relationships. It is not necessarily about the systems; it is more about relationships, leadership and good local partnership.

Tom Arthur: The focus should therefore be on ensuring that we can get partnerships to work as effectively as possible, rather than on moving to a direct funding model.

Vicky Irons: I agree.

Ivan McKee (Glasgow Provan) (SNP): I thank the panel for coming. I want to get a bit more clarity on a couple of things, and you might or might not be able to help me. The first point is about the overall level of the budgets. I have seen comments in your written submissions about health boards being instructed to give you a flat allocation in 2017-18, in cash terms. However, if

we look at NHS Scotland budgets for 2016-17 and 2017-18, we see that, in cash terms, the total budget is up by £270 million or 2.1 per cent and, in real terms, it is up by £80 million or 0.6 per cent. The health boards are getting increases in cash terms and real terms, but you have commented that they are being told to give you the same allocation in cash terms. Are both points correct? If so, where is the rest of the money? Are health boards hanging on to it, for something else? What is the context?

Katy Lewis: On the overall numbers for health, £100 million from the health budget was directed into social care, as part of the settlement. In Dumfries and Galloway, £3 million of the funding that the health board received—part of the £270 million that you mentioned—has already gone across to the integration joint board, as part of the partnership. That is not counted in the number that we use when we talk about the cash-flat settlement, which left NHS boards with a relatively small uplift of around 0.4 per cent. That is part of the challenge around the level of savings.

Ivan McKee: You are saying that the money that you are getting is the local authority money that we talked about, health board money, which is flat cash, plus the extra £100 million, on top of that.

Katy Lewis: Yes. Integration joint boards got the flat cash and a share of the £100 million—

Ivan McKee: Has the £100 million come through the health boards or directly to you?

Katy Lewis: It has come through the health boards.

Ivan McKee: Okay. I am looking at the numbers for Dumfries and Galloway, which have gone up by £6 million between 2016-17 and 2017-18. You said that £3 million of that £6 million went to you, as part of the £100 million that went to IJBs.

Katy Lewis: It will be a combination of the full-year impact of the social care fund from 2015-16, the £3 million and any other ring-fenced funding that we have had through the integrated care fund and how that has played into the budget position.

Ivan McKee: So the model is even more complicated than it first appears to be.

Katy Lewis: Yes.

Ivan McKee: You have money from local authorities, money from health boards in flat-cash terms and, on top of that, other pockets of money coming through the health boards that are allocated specifically to the IJBs.

Katy Lewis: Yes.

Ivan McKee: Tom Arthur and Colin Smyth asked how the process will evolve. It sounds as if it is already creaking under the complexity, with add-ons and other bits and pieces being bolted on. I assume that the process will evolve, but is there a danger that it will become just too complicated?

Keith Redpath: I do not think so. It might appear so at first glance, but we are involved in it and we should at least understand how it works.

As we have said, we need to be clear about the specific additional allocations. I might be wrong—my colleague Katy Lewis can keep me right on this—but my recollection is that the £250 million for social care in 2016-17 was over and above any uplift that went to health boards, whereas the £107 million for 2017-18 is part of the health boards' total uplift. That is a slight additional complication but, as I said, we understand it.

I suppose that it goes back to your question about why it looks as though there is so little and what is happening to the extra money. In my health board, by the time the share of the £107 million flowed through to NHS Greater Glasgow and Clyde, I think that something in the single figures of millions was left of the uplift to cover all inflationary pressures.

Ivan McKee: My next question is on the concept of set-aside. We have talked about what you call large hospitals. My understanding of the definition is that a large hospital is one that covers more than one local authority or more than one IJB area. Am I correct? Is that how it is defined?

Keith Redpath: Not necessarily.

Ivan McKee: Okay, so a large hospital could be allocated to one IJB or it could cover several. From reading through our papers, it seems that the concept for how that money works—again, you can correct me if I am wrong—is that the hospitals need money to provide services that the IJBs need and the IJBs fund those through a transfer of resources. The health board has the money to start with but, rather than giving it to the IJB only for it to return the money to the hospital, the health board keeps the money and gives it directly to the hospital. Part of the hospital's funding comes through that set-aside process and part of it comes directly from the health board. Is that how the process works?

Katy Lewis: I suppose that it is fair to say that the set-aside piece for the first year of operation has been almost like a notional allocation. The health boards, in conjunction with the IJBs, have worked out the amount of resource to be allocated to the partnerships through their costing mechanisms, based on the services that are directed through the integration scheme, and with a view to looking at how that can impact on acute services. In Dumfries, we do not have set-aside budgets because we have all of our acute hospitals budget within that.

A piece of work is going on with the policy team in the Government and the chief finance officers network to look at how we can make that a bit more real. It is probably fair to say that, in the first year, it has not felt real to Vicky Irons or Keith Redpath, given how it impacts on the overall resources that the integration joint boards have, but the idea is to give the IJBs influence so that they can make an impact on the delivery of acute services in their regions.

Ivan McKee: That makes sense, because the whole point is to move the resources from acute services to the social care side. We started by discussing that. However, as you make that more real, it will throw up another problem. If people who are trying to manage a hospital are not sure where their money is coming from and they have to negotiate with several IJBs, it will become even more complicated, especially given that hospitals have big, fixed costs. Has any thought been given to how that is going to play out?

The Convener: Ivan, can I bring in Karl Williamson on that?

Ivan McKee: Of course.

Karl Williamson: In Shetland, the set-aside budget was passed to the IJB at the start of the year as part of the delegated budget. Because we have just one local authority and one hospital, we put in the full cost centres that relate to emergency care, so the moneys for accident and emergency, ward 3 and the medical doctors and consultants all went into the IJB. That allows the IJB to consider the whole system. If there were any funding decisions that impacted on the hospital, they would have to be carefully discussed by the health board and the IJB. That is where partnership working comes in. You would not expect funding to be removed without the proper process to ensure that the balance of care was being moved in the correct manner.

10:15

Ivan McKee: I understand that in Shetland and in Dumfries and Galloway, where you have that one-to-one alignment, you can sit down with one another and figure it out. I am more concerned about what happens in cases where there is a large hospital servicing several IJBs, how that is supposed to work when you start having real control over that budget and over deciding what you are or are not going to put into the acute hospitals, and how acute hospitals are supposed to manage themselves in that environment.

Vicky Irons: From the Tayside perspective, I endorse the comments that have been made about the reality in the first year. The first year has been more of an exercise to describe the large hospital set-aside. We articulated in our submission that we see building financial planning relationships regarding large hospitals as being a major area this year. In Tayside, we work largely with Ninewells hospital, which covers three of the Tayside IJBs but also has an impact on an IJBs in Fife, because of the flow of patients. We are approaching that this year through a round-table approach to planning, so it is probably not dissimilar to what colleagues from Shetland and from Dumfries and Galloway have articulated about whole-system planning for different components of care. Of course, we then have to back up the jointly agreed plans with the financial and planning mechanisms that are set out in large hospital guidance.

The major focus for us at the moment in Tayside is on unscheduled care and trying to change the pattern of demand and the costs of care associated with it, so that will flow through into our large hospital guidance and our strategic plans that will emerge over the next year.

Keith Redpath: The legislation requires the chief officers and the partnerships to collaborate and co-operate where there is more than one IJB in a health board area. In Glasgow, we have been doing that and we will continue to do it. We are currently developing our commissioning intentions, so we have worked collectively as a group of six to bring those intentions together and ensure that what one IJB is saying is absolutely consistent with what the rest of us are saying. That should allow us to make a co-ordinated ask of the acute system, rather than ask it to deal with six different arrangements.

Donald Cameron (Highlands and Islands) (Con): I have a question about staffing costs. The starting point for this question is to establish who directly employs the various personnel who operate the functions that the IJB controls. Is it the IJB, the health board or the local authority, or is it a mixture?

Keith Redpath: People who were employed by the health board to provide the services that have been delegated to us, such as NHS health visitors, district nurses or physiotherapists, will continue to be employed by the health board. In the same way, people who have been employed by the local authority as home carers or social workers will continue to be employed by the local authority. There remain two employers. As I said in response to an earlier question, the legislation is drafted so that we remain with two employers, but that is open to change at some point in the future and it is open for the IJB to become an employer. It is a bit like what has been done in Highland, where the single agency model involved a transfer under the Transfer of Undertakings (Protection of Employment) Regulations of all the adult care council staff into the health board, and vice versa

for health visitors and specialist children's services, which went to the council. This has been one of those areas where it helps to have co-ordination on simple things like public holidays or admin staff grades, where there are some inconsistencies.

I think that occupational therapists are the only professional group that has historically had employment in the NHS and in councils, although in reality the two groups have done quite different jobs.

The reality at the moment is that people are employed by one body or the other; the only employee of the IJB, technically, is the chief officer—in effect we are seconded to the IJB.

Donald Cameron: Thank you for clarifying that. An adult social care worker or hospital worker in Dumfries and Galloway, for example, who is doing work that is delegated to the integration authority will nevertheless be employed by either the council or the health board. Who bears the staffing cost? Does it come into your budget, notwithstanding that you are not the employer?

Keith Redpath: Yes.

Katy Lewis: Yes.

Donald Cameron: Is that true across the board?

Vicky Irons: Yes.

Clare Haughey (Rutherglen) (SNP): I thank the panel for coming along this morning. I am not sure when the IAs are expected to produce their annual financial statements. Will you enlighten me?

Vicky Irons: Ours is due to go to our IJB at the end of June.

Keith Redpath: Ours will go to our audit committee in the middle of June.

Katy Lewis: Similarly, we are preparing ours at the moment and it will go to our IJB at the end of June. We are also preparing the annual report for the IJB.

Karl Williamson: The draft accounts will go to the IJB audit committee and the IJB at the end of June.

Clare Haughey: Thank you. The Scottish Government's advice note to IJBs on their annual financial statements said:

> "Regulations require that the Report includes financial information on the amount spent on achieving the national health and wellbeing outcomes and the amount spent on care groups, localities and service type."

How will your annual financial statements address those issues?

Katy Lewis: Are you asking how we link the finances to outcomes?

Clare Haughey: Yes.

Katy Lewis: Our financial systems do not have the sophistication to provide the level of detail that is required. The financial statement is a fairly indicative cost-book analysis; it splits our costs across the various parameters of care—acute, primary and locality care.

My partnership has been having quite a big discussion about how we move the focus away from some of the performance indicators that we can count—some of the national stuff around the treatment time guarantee and accident and emergency waiting times—and link things more closely with the nine national outcomes. The performance suite that we have been pulling together starts to set up how we will do that, with more long-term, qualitative indicators.

The work that the partnership has been doing indicates that it will probably take a three to five-year planning cycle before we get information that really starts to show how performance is moving. We talked about the ambition to shift the balance of care; we really want a measure that enables us to see whether, over time, the integration joint board is making an impact on outcomes for patients. That is certainly our ambition, but it is still very early days—we have just had our first year of operation.

Vicky Irons: From an Angus perspective, the prescribed national outcomes underpin the overall strategic plan that we have set out and our approach to that plan, which is further rationalised into four domains of change and development. Locally, we have concentrated on getting our financial plans to map the intentions that are set out in the strategic plan—the financial plans will follow those intentions but at this point will not necessarily be easily definable against each of the national outcomes. I think that other areas will find it quite difficult at the moment to map financial resources against individual outcomes.

The main thrust has been to align our financial plans with the strategic outcomes that have been set out for our IJB, so the plan that will be put to our IJB in June will not only be a financial statement of expenditure and how the budgets have been used but show whether investment of those budgets has achieved any change against our strategic plan.

Clare Haughey: I am sorry—I am a bit confused. Does the strategic plan include the national health and wellbeing outcomes?

Vicky Irons: It does, but within that we have four domains of development, which we largely map the financial resources against. The strategic

plan incorporates the national health and wellbeing outcomes, but it has proved quite difficult to drill down to match the financial resources precisely with the nine national outcomes. I do not know whether the situation is the same elsewhere; I gather that it is similar across Scotland.

Karl Williamson: We are in the same position as Vicky Irons. We are going to try to combine the performance report with the financial statements to see whether we can begin to link the finances to the outcomes, but as far as detailed mapping between the finances and the national outcomes is concerned, we still do not have a sufficient level of detail. It is work in progress.

Keith Redpath: I share my colleagues' sentiments. Our approach is slightly different in that our financial statement is a technical piece of auditing and accounting work. We would look to take information from that and build it into the public report on performance in the way that others have described. I think that it will be an evolutionary process—it is one that we will get better at the more we do it. Through the chief finance officers network, we could probably all learn from one another with regard to how we develop that over time.

Clare Haughey: It sounds like you are very focused on figures and balancing the books as opposed to matching the numbers with the national outcomes. Is that because this is something new or because you have not had adequate guidance? Why have the figures not already been linked to the outcomes? Why will it be three to five years before we get that information?

Keith Redpath: It is a new legislative requirement. This will be first time that we have all had to go through the process, so I suppose that it is inevitable that there will be good and bad.

Some of the difficulties with matching have been explained—certain expenditure might match a number of the nine national outcomes. There is no doubt that we have been focused on balancing the books and making the most of the money, but doing the best that we can with the money is not inconsistent with achieving the national outcomes, because that is what integration is there to do.

I apologise, because I have used this anecdote previously. A long time ago, when I worked in another part of Scotland and money was a bit tight, I spent three or four years defining what the social work department did. The health board said what it did, and nobody cared about the person in the middle. For me, that is the biggest difference with integration—it is all about the person in the middle, and doing the most that we can with the totality of what we have. That involves managing the money and the resources to best effect across the piece, and keeping the focus on individuals who need services. That is what we are about.

Clare Haughey: How do you evidence that?

Keith Redpath: I do quarterly performance reporting to my IJB on some of the indicators that feed into some of the outcomes. We have just concluded our first full year, but we had nine months of using the new system in the previous year, and it has been an iterative process for us. We want to provide that evidence, and we want people to scrutinise it to see whether we are making a difference.

Vicky Irons: From an Angus perspective, not dissimilarly to Keith Redpath's organisation, we submit a quarterly performance report to the IJB, which aligns use of the financial resources with the strategic intent that is set out in the strategic plan. That is still work in progress. A major focus for us is to ensure that we invest the money wisely, to achieve the objectives that we have been set up to achieve.

10:30

The Convener: Is work going on to produce a standardised, auditable set of reporting mechanisms, to enable us to compare different health and social care partnerships?

Vicky Irons: There is certainly a national requirement to produce an annual report, but I think that interim reporting is at local discretion—my colleagues might know otherwise.

The Convener: So the answer is no.

Vicky Irons: There is a standardised approach to the annual report but not to interim reporting.

Katy Lewis: The nature of the national outcomes is such that they cannot be counted easily. Qualitative measures such as patient experience are such that there is, by default, a longer-term aspect to evidencing shifts in culture and changes in the use of services. I talked about a three to five-year timescale, which very much links with the outcomes that our partnership has set out in its strategic plan. At every integration joint board meeting, we have a financial update and a performance update, so that we focus on both measures equally and link our resource allocation with where we want our performance on the outcomes in the strategic plan to improve.

Clare Haughey: How readily available is the quarterly and annual information?

Katy Lewis: All our information is published on our local website. I am happy to share our performance reporting with the committee, if you want to see it.

Keith Redpath: Likewise, our performance reports are in our IJB papers, which are publicly available on our website.

Vicky Irons: The same goes for ours.

Karl Williamson: Ours are published on the website. In the quarterly performance report, we report against the nine national outcomes. Like Katy Lewis's partnership, we consider the performance report and the finance report together at each meeting. The performance report tells us how well we are performing against the national outcomes, and if we are staying within our financial plan, I guess that we are striking the right balance and implementing our strategic plan correctly.

The Convener: Do you then report back to the Scottish Government? Does it—or should it—produce comparative data?

Katy Lewis: The health and social care delivery plan outcomes that we need to report have been set out, but those are much more the traditional outcomes that you will be used to seeing from the NHS. We can take the issue back, because I am not sure what the intention is in that regard.

The Convener: Earlier, Keith Redpath talked about cuts, Vicky Irons and Karl Williamson talked about savings and Katy Lewis talked about efficiencies. If I got hold of the dictionary or thesaurus that is handed out to IJB managers and looked up "cuts", "efficiencies" and "savings", would I find the same explanation for each word? Are they the same thing in the lexicon of IJB managers?

Keith Redpath: Not always.

Katy Lewis: Not always.

The Convener: I imagine that, if your office bought 10 boxes of paper clips last year and you have eight left, there is an efficiency to be made. I understand that. However, in the big scheme of things, when you are asked to find significant sums of money—the big numbers—are those cuts, efficiencies or savings?

Vicky Irons: I can talk only about our approach to efficiencies—

The Convener: So yours are "efficiencies".

Vicky Irons: Well, yes, because they are created to achieve a reduction in spend and, sometimes, a more efficient way of working. For example, this year we have been through a major redesign programme for care that is provided to people at home, which has involved different shift patterns and ways of working, to increase the capacity of the existing workforce.

The Convener: You would be doing that irrespective of the financial situation, because it is a better thing for you to do, would you?

Vicky Irons: And it is an absolute requirement, if we are to keep up with demand.

The Convener: That is one example. What other examples do you have of efficiencies that are driven by financial need?

Vicky Irons: Well, I guess that there are a range of—in your words—cost-cutting exercises, which are, literally, about reducing expenditure.

The Convener: Would you describe those as "cuts"?

Vicky Irons: I guess that they are more efficient ways of working, so I do not tend to use the language around "cuts".

The Convener: I understand. I am very well aware of that, but Keith Redpath used the word "cuts" earlier. That was quite refreshing, because it is the first time that I have heard an IJB manager say that. Mr Redpath, with your long experience, are you having to implement cuts?

Keith Redpath: Having used the term, I cannot back down from it now. However, when it comes to it, we need to frankly call it what it is.

The Convener: Hallelujah!

Keith Redpath: From my perspective, maintaining flat cash is a much better position to have, and it means a more protected position than that in other parts of the public sector in Scotland. However, the question is whether it is flat cash across the year. Most of our controlled budget is for staff. If I have to maintain flat cash but the pay bill goes up, the only way I can manage that is to have a 2 per cent efficiency saving or slippage target, as I said earlier. Ultimately, that means that I will probably have to employ fewer staff at the end of the year than I did at the start of the year. There may be some aspects of efficiency and doing things a bit better that mitigate some of that, but the reality is that most people would recognise that as a potential cut to the level of service. That is why I used the term "cuts".

The Convener: Thank you.

Katy Lewis: I suppose that we will be doing a combination of things. We will be buying things more cheaply and doing things more efficiently, which is what would be classified as an efficiency. We will be doing a range of service redesigns that will change how we deliver services.

The Convener: Why would you not be buying things more cheaply and doing things more efficiently anyway?

Katy Lewis: We do. We endeavour to do that. We will always be looking at that as a way to make savings as we move forward. As I said, we will undertake service redesigns to meet the demands. We have been doing work to reduce delayed discharges and doing other work in our hospitals. We will change our services to meet the demands. There will be some things that we do that you might want to describe as cuts or budget reductions.

The Convener: Go on, just say it.

Katy Lewis: We might just stop doing some things. For example, we might stop prescribing something. We are looking at whether we have a balance in terms of value for money for some things. As a chief finance officer, I am aware that we have to look at our resources across the piece and look at the population that we are providing the services to. There is no doubt that some difficult decisions will have to be made within partnerships. We have not shied away from that.

Karl Williamson: We are also trying to redesign services to do more with less, such as moving from residential beds to services in the community. The difficulty is to convince the public that we are maintaining the level of service if we are reducing costs. Ultimately, as budgets keep getting reduced, we might get to the position where we need to make cuts and reduce services. In Shetland, that might mean moving more medical procedures to the mainland and moving towards more regional models. At the moment, we are trying to drive efficiencies. Ultimately, though, we could come to the stage where what we do would probably be classed as cuts.

The Convener: I wonder whether the delay in agreeing budgets has any implications for day-to-day budgeting for people on the front line—or do they largely just get on with it and let you guys worry about that?

Keith Redpath: Yes.

Katy Lewis: Yes.

Alex Cole-Hamilton (Edinburgh Western) (LD): Good morning to the panel. I want to explore the convener's question on cuts and efficiencies a little further. Having worked in the social care sector for the best part of 15 years, I understand that efficiencies do not always mean cuts. I remember being told to box clever in terms of travel and told that people should more frequently take part in meetings in the way that Karl Williamson is doing today from Shetland, which is an efficiency and reduces a significant burden for any organisation's budget. However, we can move to the point where making efficiencies means that the things that we used to deliver are no longer delivered. That is a cut; it is when the service user at the business end of what we are doing no longer gets the value of that service.

We could debate the semantics, but I want to explore the quiet death of services when it is nobody's fault. I will give an example. The 20 per cent reduction in funding for drug and alcohol partnerships that came through in the budget 18 months ago has been perpetuated in this year's budget. In effect, that 20 per cent cut was passed on to IJBs, which were told to find a way to continue doing what they were doing, but with less money. To their credit, some authorities, health boards and IJBs have managed to do that, but in Edinburgh, for example, there has been a net reduction of £1.3 million a year in funding for drug and alcohol services, and some services have ended as a result of that.

Why do some authorities manage to continue such services when others do not? Why is no fuss made about it when that happens? It seems to me that that is the point at which it is nobody's fault—we lose services, but nobody seems to be to blame for that.

Keith Redpath: My recollection is that, last year, there was a change in the way in which such expenditure was accounted for. As you say, there was a significant reduction in funding for drug and alcohol partnerships, along with a desire for their work to continue. My health board ensured that it did. We made some efficiencies at local level. We discussed how to do that with our main voluntary sector providers and with our own staff. My recollection of our share of the cut is that it would have been a hit of about £300,000 on a budget of £3 million or £4 million. We made a number of changes that resulted in £100,000 being taken out of the budget. We did that by working in conjunction with our two major providers and by cutting our own direct provision.

As the chair of the alcohol and drug partnership in my area, I know that that was certainly not hidden. We did that in a very open and transparent way. In an ideal world, people would have liked it not to have happened, but we were able to do it in such a way that we and the providers continued to provide the most significant services.

Alex Cole-Hamilton: I am grateful for that. The issue of ADP funding is one that has been raised persistently in Parliament by the convener and me, and others, because we are not keen to give up on it without a fight. We have looked to health boards and IJBs for support in that fight. Some health boards have managed to do as Keith Redpath's has done, but some have said that there is nothing that they can do and have just reduced the funding.

My frustration is that that has happened and it seems that we are just expected to accommodate

it, even though we can see a correlation between the reduction in services and a spike in HIV infection in Glasgow. There is a causal link between the two, although we do not yet have empirical evidence on how causal the link is. Services that were keeping people safe are no longer doing so to the extent that they were.

I just wanted to put that point on the record.

The Convener: We will finish there, as we have gone a bit over time.

I thank all the witnesses very much for their evidence. I understand that Keith Redpath is retiring in the summer, so we put on record our thanks to him for his contribution on health and social care over a long period of time.

Keith Redpath: Thank you, convener.

10:44

Meeting suspended.

10:48

On resuming—

NHS Governance

The Convener: The second item on our agenda is our first evidence session in our inquiry on NHS governance. Today, we will look at staff governance.

I welcome to the committee Donald Harley, who is deputy Scottish secretary of the British Medical Association; Ros Shaw, who is a senior officer with the Royal College of Nursing Scotland; Kenryck Lloyd-Jones, who is public affairs and policy manager for Scotland for the Chartered Society of Physiotherapy, and is a representative of the Allied Health Professions Federation Scotland; Matt McLaughlin, who is secretary to the health committee of Unison Scotland; and Claire Pullar, who is the national officer for Managers in Partnership. We sought a representative from Unite the union, but it was unable to put someone forward.

I declare an interest as a member of Unite the union.

We will move directly to questions, the first of which will be asked by Colin Smyth.

Colin Smyth: Good morning, panel. What role does staff governance play in delivering an effective workforce? How would you rate the NHS's performance on staff governance?

The Convener: Who would like to go first?

Donald Harley (British Medical Association): I am happy to do so.

I put on the record that we are fully committed to the staff governance arrangements in Scotland and that the ideals that underpin them are very good, but there are definitely functional areas and probably board areas in which there are marked differences between the practical reality on the ground and the ideals in the standard.

We want to flag up three main areas. First, Scotland has a proud record on engagement and involvement. A recent study by the University of Nottingham gave Scotland high marks for its arrangements but, in practice, engagement oftentimes does not fulfil the function that it ought to fulfil. There is an element of rubber stamping in that fully formed ideas are brought to be validated rather than staff being involved from the bottom up.

Medical staff, whom I am representing today, find it particularly hard to be released for engagement, because it is not easy to provide cover for them. That is a long-standing issue. As finances become tighter in the NHS, it becomes

even harder to release medical staff, and it requires planning and foresight. Typically, six weeks' notice is required to release a consultant, and somebody must cover for them.

Monday is the busiest day in practice, particularly for general practitioners, but also in clinics in hospitals, yet all too often we see joint arrangements being organised for Mondays, which effectively—unintentionally or otherwise—excludes medical involvement in engagement. We thereby lose that practical front-line experience and the chance to improve services from that perspective.

The second area that I want to highlight is the raising of concerns. You will have read a lot of stuff in the written evidence about how effective the arrangements are for raising concerns in general. I will not rehearse that, but I flag up that there is a particular unique situation with regard to junior doctors. Their training programmes are controlled by NHS Education for Scotland, which therefore exercises considerable power over their access to—

The Convener: We will discuss the concerns that are being raised across the piece, so you could maybe hold fire on that for now. Is that okay?

Donald Harley: Okay—I am happy to do that.

The Convener: Thank you.

Matt McLaughlin (Unison): The staff governance standard is a clear ideology that was developed through partnership between trade unions, the employer and the Government of the day, and a lot of people invest a lot of time and effort to try to make sure that that continues, but that ideology or principle is starting to feel the strain, partly because some of the people who crafted it have retired or left the service, but also because of continuing budget pressure, which does not help.

It is easy to do partnership working in staff governance in a period of growth, because there are good things to say to people, but it is much harder to do it in a period of retraction and change. That is affecting current performance, particularly as middle managers feel squeezed to deliver. We hear lots of stuff about ticking boxes and consuming your own smoke. That kind of mantra starts to feed through; in the past, people were much more inclined to try to engage and talk positively, and they had the time, energy and space to listen.

In their submissions, colleagues have discussed the need for training of middle managers. That is a good thing to identify and focus on, because it is a key issue.

A more recent analysis was undertaken by the Pennsylvania State University—I think that it is in the system somewhere. It speaks highly of partnership and, in particular, the staff governance model, which is unique to Scotland's NHS. The interaction and interfaces in work in the integration joint boards are challenging that partnership agenda because another big complex beast is involved in the joint boards, and it does not necessarily have at its heart that commitment to staff governance. That needs to be worked through a bit more.

However, generally speaking, the report card would say that things are ticking along nicely, but a bit of focus is needed.

Ros Shaw (Royal College of Nursing Scotland): I agree. The staff governance standard in Scotland is strong. The tripartite agreement between the Scottish Government, the employers and the trade unions works well at national level, but we would question how aware of it staff on the ground floor are. They become aware when something happens, such as when there will be an organisational change in their area and they suddenly have to become aware, but all three partners in the tripartite agreement struggle to ensure that they get the positive messages out. Some really good work is done in staff governance and engaging with the trade unions, but that message does not always get out to staff.

It is often extremely difficult for nursing staff to engage actively because they are under immense pressure. We all know how busy the clinical areas are in the hospitals and in the community. There are huge vacancy levels in the community and hospitals, which puts incredible pressure on staff. In addition, the complexities of patients are so huge that it is difficult to get staff to become actively involved. Therefore, I question whether staff governance is working as well on the ground floor.

Kenryck Lloyd-Jones (Allied Health Professions Federation Scotland): I echo some of those last points. We are pleased that the partnership agreement in Scotland is a good and positive model that has worked. Obviously, it will feel greater strains when budgets are tight.

I will add something from the perspective of allied health professionals. AHPs feel a little more disadvantaged in that, traditionally, there is at local level no backfill for them to take on roles that do not directly deal with patients. Therefore, in order to engage, they often have to cancel appointments. That is the reality, but it is not the case in other areas, where cover is arranged. In addition, continuing professional development courses have to be paid for by allied health professionals themselves. Funding is not often

made available for CPD, and their ability to be released for it is restricted.

In many ways, the allied health professions feel somewhat disadvantaged in the overall picture.

Claire Pullar (Managers in Partnership): I agree with my colleagues that the tripartite agreement is good and strong, but it is not always delivered to all the employers and it does not cascade down through them. The work that is done at the tripartite level therefore does not always reach the people who work in the NHS.

I agree that governance is time consuming. That relates not just to reorganisational change, but to grievances being raised and to complaints and disputes between colleagues, which can take years to sort out. When we go through governance, we should ask what we want to achieve by using that framework. If we use a framework for reorganisational change, for example, we know why we are doing it: we know that there will be a change, that there is a business model to consult on, and that we need to take on board staff and stakeholder views to ensure that the right end point is reached.

However, in staff governance, when I represent a senior manager, I will often ask somebody who has raised a complaint, "Has anybody asked you what you want to get out of this?" More often than not, the answer is no. I will say, "Well, what do you want to get out of this?" and they will say, "I'd like an apology, and I'd like it not to happen again, but I don't want the senior manager to be suspended for 18 months while somebody else does an investigation and I have to bring all my colleagues through as witnesses."

Because we have good staff governance and we work well together, it would be useful sometimes to stop and take stock, review what we are doing, and ask whether it is time to evolve what we are doing, whether there are other things that we can put to one side, and how we can reintroduce skills that have been lost, such as talking to one another, rather than putting in a grievance when we feel a bit ticked off with one of our managers.

11:00

The Convener: I am sure that colleagues have met constituents who work in the health service and have a particular issue. They often come to us because they cannot work through the system. My perception is that the person on the ground floor will have been completely unaware of an arrangement or a deal that was struck or whatever at the level of the tripartite arrangement, and they will have asked, "Who agreed this? Who told us about this?" They will then have gone to their MSP for representation. They might have gone through their staff representative or union to try to get a solution, but they will have been unaware that somebody up there has agreed a course of action. I certainly find that in my constituency casework.

Matt McLaughlin: You have hit on a fairly significant challenge in the partnership arrangements. I smiled when you mentioned it, because I remember having a long discussion with Clare Haughey when she was a Unison shop steward—let us bear in mind that shop stewards are part-time volunteers who do a professional job as well—about getting sucked into the machinery of meetings.

I am sure that all members appreciate that meetings can become their own industry and that, in those circumstances, it can be difficult—when you have political directions from chief officials, local chief officers and local managers, who all tell you that we need to make a change—to make a space and place for the shop steward to have what we called in the old days a shop meeting: to go into a workplace and have a chat with colleagues. Now, a lot more is done electronically and through bulletins and flyers. As politicians, you will know that, in your profession, you can write to people until your hands fall off but, if they do not read or comprehend what you have written to them because they are busy with real life, that can be a major challenge.

We also need to recognise that, when we have localised change agendas, a space needs to be made for that interaction and a commitment needs to be made to that. There are a couple of things that challenge that a wee bit, and we are seeing more of that. Staff governance does not mean we cannot disagree. Again, I recall the conversations that Clare Haughey and I had when she was a shop steward. You can go into a meeting about an arrangement and say, "I'm sorry, but we don't agree with that," and then work through a mechanism to try to reach agreement, but people still have the natural traditional industrial methodologies available to them if we cannot get that consensus.

We should look at the number of employment tribunals that are lodged against NHS employers in Scotland, if we strip out equal pay. They compare favourably with those in every other industry, including local government, the voluntary sector and the private sector. There is a reason for that. Albeit that the machinery moves at a pace that we sometimes would not recognise as progress, there is always an opportunity to get through the staff governance and partnership routes to solutions to problems. We collectively use that with the employers and colleagues in Government to our maximum benefit. That is a key measure of where we are.

Maree Todd (Highlands and Islands) (SNP): How easy is it to raise concerns or to whistleblow if you have concerns about a colleague's practice? I worked for 20 years as a clinical pharmacist in a psychiatric hospital. My perception is that over the course of those 20 years, from the mid-1990s until recently, there was a transformational change in how easy it was to raise concerns about other people's practice or about other practices that we witnessed in the hospital. Does that reflect a national trend, or is that just my experience?

The Convener: Claire Pullar is shaking her head vigorously.

Claire Pullar: Yes—I am shaking my head. My organisation does not have reps; we have link members, so I have people I can contact directly to answer questions for me. I have some evidence with me from senior managers who say that they have never had anybody raise concerns through whistleblowing, and that it has not had a particularly devastating impact on them personally, either in their career or in their relationships with colleagues.

Whistleblowing is a vital part of staff governance and of how we safeguard our interactions, but judging from what our members say, senior managers think that there is still blame attachment when someone has the temerity to raise concerns through whistleblowing. The attitude is, "How dare you?" There are other routes to use, and whistleblowing is viewed as an undignified way of doing things. However, we need whistleblowing and we need people to feel safe in whistleblowing. I do not think that they do.

Donald Harley: In the medical field, raising concerns about a colleague is both a professional and a personal issue. For a doctor, professional reputation is all, so a slight to that is a real wound: it is felt. People tend to react against that. A toxic reaction can often be seen when a person's practice is held up to question.

In the medical field, it is not necessarily a matter of raising concerns, as people might understand it in terms of whistleblowing; it might be that the person is referred to the General Medical Council, and it would be for the GMC to take appropriate action. You then get into a tit-for-tat thing. The person might react by saying, "How can they accuse me? They're not exactly blameless, themselves," and so on.

I am not sure whether this is the time to mention this. You said, convener, that you were going to discuss raising concerns in more depth.

The Convener: Please carry on—it is fine.

Donald Harley: In their day-to-day practice in the health service, medical and clinical professionals see things that they are not comfortable with, but it is always tricky if they want to raise concerns. If the concern is about their employer, they have protections at law, but, as we have seen and as the committee will have read in the testimony of various individuals, those protections sometimes do not amount to much. Relationships and careers can still be destroyed even with those protections in place.

As I was starting to explain earlier, junior doctors are in a unique position, in that they are in a power relationship with NHS Education for Scotland, which controls access to and retention on its training programme. If the relationship with NES goes wrong and a junior doctor falls out of its training programme, that person has de facto lost their job and career, too. They have no protection against the actions of NES. That is not to say that NES is a bad organisation. Clearly, it is not—it is a very good and important organisation—but such things happen from time to time and from place to place. Arrangements have recently been put in place so that Health Education England provides those protections for trainee doctors within their training relationship. So far, however, NES has not been willing to pursue similar arrangements here, so junior doctors are probably even more reticent to raise concerns if their doing so would put their training relationship in jeopardy.

Ros Shaw: There is a big difference between raising concerns and whistleblowing. Our members come to us daily to raise concerns, usually about staffing levels, but it is early days with regard to seeing how the legislation on whistleblowing is going to work. I was at the Lothian area partnership forum yesterday, and it reported to us that it has had nine cases go through the whistleblowing policy since September last year. It has investigated those. A number of them were anonymous, which makes it difficult to feed back and get further information. People are now very aware of the whistleblowing legislation and the policy. A lot of work has been done with regard to that—certainly in the health boards that I cover.

It is always difficult for a person to put their head above the parapet and raise a concern. However, as with the BMA and our AHP colleagues, our members are in a regulated profession, so they are bound by their own code of conduct. If they see anything that puts patient care at risk, they have an obligation to raise it, and we always support and encourage our members to do that because we are about patient safety and quality.

Kenryck Lloyd-Jones: Clinicians have a duty of care and must look to that and to their code of conduct if they have serious concerns. The difficulty is, as we have said, that whistleblowing is about revealing something that has perhaps been hidden, whereas people's concerns are

sometimes about whether the quality of a service is suffering. At what point does that become whistleblowing? At what point does a service become unsafe? That is not always clear. The various professional bodies of the allied health professions are there to support and advise members on that but, of course, that relates to particular circumstances.

Whistleblowing is often seen as relating to headlines and scandals rather than as a run-of-the-mill way in which people can raise concerns where the quality of a service is being diminished.

Matt McLaughlin: I will be brief, convener, as I appreciate that you are busy. Whistleblowing is an emerging issue, but Unison's position is clear: we believe that the NHS has the machinery to deal with it. The Datix system that exists across the NHS in Scotland is a very good and principled system. What people do not get is feedback when they make a referral or a report at local level when there is something that they are not happy about. Colleagues have spoken about the need for professionals to reflect on things, which is also key.

At senior level, the NHS can be quite defensive and risk averse. A hierarchical macho culture exists in some places—almost right from the top, I have to say—and it quashes any ability for the service to properly reflect on and deal with genuine concerns in a sensitive and sensible way, so we get conflict and differing positions, which do not help. However, it is important to say that the machinery is there. It is about people investing in that.

The Convener: Some of us who were here when the Lothian waiting times scandal emerged saw exactly that culture.

I ask Claire Pullar to be brief, because we need to move on. We do not have a lot of time this morning, so I ask people to keep their answers pretty snappy.

Claire Pullar: Employees in the NHS are aware that, following the Francis report, they have a duty of candour to raise concerns, which will not always lead to whistleblowing. As we have pointed out, they are two different things. The question is how to balance that in a system that is often risk averse.

Maree Todd: I want to ask about an issue that is frequently raised with me when I am out meeting folk who work in the health service—the quality that is provided by locum and temporary staff. There is probably a much better system in place for managing people who are employed by the NHS. Is the system robust enough to manage people working in the NHS who are not permanently employed by it?

Matt McLaughlin: In the interest of keeping it snappy, I say simply that any organisation or system that relies on bank or temporary workers will have difficulty driving staff governance and quality; we have a lot of areas in which we are wholly reliant on bank or temporary workers. We would be absolutely delighted to work with the committee to resolve that.

11:15

Alex Cole-Hamilton: I am glad that Maree Todd mentioned raising concerns. She described her experience as a clinical pharmacist. I am sure that the environment for raising concerns has transformed because there are far more concerns to raise, not least on workforce planning, delays and blockage, particularly at the social care end of the spectrum, which leads to interruptions in flow throughout the NHS.

We are talking about two different things. It is okay for staff to raise concerns at the macro level—we see that and I get doctors in my surgery all the time raising concerns about the macro level—but whistleblowing is an intensely personal thing. We have seen from staff surveys across the workforce that staff have no faith in current whistleblowing structures. They are not convinced that they will be believed, that action will follow and that there will be no recriminations. How do we change that? If there is bad practice in the NHS, we need to root it out. If there are individuals at any tier who are responsible for bad practice, we need to address it, but if there is no belief in the system, we can never do that.

Ros Shaw: What we need to do goes wider than staff governance. We need to ensure that the culture that is set by the people up at the top is supportive and enabling. Unless we have that throughout the health service, staff will not feel confident that they would be supported if they raised a legitimate concern.

Claire Pullar: We have to enable people to understand that there will be no blame. We have to emphasise the fact that they not only have a duty of candour; they also need to be mindful of emotional intelligence and ask themselves how best to raise an issue.

Many senior managers have clinical or professional backgrounds and are aware that, in that part of their identity, raising concerns would be considered to be a slight, as Donald Harley mentioned. Therefore, we need to reset how we talk to one another in the NHS so that we do not accuse one another of doing things or blame one another, and so that we certainly do not blame people for raising concerns or for whistleblowing. Things usually get to the whistleblowing level only when people who have tried to raise concerns

have not been listened to. We need to reset from the top down; that is, from the political level all the way through to everybody who has any interaction with the NHS. How do we take national pride in working together, put blame to one side and seek understanding? That is the way forward.

Donald Harley: In the governance arrangements, we set great store by a constructive approach being taken to resolving concerns that are raised and working within teams in boards. As has been expressed here, and as was shown in the most recent staff survey, there is a significant lack of trust that concerns will be acted upon. It is not possible just to wave a wand and make people trust in arrangements when they perceive that there is a vested interest in bad news stories not being exposed and reflecting badly on the organisation.

Although there is a responsibility on all of us to do what we can to support the existing constructive internal arrangements, there needs ultimately to be an impartial appeal arrangement that can oversee that. It was always likely that people would see the flaw in the helpline that always refers people back to the internal arrangements, so there is no escape from the inward-looking way of addressing things. There has to be a degree of proportionality about that so that people do not always escalate matters. There needs to be a mechanism to judge whether it is right and proper that there should be an appeal, when it is safe to leave an issue where it is and when it is appropriate to have somebody who is impartial cast a second eye over the matter to say whether the issue is not best practice.

Alison Johnstone: You said that there is a need for "an impartial appeal arrangement". You are probably aware that a petition has been submitted to Parliament that calls for the establishment of a new national whistleblower hotline. Do you think that such an independent organisation would be beneficial? I see Matt McLaughlin shaking his head.

Matt McLaughlin: Our evidence on that matter is fairly well established. We do not support the view that money should be given to the private sector to develop a call-centre hotline on such issues. There are problems with governance, and the idea of a whistleblowing ombudsman is much more sensible and constructive, and would deal with the appeals issues. The ombudsman approach has worked in other sectors; it would work better than just handing money to a call centre somewhere.

Alison Johnstone: Is that view shared by the rest of the panel?

Donald Harley: Yes.

Ros Shaw: Yes.

Kenryck Lloyd-Jones: I am not sure what evidence there is that the availability of a hotline would mean that people would have a motive to call it. I wonder about the circumstances in which that would happen.

Alison Johnstone: My next question is directed at Ros Shaw and Matt McLaughlin. In its submission, the RCN highlighted that integration authorities do not operate the same partnership model as is operated between the NHS, the Government and the unions. Unison noted that integration means that

"health services and workers find themselves managed on a daily and strategic basis by non-health professionals. As a result there is a need ... to ensure that there is no dilution of the standards for affected NHS workers."

Could you expand on how staff governance has been affected by integration?

Ros Shaw: It is early days, in that the structures are just beginning to be set up and developed.

In the integration authorities, our members from the NHS are still employed by the NHS, so although they might have a manager from the council, which will have a very different culture of working with the trade unions, it would be fair to say that our members would always be able to go back through their professional structures, because they have professional accountability to the NHS. However, we are keeping a very close eye on the issue, because we have concerns that the same partnership arrangements are not in place for our members.

Matt McLaughlin: I have three quick points to make. There is significant potential for confusion when someone who understands and is steeped in one culture and one set of rules of engagement is managing a group of people who have a different culture and different rules of engagement.

I will give two quick examples. In recent months, the IJB leads in the NHS Greater Glasgow and Clyde area have decided that it would be a good idea to slash the school nursing budget by more than 50 per cent, without having referred to the staff side at a high level, let alone at a local level. That runs contrary to the work that we are doing with the Scottish Government in a host of areas on getting it right for every child. There is a major issue there in respect of the big staff governance picture. We are having to fight a rearguard action on that.

Last week, I met a group of workers who had been transferred from Parkhead hospital to Stobhill hospital. They had a clear set of shift patterns and clear contractual entitlements. A colleague from another organisation who sits above them in the hierarchy structure decided that they should be issued with a 90-day notice of change for their hours of work, their place of work

and their working arrangements. That is just not how we do things in the NHS. That generates hours of work for poor old me over a long weekend because people are rightly upset.

We are not getting it right at that level. Because of the nature and construction of IJBs, the potential exists for there to be a wee bit of a culture clash. We could do with some guidance from the Government and the health department on how things should work.

Claire Pullar: I agree with Matt McLaughlin and Ros Shaw. In Managers in Partnership, we have members who are expert managers in health. They have MScs and PhDs, and they have got to where they are in the profession because they have the knowledge, the credibility and the ability to do very difficult jobs.

They are then line managed by someone from the local authority who does not understand that part of what they do and who thinks, "Can I save money through, say, organisational change or spending your money in a different way?" If one of our members tries to explain the risk to their non-NHS manager, their explanation is not seen as credible and is not understood. We then find that the framework of governance—which we have all spent a lot of time establishing, which sets out the correct steps and which gives us a core point of understanding that we can go to and say, "That's our starting point: that's what we follow"—gets put to one side, and we end up with a bit of a mess that a lot of people have to spend a lot of time sorting out.

Alison Johnstone: That sounds frustrating.

The Convener: Presumably, that could be a two-way situation.

Claire Pullar: I imagine that someone from a local authority would say the same thing.

The Convener: Absolutely. Do you want to come in here, Donald?

Donald Harley: I will come in briefly, convener. Although we support the idea of integration, we have a number of concerns about how it is applied. For example, as far as medical staff are concerned, employee involvement and engagement are just not happening. They are barely happening for primary care staff and general practitioners, and not happening at all for secondary care doctors. People might say, "Oh, we speak to medical directors and others at that level", but they are not talking to operational doctors who deliver the services. In planning services and doing what integration is meant to do, which is to link things up and have smooth systems across health and social care, they are not involving the doctors who are doing the delivery, so they could be setting themselves up to fail at an early stage.

Ros Shaw: In 2014, we lobbied to have a nurse board member on every integration authority. We have recently done a bit on work on some of the decisions that are being made on community nursing, and unfortunately we have found that some of them are being made without the involvement of the nurse member on the board. That is extremely concerning for us. The Government's 2020 vision is all about transferring care into the community and ensuring that we have the right number of nurses and other healthcare professionals out there. However, we have a massive number of vacancies in the community at the moment, especially in district nursing and, as Matt McLaughlin has pointed out, school nursing—in fact, we are aware of the example that he referred to. I know of another example in, I believe, the Glasgow area of band 8A senior managers being stripped out of clinical decision making without there having been a great deal of consultation, and those are the people whom the nurses on the front line—the healthcare support workers, community staff nurses, district nurses and health visitors—go to for professional support and advice.

Kenryck Lloyd-Jones: I will add that we did not get legislative specification that allied health professions be represented on IJBs. Of course, an allied health profession representative would represent 12 professions; the specific things that those professions have expertise in and knowledge of will not be well understood, so even that has to be co-ordinated by the AHP representing all of them. Cutting that out from IJB decision making and lacking an understanding of the contributions that are made by those services can lead to significant gaps or less good—and sometimes bad—decision making.

Clare Haughey: On Donald Harley's point about doctors' voices not being heard at IJB level, does the BMA feed into staff-side representation on the IJBs? Are you speaking from a trade union or a professional point of view?

Donald Harley: It is both, essentially. I will say, at the risk of repeating myself, that we had hoped that people who are involved in clinical decision making at local level would be engaged by the IJBs, but our members say that that is not happening.

Clare Haughey: Why is that not happening? Should professional points of view not be fed through the medical director, and should trade union points of view not be fed through the staff-side representative who sits on the IJB?

11:30

Donald Harley: It is more complicated than that, to be honest.

Clare Haughey: I do not understand the point that you are making.

Donald Harley: I am not sure that we have the time today to go into detail.

The Convener: Maybe you could write to the committee to provide the detail.

Donald Harley: Yes, I could do that.

Clare Haughey: That would be fine.

The Convener: We have held informal sessions with front-line staff and with middle managers in the NHS. The themes that came across were that the system is under massive pressure and people are feeling the heat from their managers and the managers above them—and ultimately from, I presume, the Government and Parliament, where targets are demanded and budgets are placed under huge pressure. We have had a debate about budgets this morning.

That seems to be creating a culture within the system in which people are afraid and intimidated. They feel unable to raise concerns or are frustrated about what happens when there are concerns. Is that a reflection of the system that you are working in at the moment, or is that an exaggeration?

Matt McLaughlin: NHS workers are no different from any other group—

The Convener: I suppose that I am asking whether the pressures are now greater than they have ever been.

Claire Pullar: Yes, they are.

Matt McLaughlin: The pressures are being felt more keenly than they have ever been. Some of the issues that you have heard about—staffing levels, the culture and people having to do more for less—feed into that, particularly given that we have an ageing workforce and an ageing community in which the demands on people have become greater.

However, that argument can sometimes be overstated a bit. People need to take some responsibility for their own lives globally. In my view, everybody should be a political activist and a trade union activist. People can certainly work more positively with their trade union colleagues. If they are unhappy, I would encourage them to be active rather than passive trade union members, because that is how we will get the message through to your good selves and to others. It is tough, though. It is hard, and people are feeling the pressure.

Ros Shaw: I agree. It is tougher than it has ever been, and the budget pressures are immense. It would be remiss of me not to mention the fact that healthcare professionals and nursing staff have had a loss of earnings, which has impacted severely on the numbers in the wards. Members are coming to us and saying that they are demoralised and lacking motivation because they have had a pay cut of 9 to 14 per cent in real terms. That is significant, and the situation is the same across the whole public sector. It is also coupled with absolutely massive workloads that are leading to stress and fatigue. People are taking on extra hours, through bank and agency work, in order to make ends meet. All that means that people have their heads down—they are working—and it is hard for them to engage.

I agree with Matt McLaughlin that it would be great if all our members were active members. However, when someone is exhausted through working extra hours but relies on their unsocial hours payments to make ends meet, it is really tough. It is a really difficult situation at the moment.

Kenryck Lloyd-Jones: The reality for many front-line members is that they just do not feel empowered to change the situation; they are told, “This is the situation,” and they have to suck it up.

Claire Pullar: I agree with my colleagues—especially with what Matt McLaughlin said about people needing to take more responsibility. Often, when people raise concerns with me or when I represent one of our members, people will say that such and such a person tried to make them feel a certain way. I ask what makes them think that the person would want them to feel as bad as that and whether we could have a sensible conversation about what happened. Do we have to go down a grievance or a complaint route whereby witnesses are brought in and everyone is upset? That approach adds to the pressure, and there is a lot of pressure in the system at the moment.

Ros Shaw referred to members having to use unsocial hours payments to make up their pay. Our members do not have that option but are absorbing more and more stress. When I recently engaged with members, I asked, “What do you want me to do for you?” and they said, “Just protect our time, because we’re exhausted.” Many middle-management roles have been stripped out, which puts the interface between senior managers and junior managers between a rock and a hard place. There is no give or support, but there is a lot of blame. People feel that they cannot say no, so some members are in the workplace before 7 o’clock and leave after 10 o’clock. They work three or four hours on Saturday and Sunday, to the detriment of family lives and their physical and mental health. They are giving more and more, yet they are getting more and more blame.

We talk a lot about front-line services but not about our members. When a new hospital or clinic opens, a politician stands with people in uniform, but those who manage the laundries and the catering and those who project manage new builds and keep within budget are nowhere to be seen. They are personae non gratae because they do not wear a uniform. We have a direct discrimination system in which people do not feel valued.

Returning to the subject of rumours, there are loads of them. They start from the top and spread down, beyond the NHS, including to think tanks. On Friday, I got an email from a member that is relevant to the point that Alex Cole-Hamilton made at the beginning of the evidence session. It said, "Can you please tell me that the rumours that all the alcohol and drug partnerships are being binned are not true? It is my job—the service that I deliver through integration with the local authority." At 4 o'clock on a Friday afternoon, an entire team thought that they would have no jobs in three or four months' time, and the people who receive support from that group had a weekend with the rumours and no access to support.

There is greater pressure and less money. People are in a pressured system and need to be able to ask why someone is trying to upset them, if that is what they think, how to reality check their perceptions and who is part of the team. People such as non-uniform-wearing staff feel left out. We must cut down on gossip and rumours, because they are profoundly unhealthy.

Clare Haughey: Section h on page 2 of Claire Pullar's submission says:

> "There is widespread belief that NHS will crumble without the ongoing contribution of its international staff. As one member told us: 'The anti-immigrant culture in the UK at the moment is hugely embarrassing and personally hurtful.'"

I ask the panel to comment on the pressures that the current situation in the United Kingdom around Brexit is causing for our NHS staff.

Claire Pullar: I imagine that all the panellists will have something to say on that. The situation is unpleasant, and there is a spike in people seeking support. They feel that decisions are being made against them because they are not seen as part of the future team or workforce. Naturally, it is assumed that they will not be here. They are asked, "Why are you still here?" and told, "You should see the writing on the wall—you are not wanted," although they are also told, "We want you to work here," and, "If you were British, it would be fine." Those attitudes are permeating, and newer casework is presenting for me.

The Convener: Does anyone else want to comment briefly? We do not have a lot of time left.

Kenryck Lloyd-Jones: In physiotherapy, we have international students who have studied in the Scottish system, have qualified as physiotherapists and now work in the NHS, where they can work for two years following graduation. After that, they have to work above a certain threshold or they can no longer work in the NHS. At the moment, that threshold is set at about £35,000, which means that a band 6 physiotherapist does not qualify.

We have a few situations in which consideration is being given to ways in which such staff members can be kept on, but they simply cannot be kept on, because the rules say that it is not possible. That is at a time when we are having trouble filling vacancies in many areas, and the biggest impact is often in the rural areas and the small teams. We have concerns, which we have voiced, about the current arrangements for non-European Union people—for example, I know of a case involving a Canadian-born person. There is a large question mark over where we will be with EU workers in the future. If that approach were to be applied to EU workers in the NHS, the impact would be significant.

Donald Harley: You may already know this, but a not insignificant proportion of doctors are EU graduates. Scotland already struggles to recruit and retain enough doctors overall to meet the operational commitments that we set. In the worst-case scenario, if we were to lose EU graduates, we would have another significant hole in the medical cover that we provide in Scotland. Obviously, we all hope that that is not going to happen, but there is no certainty of that. We hear many anecdotes about people making arrangements to look for employment elsewhere in the EU rather than take a chance that there will be an appropriate settlement here, because something adverse may happen.

Ros Shaw: I agree. We cannot afford to lose EU nursing staff, either. We have a significant number of vacancies at the moment. At the end of December, we had 1,800 hospital vacancies and more than 600 community nursing vacancies just in the NHS. I appreciate that the discussion is about the NHS, but the situation is even worse in the independent sector, which relies heavily on EU nationals.

Matt McLaughlin: Constant constitutional confusion does not help anyone, particularly people who need a bit of confidence that, if they come here to work, they can stay here and invest in their futures. The issue goes beyond professional grades. In many areas, support staff are heavily made up of EU colleagues and colleagues from further afield. It would be really helpful if we could get beyond the constitutional

spin and into the delivery of service. Stuff like workforce planning will help.

Clare Haughey: I want to ask briefly about iMatter, which has replaced the annual staff survey. What are your comments on iMatter and how effective it has been? What has been your experience of it?

The Convener: Please be brief.

Matt McLaughlin: I will be dead brief. If people act on what they are told, it will be a raging success; if they do what they did with the existing staff survey, which was to completely ignore it, it will just be the same again.

Ros Shaw: The new approach has the potential to be really helpful, because it drills down to the team level. As Matt McLaughlin says, provided that people get the opportunity and space to work in their team and put an action plan in place, it could have a lot of influence.

Donald Harley: As Ros Shaw says, there is a real gain in employee engagement at team, department and board levels and in driving local solutions. The slight concern is that the new system does not cover all the areas that the old staff survey covered. I understand that the plan is to have flash surveys to cover issues such as how grievances or concerns about discrimination are dealt with. It is important that those flash surveys take place and that there is no gap in what we ask the workforce.

Overall, a lot of work needs to be done to get more people to engage. For example, my rough calculations show that only 25 per cent of doctors completed the survey. That is a relatively low figure, and it might reflect a degree of cynicism about how valuable the process is. I guess that, if people see the same figures year after year and action does not generate significant improvements in areas of concern, it becomes a harder sell to get people to take part.

11:45

Claire Pullar: Our members think that iMatter is useful, but people must be allowed to ring fence time for it, otherwise it is just more paperwork for people and they do not matter—only the paperwork matters. We need to think about why we are asking people to take part, why we are saying that it matters and why it is important. Staff must have time to prioritise iMatter, and they are allowed to prioritise it.

The Convener: I have a specific question on junior doctor hours for Donald Harley. A few years ago, Dr Lauren Connelly tragically died following an extended period of consecutive long shifts. After that, there were supposed to be changes to rotas for junior doctors and the like. The BMA has raised the issue of protection for junior doctors for whistleblowing, and it might want to raise the issue of extended periods of long shifts that leave them extremely tired. Some of them also have to travel long distances to their work, and we saw the tragic consequences of that in the case of Dr Connelly.

Has the situation changed? Is the position for junior doctors better in relation to not just the official hours that the rota says that they work but the actual hours that they work? If junior doctors in Scotland do not have the same protection as they have in England, what negotiations with the Scottish Government is the BMA involved in to advance the position so that they have protection on issues that, in many ways, are a matter of life and death?

Donald Harley: It is a complicated issue. The Scottish Government has taken action to address the concerns that we and Dr Connelly's father raised. Because of the tragic circumstances of that case, there has been a degree of emotion and sensitivity around the matter and the things that are being done are not necessarily what would have the best impact on junior doctors' quality of life. The number of days that a junior doctor works back to back is one issue that has been tackled, but we must consider the whole arrangement for employing juniors. For example, we could limit the number of such days, but that might mean that a junior doctor gets only one weekend away in a month because they end up covering alternate weekends in a complex shift pattern, meaning that their quality of life and family connections deteriorate.

Ultimately, when we seek to improve the arrangements, there must be some flexing of all those things. In the aftermath of the Connelly tragedy, there was a rush to do something rather than a decision to take a holistic approach to a constrained solution. We encourage the Scottish Government to have further dialogue with the Scottish junior doctors committee.

The Convener: Is the system better, the same or worse?

Donald Harley: It is better, but there is more to do.

The Convener: Are there negotiations on the legal protection for whistleblowers in Scotland that your submission says is missing?

Donald Harley: I understand that NES was not receptive to that suggestion.

The Convener: I thank the witnesses for their evidence and suspend the meeting briefly to allow them to leave.

11:49

Meeting suspended.

11:51

On resuming—

Subordinate Legislation

National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2017 (SSI 2017/134)

National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2017 (SSI 2017/135)

The Convener: Agenda item 3 is subordinate legislation. We have two instruments that are subject to negative procedure to consider. Both instruments were considered last week, and the committee agreed to defer consideration so that a letter could be issued to the Scottish Government seeking clarification on the reason for and the impact of the delay in the uprating for the assessment of resources and the sums for personal requirements. We have received a response from the Scottish Government.

The first instrument for consideration is the National Assistance (Assessment of Resources) Amendment (Scotland) Regulations 2017. No motion to annul the instrument has been lodged, and the Delegated Powers and Law Reform Committee has not made any comment on the instrument.

I want to raise one issue. As the Government's response does not make it clear what the financial implications of the delay in implementing the regulations will be for individuals, it would be appropriate to ask the Cabinet Secretary for Health and Sport about that when she comes before us, in order to find that out.

Do members have any other comments?

Alison Johnstone: I would appreciate that action, convener. I understand that the delay was because of on-going discussions with the Convention of Scottish Local Authorities, and I am interested in knowing the date on which COSLA wrote to all the local authorities. Perhaps we could air those issues with the cabinet secretary.

The Convener: We certainly should.

The second instrument for consideration is the National Assistance (Sums for Personal Requirements) (Scotland) Regulations 2017. Again, no motion to annul has been lodged and the Delegated Powers and Law Reform Committee has not made any comment on the instrument.

I see that no member wants to comment on the instrument.

As agreed at a previous meeting, we now move into private session to consider the remaining agenda items.

11:53

Meeting continued in private until 12:16.

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